Focus: Scotland, Wales and Northern Ireland

Standards open up border crossing

Wales makes pragmatic progress

Healthcare delivery and academia join forces
Words from the BCS Health Informatics Forum vice chair

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Our report ‘The Way Forward for NHS Informatics’ (see www.bcs.org/hif/cfreport) continues to attract considerable interest, and the BCS Health Informatics Forum (HIF) Strategic Panel will finalise the work plan to follow it up at the next Forum meeting in July. Within NHS Connecting for Health (CFH), review and change have continued at all levels. The Parliamentary Public Accounts Committee review of NHS CFH (see www.publications.parliament.uk/pa/cm200607/cmselect/cmpubacc/390/39002.htm) was published in April, and echoed many of the conclusions of our report.

Our activities led to the BCS President Nigel Shadbolt being invited to an event hosted by the secretary of state for health Patricia Hewitt that also included included the NHS CEO and leaders from NHS CFH and their major contracted suppliers. Concerns about communications and incentivising the take-up of NHS CFH applications by the NHS figured prominently in the discussions.

During the event it was indicated that NHS CFH would like to work cooperatively with the BCS on an agreed set of specific activities to help improve the programme, an invitation that we shall be taking up.

The English electronic patient record

This is among the most controversial elements of the NHS CFH strategy, and is attracting much attention inside and outside NHS CFH. BCSHIF responded to the Health Select Committee of the House of Commons enquiry into ‘The Electronic Patient Record and its use’, and this and the many other written responses and oral evidence can be seen at www.publications.parliament.uk/pa/cm/cmhealth.htm#evid

The committee has been sufficiently roused by what it has heard and read to schedule two additional hearings, and may arrange more. Audiovisual recordings of the hearings are available for 28 days after each event, and can be at found on its website.

Late last year we decided to organise two workshops on the electronic patient record, the first in Glasgow in February and the second in March at Portmeirion in north Wales. These proved both extremely lively and interesting, and this issue contains a summary of the events and how we plan to follow them up. Many of the same themes were apparent at a workshop run by the Worshipful Company of Information Technologists on electronic patient data integrity and privacy that I attended on behalf of BCSHIF. A report of the event will be published.

By the time this issue of Health Informatics Now appears, BCSHIF will also have attended a meeting run by the Wellcome Trust to consider ‘The use of electronic patient records for research and health benefit’.

Some of those who attended HC2007 will remember questions raised during one of the panel sessions about the scalability of some of the technology on which NHS CFH relies. An external proposal to investigate the generic issues involved in more detail is currently being considered by BCSHIF and other experts within BCS.

BCSHIF Health Informatics Ethics handbook

Stocks of this popular publication, the first of its kind, have almost run out, so we are taking this opportunity to rewrite it with the support of the Canadian informatics community. Jean Roberts will lead the work. We will seek help from the BCS Ethics Forum, as well as ensuring that the output accords with the revised ethical code produced by the Royal Academy of Engineering. The International Medical Informatics Association (IMIA) has agreed in principle to adopt it as a global policy.

UKCHIP

Congratulations to the UK Council for Health Informatics Professions (UKCHIP), which recently registered its thousandth IT practitioner. UKCHIP is currently refreshing its strategy, and relationships have been established with the BCS professionalism programme, acknowledged as a world leader in the field.

ASSIST

The ASSIST / NHS CFH annual conference in Leeds was as well attended as ever, and delegates heard about the progress of NHS CFH, the NHS Information Centre and the work of the NHS Institute for Innovation and Improvement.

The ASSIST AGM was as usual held on the same day, and was notable for reaffirming the merger of ASSIST and the BCS, and selecting Brian Derry, director of informatics, Leeds Teaching Hospitals NHS Trust, as ASSIST’s new chairman. We are delighted to welcome Brian onto the BCSHIF Strategic Panel.
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New website to support patient choice

A new website, NHS Choices, will go live this summer with the aim of the public and clinicians being able to access a range of NHS service information through one gateway.

The website will include: searchable comprehensive directories; comparative data on hospital waiting times, cleanliness and readmission rates; medical literature on treatments; and guides on the most common procedures.

It is part of a package unveiled by health secretary Patricia Hewitt to help patients in disadvantaged communities. Another initiative is piloting library schemes in 10 areas with specially trained librarians to help patients to choose and book.

Other products will include audio programmes for streaming to local radio stations, television content to burn onto DVDs, and pamphlets to print off at public libraries or the GP surgery.

Pick up your prescription, prompts voicemail

It will soon be possible for pharmacists to leave an automatically-generated voicemail for patients to collect prescriptions via Message Dynamics' new system. The company has reached a heads of agreement to integrate its technology with Cegedim Rx's Pharmacy Manager and Nexphase.

Pharmacies are already using text messaging to contact patients but voicemail will allow them to reach the over-65s who often do not own mobile phones.

NHS Direct handles 1,000s of polonium enquiries

The NHS Direct helpline handled 3,791 calls about polonium between 24 November and 18 December 2006. Following the death of Russian, Alexander Litvinenko, the website had 44,204 visits to its health alerts, news and radiation on polonium, which equalled 4 per cent of overall visits.

PAC recommends urgent action on NPfIT

Urgent remedial high-level action is needed for the National Programme for IT (NPfIT) if the long-term interests of NHS patients and taxpayers are to be protected, according to the Commons Public Accounts Committee (PAC). A report by PAC printed on 26 March stated that the Department of Health needed to address the conclusions and recommendations made in the document.

PAC is appointed by the House of Commons to examine the accounts showing the appropriation of the sums granted by parliament to meet the public expenditure.

The overall report conclusions were:

- The shared electronic clinical record is already two years behind schedule. No firm plans have been published for deploying software to achieve it.
- Suppliers are struggling to deliver, and the programme is unlikely to be completed anywhere near its original schedule.
- There is still much to do to win hearts and minds in the NHS, especially among clinicians. The programme needs to deliver on its promises, supply solutions that are fit for purpose, learn from its mistakes, respond constructively to feedback and win the respect of a highly skilled and independently minded workforce.
- There is still uncertainty about the costs and value of the benefits that the programme should achieve.
- The report calls on the Department of Health to: publish an annual statement outlining the costs and benefits; commission and publish an independent review of the business case; and review local service providers' (LSP) performance against their contractual obligations.

The chair of the PAC Edward Leigh said the programme, if successfully delivered, still offered huge benefits, but warned that if it fails ‘it could set back IT developments in the NHS for years’.

The report can be found at: www.publications.parliament.uk/pa/cm200607/cmselect/cmpubacc/390/390.pdf

Telecare spreads its reach

Telecare is moving towards wider spread adoption due to a range of recent moves.

Health secretary Patricia Hewitt announced on 23 May that new sites that will use hi-tech home healthcare to help older people and those with long-term conditions, such as heart disease, to lead more independent lives and help prevent emergency hospital admissions. Teams in Kent, Newham and Cornwall have been awarded £12 million to look at how best telecare services can be implemented.

A month previously, science minister Malcolm Wicks proposed to the House of Commons science and technology committee to track the movement of the elderly with satellite technology. He told the BBC that this could enable them to lead fuller lives, freedom to roam, and reassure their families.

Meanwhile, remote monitoring of patients with chronic heart failure has been shown to be effective by a review published in the BMJ. The review demonstrated that tele-monitoring reduced admissions to hospital for chronic heart failure, cut deaths by all causes by nearly one fifth and improved health related quality of life.
Consultation blamed for records delays

The overrunning of the consultation schedule was responsible for the delay to the electronic patient record in the view of Richard Granger, according to e-Health Insider. This was reportedly the crux of his argument in giving oral evidence to the House of Commons Health Select Committee as part of their investigations. This followed the report from the Public Accounts Committee on the National Programme for IT (NPfIT).

He reportedly said that the majority of the programme would still be delivered by 2010, with the spine central infrastructure due to be released by this time next year.

He said that the main problem is finding a pathway between two extremes – waiting patients and privacy fascists.

He labelled medical consensus on the national programme as oxymoronic and said that the challenges were because of the ‘tribal nature of medical practice meaning different stances and postures’.

In a later session, Dr Paul Cundy, chair of the General Practitioner’s Joint IT Committee, Dr Martyn Thomas, representing the UK Computing Research Committee and Andrew Hawker, a former system developer, reportedly dismissed Granger’s comments and called for an independent hearing into NPfIT.

When asked if he felt an independent review was necessary, Granger reportedly said: ‘Are the people calling for it themselves independent? We have a programme under immense scrutiny, and the minister took a decision last year that such a review was not necessary.’

The hearing received 68 pieces of written evidence. See: www.publications.parliament.uk/pa/cm200607/cmselect/cmhealth/422/422we01.htm

London’s configuration to stand apart

BT, the local service provider (LSP) for London, is to deliver a configuration of Cerner Millennium for London that differs from that provided for NHS Trusts across the South of England, according to a report by e-Health Insider.

The software will not be altered, e-Health Insider understands, but a different configuration will lead to the system having different features.

BT’s decision is reportedly due to problems with Millennium procured from LSP Fujitsu at the five initial NHS sites in the South of England.

79 staff at Milton Keynes had earlier signed a letter recommending that no other Trust take Millennium until problems were resolved as they believed it was not yet ‘fit for purpose’.

The majority of GPs are against sharing records

Only one in three GPs intend to advise patients to allow their medical records to be shared using the NHS Summary Care Record, according to a survey by Pulse magazine.

The majority of respondents believed that sharing records threatened patient confidentiality.

Survey highlights patient safety as main concern

Implementing technology to reduce medical errors and promote patient safety is the most important priority for a group of CIOs surveyed in the USA. Asked to identify their top five priorities, 54 per cent of 360 IT respondents in the HIMSS Leadership Survey picked the above.

The other top five priorities were: replacing or upgrading inpatient clinical systems (identified by 48 percent of respondents); implementing an electronic medical record (48 per cent); business continuity/disaster recover (35 per cent) and integrating systems in a multi-vendor environment (34 per cent).

Furthermore, 18 per cent of respondents indicated that their organisation has experienced a security breach in the past six months. The survey is at: www.himss.org/2007Survey

UKCHIP Register reaches one thousand members

The 1,000th person has joined the UK Council for Health Informatics Professionals Register. It is a register of health informaticians who voluntarily apply and have been assessed as fit to practice in informatics to support health.

Samaritans receives accolade for email service

The email service of Samaritans, which provides confidential emotional support, has landed the charity a special award.

The email service was hailed for making a difference by the judges at the annual national eWell-Being Awards, which identify and recognise projects that use ICT to deliver social, economic and environmental benefits.

First introduced in 1994 and funded by The Vodafone UK Foundation, the email service was substantially developed in 2003. In 2005, samaritans received 154,000 emails.
Linking up to break down boundaries

The electronic patient record, the issue exercising many in healthcare, was the subject of many presentations at this year's Healthcare Computing conference. This article by Helen Boddy focuses on the health record, as well as interoperability, another recurring theme at the conference.

A reassuring note for health informaticians was sounded at the start of the HC 2007 conference: Lord Hunt, minister of state for quality, Department of Health, emphasised the importance he attaches to the role of IT to the healthcare arena in his keynote speech.

'As minister for quality, the number one issue is raising the bar for quality of care, and using IT as much as possible to do that... There's no question in my mind that we need to develop our systems.' he said. Lord Hunt had only taken up the post ten weeks earlier, although it is an area with which he is familiar from his previous appointment as a parliamentary under secretary of state with the Department of Health between 1999 and 2003. He resigned from the post in protest over Iraq.

A host of topics were covered in the five streams at the three-day conference, run by BCS Health Informatics Forum (BCSHIF). These included UK-wide national programmes, understanding healthcare, professionalism, clinical systems, user needs and systems requirements.

BCSHIF members presented a large number of the papers and chaired many sessions.

Alongside the conference, the British Journal of Healthcare Computing and Information Management ran an exhibition with more than 100 exhibitors. As well as demonstrations of technology on fairly conventional stands, visitors were able to climb aboard a bus, and visit a virtual patient's clinic.

England's National Programme for IT (NPfIT) was mentioned in many of the presentations. Topics addressed included progress made, lessons learnt, next steps, centralisation versus localisation, interoperability, and issues in moving towards an electronic patient record – from policy and strategy to practical tips from those implementing systems.

Delegates also heard presentations on the different approaches being adopted in Scotland and Wales and their experiences of introducing electronic patient records (see following articles).

NPfIT goes local

In his speech, Lord Hunt admitted that NPfIT to date had not always gone smoothly, partly due to its centralised nature.

'I think the national approach to the programme was the only way to have achieved change with any scale at all,' he said. ‘We have now made sufficient progress to change the focus to local ownership.’ This was the reasoning behind the recent creation of the NHS Local Ownership Programme (NLOP).

A less centralised approach to NPfIT was backed by other speakers at the conference. Prof Colin Tully, one of the gang of 23 academics who proposed a technical review of NPfIT, described the programme as ‘too big, too fast and no one knows where it is going.’ He proposed devolving it to its lowest level.

Lord Hunt also admitted that trying to do too much too quickly had caused some of the problems associated with NPfIT, a view echoed by other speakers at the conference. Ian Herbert, vice president of BCSHIF, commented that NPfIT is trying to overcome some problems that were in the NHS before the advent of NPfIT, such as patient record control. ‘They [Connecting for Health] are hitting rocks because they

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are going so fast,' he said. The speed of the letting of the first contracts has also resulted, according to Phil Sissons of Magic Consulting, in suppliers being confused as to what they had agreed to deliver.

Lord Hunt was at pains to stress that progress had been made, most recently with the GP2GP record transfer and the trials of the Summary Care Record. The Croydon PCT had started using the GP2GP system a few weeks earlier. 'By 2008, we expect it to be available to 45 million patients,' he said. 'Given that 3.5 million patients change GP each year, an extraordinary mobility of patients, this scheme will mean that instead of records taking an average of six weeks to be transferred, they will be there for the GP to see at the patient’s first appointment. This issue of slowness of transfer of records has been a historic problem and now we have a chance to tackle it.'

Complexity of electronic records

Lord Hunt admitted, however, that the electronic health record has been less of a success story. 'The national Summary Care Record containing the clinical record has been delayed by around two years against the original plan,' he said. 'There are all sorts of reasons for this. It is partly due to its complexity, partly because of the need for consensus on its contents, and partly because of patient confidentiality.' He admitted that in the past too much had tried to be done too quickly, and that the pace would therefore now be moderated. Efforts would now focus on: electronic prescriptions; electronic prescribing; Acute Trust Patient Administration Systems (PAS); and integrating primary and secondary care.

He highlighted that security of the electronic patient record was an important issue, and that care must be taken to address public concerns. In a session devoted to the personal health record, Murray Bywater, director of Silicon Bridge Research, commented that the ambitious nature of the electronic health record should not be underestimated. 'No other country has one for more than 4 or 5 million patients, and the largest successful scheme is the Veterans Association in the US with 6-7 million. Even they, when pressed, admit that although they are identical systems, they are implemented differently.'

'Scalability, complexity and availability have to be looked at for the technical platform [for the electronic health record]. Something may work at the GP level but it’s more difficult when scaled up.'

Phil Sissons, however, was of the opinion that, given that England’s GP electronic health record is the ‘best in the world’, Trusts ought to be brought up to a par with them, after which the systems can be joined together.

This was all too much too quickly, however, for several speakers who suggested taking a step back to first define the electronic health record so that ‘we know when we have one, and more generally to decide exactly what the programme should be delivering’.

Ian Herbert suggested the problem was more fundamental still: ‘NPfIT is a misnomer. There is no such thing as an IT project, merely business projects enabled by IT. Colin Tully agreed that the way forward has to be as a business change programme.

Given that Ian views NPfIT as being about business change, he identified another problem: insufficient funding has been allocated to training staff. ‘So far NPfIT is under spent, but we still need more money than allocated when you take into account the training needed to accompany a business change programme.’

Generally speakers considered the success of the programme crucial to the provision of high quality care and were keen to participate in resolving the complex outstanding issues to ensure this success. This was highlighted by Sheila Bullas. She described how the Princess Alexandra Hospital, in common with others, had started and stopped procurements as new national strategies came along ‘suffering from planning blight’ and ‘always at the end of the list to get systems’. As a result the hospital desperately needed the programme to succeed.

‘We now need an open discussion about the way forward,’ advocated Dr Manpreet Pujara, a GP in Rochester, and chair of the EMIS National User Group. Much could be achieved through more communication involving all healthcare stakeholders, including health informaticians.

Interoperability counts

Interoperability is going to play a big part in ensuring future success of systems, suggested speakers. Various technical solutions relating to different interoperability scenarios were presented at the conference, as well as more theoretical points being presented. A demonstration of the Connectathon was run throughout the event by Integrating the Healthcare Enterprise, an international organisation that is concerned with the communication of information between medical devices and clinicians.

Semantic web fits with health

Joining up information got a mention very early on in the conference when BCS President Nigel Shadbolt gave a keynote speech on the semantic web, which has the potential to help join up certain pieces of information.

‘With the semantic web, we can
build services so that the patient record is generated automatically from other patient information. Health informatics is about core content issues, and the semantic web is right up its street because it is, for instance, about equipping content with rich metadata and ontologies.

‘In health informatics you’ve been organising terminologies already, via for example SNOMED CT. The difference with the semantic web is that the interoperability exists on the web.’

One of the driving features of using the semantic web is being able to track how information is changing, he explained.

Half way on user interfaces

One interoperable solution that is closer to being ready to use is the Common User Interface, as Andrew Kirby of Microsoft Solutions explained at the conference. The Common User Interface is aimed at clinicians who often use systems supplied by different vendors to do the same task, and waste time learning and remembering how to use the different desktop interfaces. Connecting for Health has therefore tasked Microsoft Services to come up with a toolkit that will help ensure that all vendors create similar desktop applications – the Common User Interface. The four-year project is now half way through, and 40 of the proposed user interface guidelines have now been developed.

Telehealth guidelines

Guidelines for interoperable telehealth are also in the process of being developed. One presentation focused on the work to join up telehealth by the international Continua Health Alliance, a collaboration between more than 100 companies including medical device manufacturers, technical companies, drug companies and healthcare providers. Continua is selecting devices that are interoperable – the sensors, connectivity and computation products – and is joining them up.

It aims to enable some healthcare, such as for chronic diseases, to move out of the hospital and into the home via personal telehealth, explained David Whitlinger, president of the Continua Health Alliance, and director of healthcare device standards and interoperability of Intel Corporation.

Uses of joined-up telehealth solutions could include monitoring the elderly with results from sensors, on toothbrushes, and pill minders, for example, fed back to loved ones to check their behaviour was normal. If not, sensors could be linked into a system that would raise alarms.

David said that Continua expects to publish guidelines on which products are interoperable by the end of the year, and give them certification and logos.

On questioning, David admitted that telehealth is still expensive, but he expected that there would be a scale advantage when more of these products are adopted. He further said that studies show that quality of healthcare is better from telehealth compared to being in hospital.

If a patient is sent home to conduct self-monitoring, for instance for chronic diseases, the hospital is no longer paid for that patient, and it comes under the remit of social care, pointed out Kevin Dean in a presentation about emerging technologies. There is a risk that such organisational issues constrain progress.

He believed that there are still few really connected health applications, despite all the talk of eHealth. He highlighted the Map of Medicine (which details 370 care journeys for clinicians so that they can refer to best practice) as being the first time that an application joins up primary, secondary and tertiary care.

Non-technical considerations

Furthermore, according to Kevin, interoperability is not just about technical developments. There are some huge non-technical questions such as:

- How do we make sure content is safe?
- Who’s going to design the systems?
- Who’s in control of them?

Ian Herbert also identified some non-technical interoperability issues regarding the electronic health record. ‘There are questions of who owns the record and what information should be shared,’ he said. His point was emphasised in an ‘Understanding Healthcare’ session at the conference when a hospital consultant commented that it wasn’t helpful to him to receive 40 years worth of notes on a patient; he much preferred a concise summary of the current problem from a GP.

But will GPs even be around to see interoperability of the patient record? Kevin suggested that that in 10-15 years there maybe won’t be enough doctors to see all their patients, so we will receive automated healthcare. Furthermore, it is possible that virtual worlds such as Second Life could maybe provide some sort of answer, he said.

‘Compared to what Lord Hunt said about not going too fast too quickly, it’s a very different world,’ Kevin said ‘We need to keep up.’ Read Lord Hunt’s speech at: www.dh.gov.uk/en/News/Speeches/DH_073343

HC2007 conference proceedings

The HC2007 conference proceedings contain 22 papers and 16 posters covering a wide range of contemporary health informatics topics addressed during the conference. Also included is a copy of the BCS report ‘The Way Forward’. Copies of the conference proceedings are available in book form (£20) and CD-ROM (£7) including p&p from:

HC2007 Conference Secretariat
Amicus Conferences
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DH_073343
Blurring health data widens sharing options

Being able to share health records is not just about passing patient details between clinicians who deal with the same patient; the data is also valuable for research and analysis. Rob Navarro of Sapior explained at the BCShif meeting in April how his company is looking at blurring health records so that data can be used by a wider community. Helen Boddy reports.

To predict the most likely reasons for emergency service call-outs, reliable data sets of health problems need to be analysed. To do so, it is not necessary to know the details of individual patients’ illnesses, as long as they can be grouped together.

There are various other scenarios where government, research institutes, commercial developers of healthcare products and other bodies could use health data to improve healthcare services through research and analysis.

‘There is quite a lot of value in health data,’ said Rob. ‘There are a lot of new applications to analyse data patterns. Pharmaceutical companies want to see if their drugs make a difference. There is also an emerging trend to develop preventative medical reminders, for instance for families disposed to certain hereditary health conditions.’

Sapior has therefore developed a way of blurring health records data that would make individual patient record data unidentifiable so that it can be released to a wide set of government agencies and commercial bodies. The important thing is that it is not possible to deduce or infer from this data anything about an individual patient, while keeping it meaningful in terms of being able to distinguish, for example, geographical patterns.

Rob made it very clear that what Sapior is looking at is not aimed at clinical use of data where NHS staff need to be able to see details about the patient sitting in front of them. In that case blurring of data would not be appropriate. For staff looking at actual patient data, he suggested instead that details would be kept secure by role- and time-based control of who could access the system, encryption and audit logs, and surveillance of which data is accessed and for what it is used.

When data is to be made available to a wider community, there is no need for it to include patient-identifiable data. Rob explained, however, that simply pseudonymising data was not secure enough as ‘inference’ could be used to work out patient details by linking some information to other known information, such as details publicly available on the electoral roll. Inference attacking was publicly demonstrated in August 2006 when pseudonymised search records were released by AOL only to then be identified by journalists using these methods.

‘Inference attacks are the biggest weakness,’ explained Rob. ‘For example, if you know when someone has visited a doctor, you can work out which record must belong to that person if no-one else has visited the same variety of healthcare providers on exactly the same sequence of days. It is our thesis that if we deal with inference attacks we can open up the data to a wider group.’

Sapior has therefore developed a solution in which similar values in all fields are grouped and then blurred to make each record non-unique. The technology radically extends ‘k-anonymity’. The idea is that at least ‘k’ records are made the same with just one identifying field being different.

K is derived from the risk of illicit re-identification associated with the user of the data – the greater the risk, the bigger the k, and the more blurred the data is that they receive. Therefore the riskier the recipient, the more blurred the data would be that they receive.

‘If records are ambiguous we can stop inference attacks from happening,’ claimed Rob.

Sapior is running a trial of its system this year with a commercial company and is looking to run a trial with an NHS body (the Information Centre for Health & Social Care, for example). Anyone interested should contact Robert.Navarro@sapior.com.
The number’s up

The way forward for the ongoing work on electronic health records was put under the microscope at a recent BCS Health Informatics Forum (BCSHIF) workshop. Peter Murray, founding fellow and director of the Centre for Health Informatics Research and Development (CHIRAD), provides a round-up of the wide-ranging discussions.

‘I am not a number, I am a free man. I will not be pushed, filed, stamped, indexed, briefed, debriefed or numbered.’

This is one of the most famous quotes from the 1960s TV series ‘The Prisoner’. Portmeirion in Wales, where the series was filmed, was an ironic (or iconic) setting for the second of two workshops on health records, given what we in the UK, along with many other countries, seem to be trying to achieve in terms of numbering, indexing, filing, and so on of many elements from our health records.

This article provides my initial reflection on the workshop proceedings and pulls out what I think were some of the interesting issues.

The two recent workshops in Glasgow and at Portmeirion brought together BCS Health Informatics Forum (HIF) members, clinicians (GPs, hospital doctors and nurses), academics, health records managers, and others. All four home countries were represented at the events, plus wider European participation from Norway and The Netherlands.

The events were held in Wales and Scotland to emphasise that BCS is a UK-wide organisation, and try to avoid the narrow thinking of NHS Connecting for Health’s English approach. Discussions started by sharing an understanding of what is meant by electronic health, medical and patient records, ongoing work, and their implications.

The further aims were to identify the major issues to address, for the UK and international interest, and what needed to be done. We also wanted, as Sheila Bullas, one of the workshop leaders emphasised, to get away from a navel-gazing discussion about the past, avoid ‘motherhood and apple pie’ statements and engage in some critical thinking about the way forward.

A wide range of issues emerged, and there were differing views on the priorities for addressing them. The Glasgow event highlighted many issues specific to Scotland, and the Scottish Executive’s different approach. While the Welsh event did not focus as heavily on Welsh issues, it was clear that for many of our Welsh colleagues, the best approach would be very different from that of Connecting for Health.

Interoperability required

Many technical issues emerged, as did the need for systems to support interoperability, especially across borders, and long-term access to records in the event of system changes. However, I want to highlight more of the cultural and organisational issues.

Issues of access to records, including who should have access and for what purposes, issues of cultural change and the impact of electronic records on professional practices were discussed, along with the implications of telehealth and other future developments on the nature and use of electronic records. The participants saw the development of electronic records not only from technical viewpoints, or from their own professional backgrounds, but explored many of the wider implications.

Discussions included the changing role of the patient and their expectations, the implications of demographic change and the possible creation, or reinforcement, of digital exclusion and disadvantage, and the need to move to a real health service, rather than simply a crisis-response illness service.

The integration of paper and electronic records and the necessary migration from legacy systems generated much discussion, especially at the Scottish workshop. Patients currently have multiple paper records held in many different locations by different health professionals, and often for differing purposes. Is it then adequate to scan paper records into an electronic record and call them electronic? There are many issues around the structure and coding of such input, around how the information is translated into an identifiable format, and about future access.

The practical and philosophical issues of a move to integrate all of these into possibly one lifelong electronic record have, it was felt, been vastly underestimated, and the idea of ‘one patient, one record’ is probably unsustainable. This seems to have been recognised in the Scottish Executive’s ‘Delivering for Health’ strategy, which seeks to move towards different models of care delivery (‘away from reactive, crisis management, acute-orientated care towards anticipatory, preventative and continuous care’) and for a comprehensive set of information and communication systems built around the electronic health record. The strategy explicitly states that ‘patients will have access to their own electronic health record’.

Patients at the centre

Moves towards more patient-centredness and greater collaboration, in both healthcare delivery and so, of necessity, health records, were seen as inevitable. As more patients use a wider range of healthcare services, we will need to explore the nature of the ‘healthcare team’ and who has
legitimate access to the record(s).
Should local pharmacists have access, should homeopathy practitioners?
Should they have access to other parts of the record? The rights and obligations of a wide range of stakeholders will need to be explored alongside the role of the patient in determining rights.

Will politicians be brave enough to vest ownership, and control of access to the record primarily with the patient? Irrespective of how far along this road we go, there was a view that the patient will be central to consent and control perhaps in a ‘primus inter pares’ (first among equals) role. However, with the variety of records that exist we cannot adopt a ‘one size fits all’ approach to future health records.

We have legislation on the ownership of the record, but this was felt to be flawed, as might be the whole question of ‘ownership’. Participants were keen to see work undertaken to deconstruct the issue of ‘ownership’ of records, explore whether it is a useful concept, and whether a better set of discussions might be around who has rights of access to the record and who holds copies of it; even whether ‘the record’ might be viewed differently, as it is often a composite of different things from different sources.

There were unsurprisingly different views of what ‘the record’ is: each a version of the truth from a different perspective; each setting the boundary in a different place. Work to address shared understandings will be vital; structure of records is good, context may be even more important.

**Collection criteria**

Records contain data collected at specific times, and, in developing any records architecture, thought must be given as to determining what data to collect – and to store long-term – with a view to what might be needed or relevant in the future. This is particularly relevant when those contributing to the record are not necessarily those who use it, with the result that much that is implicit must be explicitly recorded.

The current digital recording of clinical measurement and images results in an explosion of data which will require additional tools for visualisation. It was felt that there is not sufficient understanding of this issue and that a computer science perspective is required.

There was concern about whether current developments, based on today’s or even yesterday’s technologies, take sufficient account of technology developments we already know of or can predict. In the future, will we need large, industrial-modelled electronic records, or should we look towards smaller, decentralised and patient-specific databases? What are implications when ‘you are your own record’ through the use of wearable and implantable devices and personal area networks? Will we need to start again and spend another £12 billion for the NHS to catch up with the technology that the rest of the world will be using? Does the information ‘pull’ approach epitomised by browsing others’ records (or a single centralised one) replace the ‘push’ approach (represented by encounter messages, referral requests and discharge messages), or is it just an adjunct to it?

**‘As more patients use a wider range of healthcare services, we will need to explore the nature of the ‘healthcare team’ and who has legitimate access to the record(s).’**

We considered what sort of society we wanted and recalled the warning of information commissioner Richard Thomas that the UK could ‘sleepwalk into a surveillance society’ as a result of collecting more and more information about people that is accessible to many people and shared across many boundaries; just what should shared health and care records aim to do?

This report provides the merest taster of the breadth and depth of discussions. So, where do we go from here? An action plan is being developed. BCShIF can, and will, play a major role.

Given the scope of the actions, many other organisations will need to be involved as well. Much of the work might only be possible through the national organisations responsible for implementing electronic health records, and cannot be undertaken alone by volunteers within a charitable organisation such as the BCS.
Wales pursues pragmatic progress

Wales is approaching its IT strategy, Informing Healthcare, in its own quiet and unassuming way, says Dr Robin Mann MBCh BMBCS. Here, he reviews the progress and plans of the devolved Welsh initiative, which includes the introduction of the individual health record.

‘What about Wales?’ ‘Wales? That’s in the south-west isn’t it?’

When I overheard that conversation about five years ago, shortly before NPHIT and way before I was seconded into the Informing Healthcare Strategy Implementation Programme (IHC), I was left with a strange feeling of disquiet. Of course, I am sure they did not really think that Wales was part of Cornwall, rather assumed that Wales’ IT strategy was somehow linked to south-west England’s electronic patient record procurement, but nevertheless it was another example of Wales being regarded as the backwater of the UK.

Wales has a completely devolved national health service, which is only dependent on Whitehall for its allocation of UK funds. Devolution means that Wales’ priorities are different from England’s and this has resulted in areas where care is better: for example, figures extracted from the Cancer Information System Cymru (CanISC) have shown that Wales has the best lung cancer outcomes in the UK. The data that demonstrated this was so much more complete than that from England that the figures were initially assumed to be a mistake.

I have not heard anyone say that we ‘should be doing the same as England’ for ages. Whilst media and political interest across Offa’s Dyke have reached unprecedented levels for health informatics, Wales continues in its own quiet and unassuming way, making incremental and pragmatic progress at a pace many would regard as remarkable.

The Informing Healthcare strategy was only published in 2002 (four years after Information for Health) but Wales now has more than one tenth of its population served by the first increment of the ‘Individual Health Record’ (IHR) – a health record containing the information, considered by clinicians to be the most important for the overall care of the individual – available in ‘out of hours’ centres throughout the south-east of Wales.

‘IHC’s clinical design function bridges the gap by gathering the raw requirements from clinicians and creating a coherent and above all safe design.’

The initial deployment was started on schedule and within budget, and when complete one third of the overall population of Wales will have individual health records. The information governance model has been developed with the BMA (the chair of the Ethics Committee is on the group) and other professional and local bodies. The challenging informatics issues associated with the integration of data from different source systems have largely been resolved, and ‘highly sensitive’ data has remained firmly in the hands of the people the public trust the most – the GPs.

Yes, that feeling of unease has been completely replaced by a quiet confidence that the theory that IT can improve services and enable safer patient care is not only true, but can be delivered.

Last September the Informing Healthcare programme put itself through a public international peer review. Leading figures from healthcare informatics in Holland, Denmark, New Zealand, Scotland, Finland, Canada and England were invited to critique Wales’ approach. The encouraging results of this review, although published, were never reported by the likes of e-Health Insider or Private Eye.

Our confidence is largely due to Gwyn Thomas (previous CEO of the NHSIA and UKCHIP board member), who became the IHC programme director in 2004. Gwyn’s quiet unassuming style, complemented by superior leadership and influencing skills, has established relationships and built trust. The effect has rippled down through the programme to the staff, who are in no small part responsible for our achievements.

This extends not only to those that work within IHC headquarters, but to all in the health informatics profession in Wales including the clinical, technical and project management staff distributed across the principality.

IHC has made efforts to link with local organisations by funding project managers and support staff in every hospital Trust. IHC has directly engaged with many other clinical and technical staff who have contributed to the programme with full support of their employing organisations.

From the start, Informing Healthcare has focused on service improvement: it has invested in building relationships with stakeholders,
education and training, professional development improving access to the knowledge base, project management and organisation preparedness as much as the development of new IT services. As a result, duplicate patient IDs in electronic systems have been reduced from 4.6 per cent to 1.4 per cent, 15 per cent of the workforce have registered on ECDL courses, the NHS e-library has doubled in size and the NHS has agreed an approach to developing a national technical architecture, where the agreed position is to do things 'in common' unless there are clear benefits from doing things differently.

Local input sought

Informing Healthcare has actively supported local innovation and, through its service improvement projects, IHC has learned: how a simple colour coding of ward patient lists can reduce average length of in-patient stay by two days; how to get electronic discharge summaries to GPs; which information the public regard as really sensitive; what information is needed to support unscheduled care and which online health services patients really want. This learning is now being channelled into three main development areas:

- The Individual Health Record will be extended across Wales in out-of-hours care settings and further development will see it introduced into other unscheduled care settings.
- Patient access to services will be developed further with projects to enable citizens of Wales to book GP appointments and order repeat prescriptions online. Access to services will develop incrementally until citizens are able to access their own Individual Health Record.
- The Welsh Clinical Portal will become the first major component of the new national architecture. Wales has a strong history of in-house development and organisations have agreed to release staff to help develop the new portal. It is being designed through a ‘user-centred design’ approach, with front line staff from organisations across the country being involved directly through design workshops. This is a striking example of the patient-care centred approach that IHC is taking.

The other unusual aspect of the IHC approach is that of clinical design (okay, I admit that I am slightly biased in this area): where clinical designers intercept and interpret user requirements before they are handed to technical developers. When there is no clinical design, technical solutions are likely to be very specific to specific user groups.

This is great in the specialty context but the solutions inevitably become silos of information that cannot support the patient journey through a modern healthcare environment with multidisciplinary teams and care networks. Healthcare is complex and individual users rarely have a complete grasp of all areas. Likewise, technical analysts rarely have a complete understanding of the whole of healthcare, which is so important in developing national information services.

IHC’s clinical design function bridges the gap by gathering the raw requirements from clinicians and creating a coherent and above all safe design, represented in semi formal models that technical developers can work to. This approach is proving to be very positive: the design for the Welsh Clinical Portal has been widely approved by doctors, nurses, pharmacists and other healthcare professionals. The first version of the portal, with functionality to request tests and view existing records will be deployed in two hospitals before the end of 2007.

So is this side of the valley really this green? There are of course great challenges still to come – anyone who claims this is easy is either ignorant or trying to sell you something. But Wales is the country of myth and legend. Which of these will health informatics in Wales turn out to be? Time will tell, but I’ve already decided: it will be legendary.

Robin Mann is head of clinical design for Informing Healthcare. He stopped practicing medicine in 2001 when he established, and then managed, the health informatics unit at the Royal College of Physicians of London. He was seconded to the Welsh Assembly Government to work with IHC in 2004 and took up substantive employment in 2005. He is on the UKCHIP’s Education, Training and Development committee and became a BCS member in 2006.
Health delivery and academia join forces

Assistive technology and smart home technology are important subjects for healthcare delivery and academia in Northern Ireland. They are just one area among the many current projects and initiatives described by Paul McCullagh of the University of Ulster and Paul Comac of the HSC ICT Training Group.

As in other parts of the UK, the area of ICT in healthcare delivery is undergoing significant change in Northern Ireland.

On 9 March 2005, the Minister for Health, Social Services and Public Safety Angela Smith launched a 10-year development programme, backed by an additional investment of at least £95 million, with the intention of delivering new systems and technology across the Health & Social Care Service (HSC).

The programme’s aims, which mirror other regions of the UK, include:

- new computer systems to link GPs to hospitals;
- electronic health care records, appointment details and up-to-date information to be available when and where it is needed and with more emphasis on quality healthcare;
- patients to have more information about the care being planned for them and that patients should not have to wait as long for appointments, tests, diagnosis or other treatment.

Projects include GP ICT connecting all GP surgeries to the HSC network for secure internet access, email and the roll out of electronic transfer of pathology results from laboratory systems to all practices.

A second project is the Health and Care Number, replacing numerous hospital numbers with a new unique patient identifier. Electronic registration at GP surgeries, GP systems, PAS systems will all utilise this number.

Thirdly, the Person Centred Community Information System (PCIS) aims to establish a single integrated community health and social care record for all patients and clients in respect of community based services. In4tek’s PARIS system is the preferred option based on experience gleaned by the South East Belfast Trust.

An Electronic Prescribing and Eligibility System (EPES) will also be developed, installed and supported. The contract, worth £6.8 million over five years (awarded to Hewlett-Packard) will involve all community pharmacists within 24 months. A 2-d bar code on GP prescriptions containing all of the information on the prescription will then be read in to pharmacy systems, and information will then be transferred electronically to the Central Services Agency for checking and payment purposes. The project will reduce error, provide greater efficiency, reduce fraud and provide accurate prescribing rate statistics.

A GP Payments Calculation and Analysis System (PCAS) was implemented in March 2005. Disease prevalence statistics were calculated by using data provided from each GP system and the PCAS system was used to calculate the number of quality points due to each GP practice under the new contract.

A cervical screening system (using the Exeter System) for the purposes of
call and recall was introduced, with the aim of electronic transfer of cervical screening data to practices. Phase two will replace the cellular pathology systems with a standard system already operating in the Belfast Link Laboratories and will deliver a complete, integrated, regional cellular pathology record. 

An Electronic Referral Management System (ERMS) aims to reform outpatient services and is designed to reduce waiting times for treatment.

In addition to the upgraded ICT infrastructure, there has been major organisational restructuring as a result of a review of public administration resulting in: one regional health and social services authority to manage performance; seven primary care-led commissioning groups; and five health trusts (instead of the previous 18) providing the services.

Links with other groups

Health informatics interests are coordinated through the BCS Health Informatics Forum. There are also strong links with the Healthcare Informatics Society of Ireland, with many research papers presented at this forum. A number of high-profile international and knowledge transfer meetings with a health informatics theme have been organised in the last few years including: European Society for Engineering and Medicine (Belfast, May 2001), third European Workshop on Personalised Health, (Belfast Dec 04), International Conference on Smart Homes Technology (Belfast, June 06).

In December 2004, The Ulster Institute of eHealth (Ulster eHealth) was launched. This is a forum to promote collaboration between academics at the University of Ulster and professions allied to health at Ulster Community & Hospitals Trust (now South Eastern Trust).

The Ulster eHealth website provides information to the citizen on treatments associated with pain and for the better control of type 2 diabetes, to promote breastfeeding, and manage strokes.

The Queen’s University Belfast hosts a healthcare informatics research group. Research topics include: digital microscopy and machine vision in cancer diagnosis and prognosis; signal processing and compression in medical imaging; surgical informatics; information and communications technology in primary care; decision support systems in clinical decision making; telemedicine.

The HSC ICT Training Group provides a seminar programme for dissemination of important health informatics advances to the local sector by local, national and international speakers. Areas of interest include: telemedicine, and store and forward referrals; ICT in health and social care; hospital information systems; general practitioner systems; assistive technology, home monitoring and smart homes; chronic health management for conditions such as diabetes and coronary heart disease; data mining and decision support; eHealth and information to the patient; nursing informatics; and health informatics education.

‘The objective is to research and prototype a portable, easily configurable device that is available to those people with memory lapses and other symptoms of dementia and associated disorders.’

The seminar programme provides synchronous video-conferencing to outlying hospitals, and provides a link between academia and practice. Dr Victor Patterson, a consultant neurologist at the Royal Victoria Hospital and co-editor of ‘Introduction to Telemedicine (second edition)’, routinely performs teleneurology as part of his clinical practice.

An area which is important to healthcare delivery and academia is the introduction of assistive technology and smart home technology. University of Ulster in collaboration with Dundalk’s Institute of Technology have contributed to the design of a 12-unit housing pilot in Dundalk, to be ready for occupation in 2007. The ‘Nestling’ project was so-named to convey the concept of having technology unobtrusively ‘nestled’ into the homes and devices, even the fabrics, that people wear.

The South Eastern Trust has commissioned smart home technology from Tunstall to provide support for chronic patients and has teamed up with Nestling to provide cross border collaboration in this area.

The University of Ulster has been awarded funding of over £250,000 to carry out multi-disciplinary research in a new European funded project called CogKnow. The project is focused on helping to address some of the problems faced by ageing people with early signs of mild dementia.

The three-year project involves 11 partners with a range of scientific and medical expertise from across Europe, including organisations from Estonia, Malta, Scandinavia, Spain, France and Netherlands. The project is aimed at helping people to remember, maintain social contact, perform daily life activities and enhance their feelings of safety.

The objective is to research and prototype a portable, easily configurable device that is available to those people with memory lapses and other symptoms of dementia and associated disorders.

A further project, Di@l-log, allows doctors to monitor and track diabetes patients from home using intelligent spoken dialogue technologies which can relay patient data directly to the clinic through telephone conversations. This is about to proceed to a clinical trial.

References can be found on the BCS website: www.bcs.org/hinow
Standards open up border crossing

England and Scotland are sharing information in some instances but they are still few and far between, according to Ken Robertson, clinical lead for IM&T in Scotland. He gave a presentation at HC2007 on where Scotland and England are already collaborating, future prospects and the necessity of standards. Helen Boddy reports.

‘The reality is that there is very little information being shared at the moment,’ said Ken Robertson. Even in Scotland, which is a small place, passing information across boundaries of the different stakeholders is a complex business. Ken explained that Scotland has Community Health Partnerships (CHPs) and within each of those there are several GP practices. CHPs have boundaries, which often overlap. Health boards have several CHPs and several boards constitute a region, of which there are three.

At the moment Ken believes UK collaboration is an uneven game ‘with the English elephant sitting on the blind Scottish mouse’. Nevertheless he believes progress is being made.

The bottom line needed for information sharing has changed little, according to Ken, since he spoke at the same conference in 2005, when his list of the bottom line for data sharing was:

- GP records;
- Prescriptions;
- Data sets for:
  - benchmarking;
  - clinical governance;
  - WHO and other government purposes.

‘Prescriptions are one of the currencies of the health service and it would be nice if patients were able to encash prescriptions wherever in the UK they were given them,’ he elaborated. ‘And we also need to be able to exchange information to cover benchmarking and clinical governance (which of course is very much to the fore).’

Ken added one more point – allergies and updates – to his 2005 list as that is ‘now very much in the landscape’.

The extent to which information is shared between England and Scotland varies. On demographics, Scotland has an agreement in principle with NHS Connecting for Health that English patients can use their NHS number in Scotland and Scottish patients, the equivalent CHI number in England. There is no duplication because of the way the numbers are allocated.

‘However, that is as far as it goes,’ said Ken. ‘Scotland is under some pressure to consider the use of the Spine service again, which may have considerable advantage, but the devil will be the detail, as they say.’

In Scottish general practice, GPEX has in the past allowed an exchange of an extract of information from one practice to another, according to Ken. The GP2GP system has now been used a little in Scotland and he expects it to increase.

Scotland has just completed a pilot of the Document Scanning System (Docman) Transfer, which allows the exchange of scanned documents (bitmap images). ‘In the past there has been a lot of talk about data exchange but perhaps we should start with information exchange for care and then move onto data exchange, he said.

As the Requirement for Accreditation (RFA) process has been scrapped, Scotland uses an advanced functionality programme to keep suppliers up to speed with what is considered important, for example contributions to the Emergency Care Summary. Through the Scottish Care Information (SCI) Gateway (a national system that integrates primary and secondary care systems using familiar and highly secure internet technology) there are still exchanges across borders from Dumfries to Carlisle, which Ken rates as ‘going fairly well’.

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The Scottish way of joining up community and GP information systems is through procurement of the Information for Primary and Community Care (IPACC) system. At the moment procurement is being scoped to allow real collaboration between community and GP systems.

‘The Emergency Care Summary has been rolled out across the country and now Connecting for Health is copying us,’ said Ken. It contains certain drugs, repeat prescriptions and allergies and contact details. It works on the consent model – implied consent for extraction of information from general practice but explicit at time of access, unless the patient is unconscious, and that is
heavily audited. ‘I think that less than 100 out of 5 million patients have opted out of it,’ said Ken when questioned.

Moving onto the impact of the business model and payment by results, Ken claimed it is not helping collaboration because of putting too much emphasis on bean counting. From a clinical perspective, the lack of clarity around what is happening with the care record service makes it difficult for us to collaborate properly.

In terms of drugs, Scotland like England has been piloting electronic transfer of prescriptions (ETP) and hospital electronic prescribing and medicine administration (HEPMA) systems. Scotland is in the process of refining requirements for HEPMA and will go the market for a pan-Scotland HEPMA system. Scotland is also procuring a system to support chemotherapy.

‘I know these are being paralleled south of the border but there isn’t really any great effort to align that work, Ken said. ‘But we are aligned on the Dictionary of Medicines and Devices.’

On clinical data standards, Ken said that Scotland has 45 clinical standards, which are extensive, and a health and social care dictionary with more than 3000 items.

Scotland is represented on the NHS Information Standards Board, but much of its work is around messaging and high level auditing, which Ken described as ‘depressing’.

Scotland has been cited in the development of the common user interface. ‘This is interesting, exciting and essential but we shall have to wait and see what emerges from it,’ said Ken.

The major Scottish vehicle for delivering clinical information standards is the generic clinical systems toolset. Scotland now has live substantiations for cancer and mental health.

Perhaps the biggest change in terms of standards in the NHS, according to Ken, is the realisation that concentration just on SNOMED CT is not enough.

‘The interest in HL7-CDA’ [Health Level Seven Clinical Document Architecture] is encouraging because it does look as though we are going to pay some attention to the rich information that we have and if we can file it in such a way that it is at least reusable it and shareable,’ he said. ‘I think there is real scope for collaboration across the UK in this area’

HL7 is one of several Standards Developing Organizations accredited by American National Standards Institute (ANSI) that operate in the healthcare arena.

On SNOMED CT Ken hoped that something would happen to solve implementation issues. ‘At some point we are actually going to decide we are going to eat this elephant because we have to convert, especially in primary care, a huge amount of data, and that’s not going to be a small task,’ he said.

In conclusion, Ken said: ‘I think it is abundantly clear that we are not going to have the same systems, but we might have some the same. We will therefore be dependent on standards. I think there is no doubt that we could collaborate better across the UK, but the hard bit is that a great deal of common sense is required to do so.

‘I think that it’s time that the clinical community takes ownership of this problem. I genuinely don’t believe that the technical architects can help us unless we give them a clear steer of what we need. In this regard, I think there is a clear role for the professional bodies who will also be involved in helping to mandate standards.’
Knowledge shared is knowledge doubled

Improving eHealth knowledge can release precious clinician time, ultimately improving patient care. NHS Education for Scotland is therefore setting up an eHealth knowledge sharing tool for NMAHPs in the form of an e-Library. Kathy Dallest and Ann Wales from NHS Education of Scotland explain.

The sharing of information surrounding the actual benefits of eHealth is patchy and rarely managed by nurses, midwives and allied health professions (NMAHP). This often leads to inadequately defined requirements for eHealth systems and the consequent lack of uptake by NMAHPs.

Yet real and tangible involvement of informed frontline healthcare practitioners in the specification, design and implementation of health ICT systems has been called for in the recent Audit Scotland report, ‘Informed to Care’, and various others.

To address the critical gap in awareness and information sharing, the Knowledge Services Group within NHS Education for Scotland has been commissioned by the Scottish Executive Health Department to deliver solutions to facilitate development of an NMAHP eHealth Managed Knowledge Network (MKN). A dedicated special e-Library (or portal) will be created within the NHS Scotland e-Library (www.elib.scot.nhs.uk), incorporating communication, information resource management and retrieval functionality.

Knowledge is shared, created and accessed in order to facilitate development of an eHealth environment where knowledge, experience and information can be exchanged, created and accessed in order to support NMAHPs at various levels of interaction within the eHealth domain. The goal of the project is to embed these aspects of quality information management and informatics practice into NMAHP clinical and professional practice.

The objectives of the project are to support clinical engagement necessary to realise the benefits offered by the eHealth strategy and its programmes; to actively facilitate learning, development and sharing of information and best practice, including use of communication functionality on the e-Library; to manage the information resources used by the communities of practice; to identify and provide access to the existing knowledge base on NMAHP eHealth; and to develop and create new information resources.

**Network and communication**

Some early network members are clinical leaders, influential in national and local strategic business and development plans. Some have a specific eHealth job within information or IM&T departments and directly support system implementation. Others are clinical practitioners who regularly use technology. The network also supports practitioners new to eHealth/informatics. The 105-member network collectively manages its information resources, communicating through the Shared Space (URL at end and see screenshot opposite).

NMAHP eHealth is home to six discrete communities of practice and project groups, one of which is the NMAHP eHealth leads. Each nurse and AHP director from every NHS board in Scotland (14 of them) has sponsored a lead for eHealth in each of acute nursing, midwifery, the allied health professions and primary and community care and mental health areas. These people support Heather Strachan, the eHealth lead for NMAHPs within SEHD, to deliver a portfolio of projects aimed at maximising benefits offered by the National eHealth Programme. Communication within this community is multidirectional and transcends organisational and role boundaries.

The NMAHP eHealth special e-Library, which incorporates and builds on the existing Shared Space, will be a dedicated portal that provides focused and targeted information resources specific to the needs of the MKN. It will provide access to all the e-Library services, such as NHS Scotland fulltext online journals (over 5,000),

**Purpose and objectives**

Essentially this is a change management project which aims to create an environment where knowledge, experience and information can be shared, created and accessed in order to support NMAHPs at various levels of interaction within the eHealth domain. The goal of the project is to embed these aspects of quality information management and informatics practice into NMAHP clinical and professional practice.

This project builds upon the existing NMAHP eHealth ‘Shared Space’, a collaborative workspace employing electronic communication and information resource management tools. Building upon previous lessons learned, this project is an extension of eHealth knowledge management (KM) across all NMAHP disciplines, and is designed to facilitate engagement and leadership development.

Blended methodologies from the clinical, education, business, health informatics and KM domains are being employed. Improving knowledge and understanding and focusing on the benefits of eHealth can release precious clinician time to deliver positive outcomes for practitioners. Ultimately this improves the patient experience, quality of care and increases patient safety. This project offers substantial benefits through sustainability, and the methodology will be transferable to other settings and professional groups. It is an important step towards supporting all clinicians involved in eHealth.
focused implementation plan for the MKN. Evaluations so far have been positive.

Additionally an online questionnaire gathers information on relevant content such as journals and other published sources as well as information seeking behaviours. Another will gather self assessment data about KM competencies. This will be fed back to the participants and also informs the MKN’s future plans.

A robust communication plan ensures communications reach the community that the project needs to engage via: a leaflet; messages at all CPD activities at key events; a conference poster for the NHS Scotland event; a bi-monthly electronic newsletter; and a communications pack for the MKN launch in November.

Membership of the Shared Space, since its introduction to the NMAHP eHealth community in October 2006, has increased to 105. The number of visitors increased month-on-month to 185 in March. Activity rose to 4,365 hits in March, with visits to more areas of the site. Resources are now being added by the membership and knowledge exchange through discussion is increasing.

The Shared Space is growing organically with members contributing bibliographic databases and other information resources. Additionally, information relevant to this domain will be filtered and organised in ways that help NMAHPs find what they are looking for; such as via appropriate subject headings. Federated search technology will be used to retrieve information from remote sources, and further functionality will be developed.

The project team is currently undertaking an information and knowledge audit with key stakeholders, analysing information flows, sources, needs, user characteristics and gaps. The audit also includes a KM competency training needs analysis. This will inform the technical specification and information content for the special e-Library and future plans.

Given the short timeframe, and the demands on clinical resource, a novel approach to requirements gathering for the portal construction has been taken. The project team is delivering a KM CPD package that maps to the Knowledge and Skills Framework (KSF) Information and Knowledge Dimensions 1 and 3 at Level 4. The data and information outputs of the various learning exercises within the package are being analysed to inform the specification for the portal, and develop a KM strategy and outcome-to the knowledge base. The facilitator adds relevant news, resources and discussion topics. There is realistic optimism that this will be a collaborative and knowledge sharing tool with the development of the special e-Library – to be launched on 6 November at the Scottish Clinical Information Management in Practice (SCIMP) conference.

Getting involved is easy and anyone with an interest can join the NMAHP eHealth Shared Space at: www.elib.scot.nhs.uk/SharedSpace/nmahp/Pages/login.aspx

Kathy Dallest is a nurse informatician and presently MKN facilitator, Knowledge Services Group, and Ann Wales is programme director for knowledge management.

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NMAHP eHealth Shared Space homepage
Are we nearly there yet?

ICT bringing services closer to the patient is what modernisation should be about, believes Keith Clough. In this article, he takes a look at lessons from the past and considers whether we are any closer now to the destination.

‘Are we nearly there yet?’ is the question often asked by the smaller passengers on the back seat of the car. They probably have only a vague idea of the intended destination and had no (or very limited) input to its choice. They were probably given no option as to whether they wanted to go on the journey and may even have had other things that they would have preferred to do. However, based on past experience, they probably have confidence that the driver knows where they are going and how to get there. They may have concerns that the driver does not usually welcome advice (or even stop to re-visit the map) when lost.

Do you see any similarities in respect of the current plans for IT in the NHS in England? Do we hear clinicians (and some managers) asking the question ‘Are we nearly there, yet?’ What about their confidence based on past experience?

What’s changed in 20 years?

Many of us who were working in NHS computing 20 years ago thought then that we were nearly there. Most hospitals had some computer systems working and nearly all GP surgeries were computerised. The only thing needed – we thought – was for these systems to communicate with each other. Once that had been achieved, a number of other things would be possible, including changes to the way healthcare was delivered and where it was provided. The ‘C’ was to be the most important letter in ICT.

Where did we get it wrong? A few of you may remember that in the late 1980s, the NHS had 14 regional health authorities (RHA) in England. Each RHA had a regional computing unit (RCU) with at least 100 staff – some had more than 200. Each RCU had a capability to write, run and install computer applications – such as PAS, pathology, child health and financial systems. Furthermore, some regions wrote and even ran applications for other regions.

We worked as though there was a ‘national’ health service. We even worked closely with our colleagues in Wales, Scotland and Northern Ireland and with those employed by the Department of Health.

Our shared wisdom at the time – based on some successes (and a few failures) – had reached several ‘conclusions’.

Here, in no particular order, are 12 of them:

- The most important issue is implementation since it involves many, already over-worked individuals from a number of different professions (and possibly different organisations).
- The rate of implementation roll-out is more dependent on the health authority’s willingness and capability than to any capital budget constraints.
- Maintaining the interest and enthusiasm of users is vital for a successful implementation.
- The importance of the procurement process is often overrated. Many health authorities got good results from poor systems and some got poor results from good systems. The local implementation is the most important factor.
- It is extremely difficult and usually very costly to anglicise an application written for the American market.
- When offered a ‘working’ system, insist on trying it yourself – demonstrations are easy to fake.
Most staff at the Department of Health have a very limited knowledge of how the NHS is managed and how healthcare is delivered. The power of the medical mafia should not be underestimated. There is often more than one and each has its own agenda.

If it ain’t broke, don’t try to fix it.

Are any of these conclusions still valid today? If so, are they recognised as constraints by those in the driving seat? As far as I can remember, the needs of the patient and their lay carers was not a prime consideration.

As we were working for RHAs, we had only a limited knowledge of what was happening in the computerisation of primary care or, to be more accurate, GP surgeries. Only later, when I became involved in telemedicine, did I realise the communications gulf between those working in the primary care sector and those working in secondary care.

In my view, ICT starts to make a real impact on modernising healthcare delivery when patient information is transmitted rather than, for example, the patient having to visit or stay in the hospital for tests. Any subsequent necessary treatment can then often be administered at the surgery or even in the patient’s home. There are already many examples of ICT being used in this modernisation process bringing services closer to the patient. Unfortunately these techniques, although demonstrated locally, have not been widely implemented as they are thought to be post-NPfIT.

Hence, the answer to the original question must be an emphatic ‘no’. But then, because of medical developments and changes in how healthcare is provided, the destination is not fixed and the answer will always be no.

However, it may be possible to reduce the journey time – especially if we can cut out some of the detours which provide little or no benefit to patients or clinicians. Is it time to re-visit the map, review the destination and even get the views of the clinicians and patients?

Keith Clough is co-ordinator of The e-Health Innovation and Professionals Group and treasurer and deputy chairman of the BCS Health Informatics Interactive Care specialist group.

Glyn Hayes receives special accolade

The outstanding contribution to health informatics by Glyn Hayes, chair of BCS Health of Informatics Forum (BCSHIF), was recognised with a special award at this year’s Healthcare Computing (HC2007) conference.

‘Glyn has been a major influence in looking at GP computing in the UK,’ said Prof Stephen Kay, chairman of the HC conference programme committee.

‘The award is in recognition of his lifelong achievement in health informatics, his sustained leadership in the discipline and his promotion of professional standards.’

From early in his career as a GP in the 1970s, Glyn became involved in the development of GP systems. He was also a founder member of the BCS Primary Health Care Specialist Group, was later chair and is now its president. He is also president of UK Council for Health Informatics Profession, and is on the executive and programme committee for HC.

Ian Herbert, vice president of BCSHIF received the award on behalf of Glyn, who was not able to attend the conference because of ill health. ‘This place [HC] is not the same without Glyn,’ said Ian. ‘I know he will be very pleased to receive this honour.’
SCOTLAND SPECIALIST GROUP

Meet the Specialist Groups

Scotland

Specialist groups are the grass roots of BCSHIF. Introducing the work of a group is a regular feature in ‘Health Informatics Now’. This article focuses on the work and activities of the BCS Health Informatics (Scotland) Group (HIS), written by its chair Charles Doherty.

BCS HIS is a multi-professional group that aims to promote the development and use of health informatics in Scotland to support effective, evidence based, efficient health and social care. This is intended to benefit the health of individuals, communities, and populations that receive health and social care and the staff and organisations that deliver these services.

The group is a long-standing member of the BCS Health Informatics Forum (BCSHIF) but became dormant when its most active member and leader, Ray Jones, left Scotland for warmer climes (Plymouth). In 2003, spurred by BCSHIF chair, Glyn Hayes, a group met with the aim of re-establishing the BCS Health Informatics presence in Scotland. This group gained the support of stalwarts of the health informatics scene in Scotland such as John Brydon, Derek Hoy, Sue Kinn, and Kathy Dallest and was led by Heather Strachan.

After some hard work re-writing the constitution and terms of reference, successfully organising meetings and disseminating information about the group, the corner has been turned and the membership is again beginning to grow: it currently stands at 222. The committee has now been reconstituted and poised to build on a solid foundation.

Objectives

Firstly, the group aims to represent Scotland’s health informatics community on national and international groups to promote and influence the development and direction of health informatics. We already have representation in many important organisations and fora in Scotland, the UK and beyond. We are thus in a good position to achieve our second and third objectives – to promote the sharing of good practice across our constituency, the Scottish health informatics community, agencies and organisations; and to provide a Scottish health informatics perspective within Scottish and UK developments in health and social care.

Finally, we aspire to act as a consultation mechanism for relevant national and international projects, policies and standards on health informatics and to initiate health informatics projects with appropriate partners. This is beginning to happen, but we have yet to fulfill this objective to our potential.

Activities

These are geared towards our aims and objectives, and revolve around meetings, communications and conference organisation to promote health informatics nationally. For each of the past three years, we have organised a national health informatics conference. The issues around sharing information from these strikingly different paradigms led to an interesting and lively debate.

Our latest conference, eBrochan in November 2006, in collaboration with BSC HI (Nursing) specialist group again was excellent, our best yet, and attracted over 70 delegates. The full conference report is in the March edition of Health Informatics Now. Our profile as a group and our reputation for being able to network and organise nationally important conferences is at an all-time high.

In the forthcoming year our national conference is on November 23, again in Glasgow Caledonian University. The focus is as yet undecided, but there are enough exciting developments to create a diverse and interesting programme. Watch this space. We also plan to test demand for more frequent small-scale events, and, for the first time, we aim to organise a session at HC2008.

Our website is now in expert hands and we look forward to developments, perhaps moving towards a site with more of a community network philosophy rather than the current static web pages. This interactive mechanism could better serve the needs of our growing membership who currently only receive periodic newsletters and email bulletins as issues arise. Being more responsive to our membership’s needs and to engage them in the organisation and running of the group is a challenge to all specialist groups as we are run on a voluntary basis. The mechanisms for doing this as yet are not entirely clear, but we are working on it.
Who’s who on the committee

Chair, Dr Charles Docherty

Charles is a senior lecturer in practice-based learning at Glasgow Caledonian University. He teaches eHealth to pre- and post-graduate students and for two years has organised and delivered a health informatics elective for nursing PhD students in Jordan. He represents his university on the International Medical Informatics Association, the BCS nursing specialist group on Connecting for Health’s national advisory group, and is an organising committee member of the Association of Common European Nursing Diagnoses, Interventions and Outcomes. He represents BCS HIS on the National eHealth NMAHP clinical leads group in Scotland. His PhD is in the educational use of multimedia.

Vice chair, Lachlan MacPherson

Lachlan is a capacity planning manager in a remote and rural health board in the Western Isles. He has responsibility for emergency planning and medical rewards. His background is in electronic engineering and he has an MSc in Operational Research.

Treasurer, Dr Sue Kinn

Sue is currently a civil servant, working in the Department for International Development where she manages a programme of research in health and education in developing countries. Previously Sue was a health services researcher with interests in the involvement of patients and members of the public in health research, public health and health informatics. Sue has also worked in the NHS in clinical audit and as a computer specialist. Sue originally trained as a cell biologist and worked as a laboratory researcher for several years.

Co-treasurer, Fiona Black

Fiona has worked for NHS National Services Scotland Information Services Division (ISD) for six years, in a variety of information development roles. She is currently information governance development manager for ISD’s information governance programme. She has an MSc in health informatics.

Secretary, Praveena Oliphant

Praveena is currently the patient information manager, Cancer and Palliative Care Information Service at Dykebar Hospital in Paisley.

Webmaster, Kathryn Trinder

Kathy is a learning technologist at Glasgow Caledonian University. She has an MSc in eLearning, and is currently a lecturer and research fellow in e-learning with the Caledonian Academy.

Committee members

Derek Hoy is a research fellow in the Research Centre for Nursing, Midwifery and Community Health, Glasgow Caledonian University. Derek’s recent projects have included WISECARE, networking oncology nurses round Europe, knowledge mapping and topic mapping systems for NHS Scotland; and Community Information Standards work for NHS Scotland. He currently represents BCS HIS on Scottish Clinical Information Management in Practice (SCIMP).

Kerr Donaldson is project manager, Scottish Social Care Data Standards Project. Wendy Dungavel is an eHealth trainer at Beatson Oncology Centre, Glasgow. Raymond Duffy is a lecturer with degrees in biology, health promotion and education. He works at the University of Paisley, where his main role is in delivering post registration education. Specialising in online learning as an e-tutor for a gerontological nursing programme, he has been involved in writing and editing support materials for modules and courses designed to be delivered online.

Co-opted members:

- Colin Brown, SCIMP
- Moira McLaughlin, EHRIM
- Sharon Levy, RCN
- Heather Strachan

Heather recently stepped down as chair of BCS HIS but retains a co-opted position on the group to provide a direct link with the Scottish Executive Health Department as the eHealth lead for nursing, midwifery and allied health professions. Heather’s various previous posts have involved management, practice development, research and healthcare governance. She is an honorary member of the International Medical Informatics Association special interest group on nursing informatics.
Clinical decision support systems which will advise clinicians on providing the best treatment for patients are slated to be introduced in the UK in 2009-2010. A talk by Dr François Dupuits from the Netherlands to the Northern Specialist Group highlighted useful lessons from a county where they are already in use, writes the group’s chair Tom Sharpe, based on a meeting report by Phil Paterson.

Clinical decision support systems (CDSS) provide direct advice and assistance to clinicians to help them provide the best treatment for patients. Leading experts have presented cogent arguments for their introduction. Up to 97,000 deaths per year were attributed to medical errors in the US, according to Professor John Fox who gave a previous talk to this group. Dr Jeremy Rogers estimated that only 70 per cent of acute patients received appropriate treatment. Professor Alan Rector said that the complexity and rate of growth of medical knowledge is such that (evidence-based) medicine is now a ‘humanly impossible task’.

CDSS could make a real impact in helping to address these issues. Professor Fox showed how the efficacy of a decision support system intervention compared favourably with that of a powerful prescription drug.

CDSS were included as a part of phase 3 of the National Programme for IT and slated for introduction as early as 2009-2010. Although there is a strong research base in the UK, the theory and transfer into practice of CDSS are notoriously difficult areas, and it will be interesting to see how much can be up and running in that sort of timescale. Meanwhile, it is useful to see what we can learn from experience with practical use of CDSS in other countries.

Lessons from The Netherlands

Dr François Dupuits is a researcher with over 20 years’ experience in medical decision support in the Department of Family Medicine at Maastricht.
University in The Netherlands. After presenting a paper at HC2007, Dr Dupuits agreed to come to Manchester and talk about his experiences to the Northern SG before returning to the Netherlands. The rest of this article highlights some of the points raised in his talk and the ensuing discussion.

CDSS support humans in making a choice – the user often has to give additional information to the decision support system and make a choice from the resultant options offered. They are different both from information systems (which present data) and from expert systems (which offer a ‘best’ solution but do not provide interaction).

There are two types of CDSS – passive and active. Passive CDSS merely present relevant knowledge to the user. Active CDSS combine data input by the user with knowledge built into the system to come up with an overview of possible decisions for the user to select from.

The three fundamental components of CDSS are: the data base, the knowledge base and the dialogue and management software. The database contains patient details. The knowledge base contains the standards and guidelines. The dialogue and management software guides the process of selecting decision options for consideration and then presenting these options to the user.

An innovative phased development method was used to create applications at Maastricht. Careful evaluation of these systems was carried out at all stages of development. Although several applications including a number of CDSS have been developed, there was only time for Dr Dupuits to cover two of them in his talk.

The BODE and eXPert system is based on six clinically-oriented information sheets related to a patient, covering signs/symptoms, physical examination, diagnoses, known diseases, medication and medical test requests. Dr Dupuits showed examples of these information sheets and described how they are used in practice.

The aim of the ‘Quality of Life’ (QoL) system is to advise adults concerning their quality of life and way of living. It can be used not only by patients but also by carers, helping them make the right decisions on the care they should provide to their patients. It can also be used to enable researchers to study the quality of life of these adults and the impacts of diseases on this quality.

Discussion

One of the problems of CDSS in general practice in the UK is that there isn’t time for a busy GP to use them. This is related to the problem of using a keyboard to enter data into a computer. It is possible that the amount of input can be reduced by careful structuring of questions, and alternatives to the keyboard can be found.

CDSS must be safe. In one year’s time the Maastricht team expect to have a system that will present tests and drugs and available standards and will advise on their use. All the positives are included now, which filter out ‘rubbish’, but not yet the warnings – these will come later in a separate part of the system.

Another known problem is that CDSS don’t work very well when you try to introduce them more widely, or transfer them from one geographical region to another. The Maastricht system is already in use throughout one province, and it has been successfully transferred to another province, so this need not always be true.

Knowledge has to be kept up-to-date and be continuously monitored. In the Maastricht project, this is done by a Quality Circle, a panel of experts on a topic like diabetes which meets regularly (referring to a larger panel where necessary) and produces monthly updates to the knowledge base. In the UK, the data collected in the NHS Care Records Service could be of immense value in building or validating knowledge bases, but human expertise will still be required.

Conclusions

CDSS can provide many benefits. The work in The Netherlands has shown improved correctness, better diagnoses, and a growing effect on medical practice. CDSS can also result in cost savings as health professionals work more to standards and more rational decision making, avoiding unnecessary tests.

There are a few caveats. CDSS are only successful when users are involved in their life cycle. They should only be used as a tool in supporting decision making; users appreciate the freedom to follow or reject the advice given. The underlying knowledge base must be capable of being continuously updated, and the decision-making process must be open to inspection. Although the systems discussed are essentially stand-alone, integration with medical information systems is preferable in time.

No doubt we shall be seeing a lot more of them in the future.
The BCS HI (Northern) Group arranges an eclectic programme of lectures each year, covering different disciplines with speakers from widely differing backgrounds. The audiences are correspondingly varied in terms of both the types of people who attend and the numbers. In this article, Phil Paterson and Tom Sharpe of the group give an overview of the talks that related to the National Programme for IT.

The most popular meetings over the last three years have undoubtedly been those related to the National Programme for IT (NPfIT) in the NHS, where our speakers have presented very well-informed and interesting talks from a range of different viewpoints.

Not too surprisingly, most speakers on NPfIT ask for confidentiality within the audience, which allows them to air their views and answer questions openly in a non-threatening, neutral, professional environment which benefits the speakers and the questioners in the audience. The downside of this is that we cannot give much post-event publicity to who said what in case their position is compromised as a result.

Conversely, our speakers in the less ‘political’ areas of health informatics are usually delighted to get extra publicity through vehicles such as Health Informatics Now, which allows us to contribute to the magazine on a regular basis. In this issue we are focusing on decision support in medicine but, lest we forget, I would like to highlight the fascinating talks we have enjoyed on NPfIT so far in 2006-7.

We started off in October with an irreverent talk from industry expert Phil Sissons on ‘Things you didn’t want to know about NPfIT’, which examined some of the options and choices – right and wrong – that were made in the early days of the programme. This was quickly followed in November by Paul Charnley, regional implementation director for the North West and West Midlands cluster, enlightening us on how things are going in our region and how key issues are being addressed.

Moving into 2007, in February we heard all about the PACS success story from Dr Rhidian Bramley, consultant radiologist and national clinical advisor to the PACS Programme and in March we heard the ‘clinicians’ view’ of the national programme from Professor Mike Pringle, a national clinical lead for GPs, with emphasis on the Summary Care Record and clinical governance arrangements.

In between, we had organised a session at the Healthcare Computing 2007 conference in Harrogate at which Jeremy Nettle, the new chair of the Intellect Healthcare Council, presented the IT industry’s response to the impact of NPfIT on the market, bringing out some of the issues involved and summarising current progress before reflecting on Intellect’s response to the government’s Health Select Committee. The theme that came over was that in the eyes of the suppliers the national programme is maturing and the mood is positive.

By the time Health Informatics Now is printed, we will have had our last NPfIT meeting of the academic year. Andrew Spence, healthcare strategy director at CSC, local service provider (LSP) for three of the five clusters is due to describe how the role of the LSP has evolved over the last three years and how it might continue to evolve in the future, how the LSPs add value and how CSC approaches the delivery and support tasks.

As mentioned previously, we can’t go into details of the content of the talks, but the overall message has been pretty upbeat. Whilst there is always going to be a certain amount of positive spin on the delivery of NPfIT, in our opinion the fact that insiders are prepared to put their heads above the parapet and speak openly about the issues involved is significant in itself. It says a lot more both about the state of the Programme and the relationship between NHS Connecting for Health and the BCS than some of the more negative messages that have been sent out recently.

Where else but the BCS can people get such a breadth of vision of how IT is developing in the NHS and speak without fear or restriction to some of the top movers and shakers who are influencing progress from their different positions? The only way to catch those off-the-record remarks and get the inside story is to come along to our meetings.
Forthcoming events

June

ASSIST North West Branch
PACS site visit, preceded by AGM
20 June. 2.30-5pm
Countess of Chester Hospital, Chester
http://northwest.assist.org.uk

ASSIST West Midlands Branch
27 June 2007. 10am-3pm
Branch AGM and Microsoft – common user interface; NHS WARP – neighbourhood watch for NHS IT security,
Fujitsu – NHS service desk, CfH social care integration
Trinity Park near Birmingham NEC
www.assist.org.uk/branches/Westmids/Index.htm

Interactive Care Specialist Group
Speaker to be confirmed
28 June. 6pm
BCS, 5 Southampton Street, London, WC2E 7HA and interactive teleconference
www.hilcsg.bcs.org/events.htm

July

Health Informatics Forum seminar
10 July. 12.30pm for 1.30pm
BCS, 5 Southampton Street, London, WC2E 7HA
To reserve your place, email: christine.mayes@hq.bcs.org

London and South East Specialist Group
19 July. 5.30pm (refreshments) for 6pm
Update on London programme
Presenter: Kevin Jarrold
BCS, 5 Southampton Street, London, WC2E 7HA
www.hilsesg.bcs.org/events.htm

September

ASSIST North West Branch
Informatics and the 18 week wait – follow up workshop
11 September, 1.30pm
Wrightington Conference Centre
http://northwest.assist.org.uk

Northern Specialist Group
Connecting for Health: ‘The Road not Taken’
Presenter: Prof Rajan Madhok
26 September. 6.15 for 7pm
Manchester Conference Centre, University of Manchester;
Sackville Street Campus, Manchester, M1 3BB
www.bcs-nmsg.org.uk

October

ASSIST North West Branch
SNOMED CT Pilot
4 October. 3 pm
Neurosciences Lecture Theatre, Salford Royal Hospitals
Foundation Trust
http://northwest.assist.org.uk

ASSIST North West Branch
with the NHS North West Strategic Health Authority
One-day event in w/c 8 October
http://northwest.assist.org.uk

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

November

Northern Specialist Group
15 November. 6.15 for 7pm.
NHS Connecting For Health – The Nurses’ View
Presenter: Barbara Stuttle
Manchester Conference Centre, University of Manchester
www.bcs-nmsg.org.uk

London and South East Specialist Group
22 November. 5.30pm (refreshments) for 6pm
Speaker to be confirmed
BCS, 5 Southampton Street, London
www.hilsesg.bcs.org/events.htm

Scotland Specialist Group
Conference
23 November
Glasgow Caledonian University
www.scotshi.bcs.org.uk/Events.htm