Focus: education and training

Healthcare added to ECDL portfolio

Home carers train to use hand-held devices

Electronic records require nurses to upskill
Words from the BCS Health Informatics Forum treasurer

Prof Graham Wright

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Education: the cornerstone of our raison d’être?

The British Computer Society Health Informatics Forum (BCSHIF) has, as one of its fundamental functions, the support of knowledge acquisition. Indeed, a cornerstone of the BCS is the Learned Society and Knowledge Service Board.

‘What can a learned society do for us?’ was the title of a Thought Leadership debate for academics to discuss what a learned society should deliver to the computer science community. The report is on the BCS website: www.bcs.org/thoughtleadership/lsociety

Thought Leadership debates are events supported by the BCS. Health informaticians were involved in one entitled ‘Are the European and UK Health Informatics communities working together as they should?’ See: www.bcs.org/thoughtleadership/hi/euro-uk

Bringing people together to discuss and debate has been a feature of the BCSHIF events this last year and included two 24 hour workshops on the ‘Patient Record’ – see ‘The number’s up’ in the June 2007 issue of Health Informatics Now: www.bcs.org/hinow

An important part of this initiative was that they were held in Scotland and Wales to avoid BCSHIF becoming too London centric. That said, we do have excellent meeting rooms in Southampton Street that are now used by the London Medical Group and will be used next September by BCSHIF to host the European Federation for Medical Informatics (EMIF) Special Topic Conference on Open Source Software in Healthcare.

There have also been the various groups’ conferences and the BCSHIF annual Healthcare Computing conference at Harrogate, all of which contribute to the learning and exchange of knowledge. See the forthcoming events page in this newsletter for details of more meetings.

The health informatics specialist groups have also held their own series of workshops as local events, with the exception of the nurses who have been roaming the UK having joint meetings with other groups. Should we encourage the other groups to have joint events with the BCS health informatics specialist groups?

This August saw the International Medical Informatics Association (IMIA) triennial conference in Brisbane, Australia. IMIA is a country membership organisation and BCS represents the UK. It is therefore in a way ‘our’ triennial conference. BCS for many years has been supporting delegations; indeed members of BCSHIF hosted the 2001 conference in London.

This year a group of 30 members made their own way to Australia to attend the conference: www.medinfo2007.org

All were active at the event and presented their work to the world of health informatics in workshops, tutorials, panels, and poster and paper presentations. Many were also involved in working groups and the IMIA General Assembly, the governing body of IMIA.

For those who could not attend the delegates have agreed to bring some of the conference to you. Rod Ward has a blog called ‘Informaticopia’, which has a brilliant day-by-day view of the conference and social events, including excellent photographs. Catch it all on: www.rodspace.co.uk/blog/blogger.html

I spent much of my time interviewing “the great and the good”, resulting in 20 interviews lasting from 10 to 30 minutes. All of these are being uploaded onto the CHIRAD websites and there will be a link from the BCSHIF pages to these broadcasts.

In the next issue of Health Informatics Now we will be printing some reflections from the UK delegation and hope that this will encourage you to start thinking about writing a paper for Medinfo 2010 which will be in Cape Town, South Africa.
HEALTH INFORMATICS NOW is the newsletter of The British Computer Society Health Informatics Community. It can also be viewed online at: www.bcs.org/forum/hinow

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Specialist and Member Groups
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The Irish government is planning to invest €490 million in e-health over the next seven years as part of its national development plan for health, according to E-Health Europe.

The funds will target systems that improve patient care in hospital or community settings, with an emphasis on support for community-based health professionals.

The six-year funding will be used to deliver Ireland’s National Health Information Strategy, first published in 2004. The new plan is expected to set out implementation details.

Ben Bradshaw becomes NHS IT minister

Ben Bradshaw is the new minister responsible for the National Programme for IT, replacing Lord Hunt, as minister of state for Health IT, according to the Department for Environment, Food and Rural Affairs and the Foreign and Commonwealth Office.

Computers succeed at adjusting doses

Computers have proved themselves to be as effective as trained medical staff at calculating anticoagulant to be as effective as trained medical professionals, according to the results of the GP Patient Survey conducted by the Computer Department for Environment, Food and Rural Affairs and the Foreign and Commonwealth Office.

The six-year funding will be used to deliver Ireland’s National Health Information Strategy, first published in 2004. The new plan is expected to set out implementation details.

The theft of a USB drive at the Nottingham University Hospitals Trust has shown the need to keep portable devices properly secure.

‘Trust policy states that confidential data should be stored on 128-bit encrypted USB sticks, with “if found” labels on them, and be used solely on the Trust’s computers,’ wrote Matthew Daunt, an F1 doctor at the Trust in a letter to The Pharmaceutical Journal. The Trust has shown the need to keep portable devices properly secure.

However, to date, policy has not always been followed, according to Matthew’s enquiries among 50 junior doctors in the Trust. Thirty-six of them stored patient data electronically, 10 using a USB stick, three a floppy disk, and 13 a hospital computer hard drive. None of the USB sticks had 128-bit encryption, and only three had password protection.

The Trust now intends to supply 128-bit secured USB sticks, and aims to raise awareness and compliance.

Central NHS expenditure rises by 87 per cent

The NHS in England has a projected expenditure of £726 million on information management and technology (IM&T) projects in 2006/07, a rise of 87 per cent on the previous year, according to a survey.

Meanwhile, the projected total capital expenditure on IM&T rose only by 17 per cent to £336 million, according to figures from the NHS Information Management and Technology (IM&T) Investment Survey 2006/07. The survey was completed by 95 per cent of NHS organisations.

Increases in revenue expenditure on IM&T rose less, up by 17 per cent to £1.24 billion and centrally by 10.2 per cent to £580 million.

Patient survey results to be added to NHS Choices

Results from a national patient survey are among updates that the Department of Health (DH) intends to make to the NHS Choices website to improve the information available to patients.

The announcement was in response to the results of the GP Patient Survey to which more than 2 million people responded. The DH says it will move quickly to provide patients with better information about GP practices through the NHS Choices website. Meanwhile, the results are on the DH website, where for the first time the public can view their practice’s results and compare them with other practices locally.

This data will cover practice opening hours and the times GPs are available for appointments, results from the national patient survey, care indicators of patient experience and what extended services the practice offers.

As part of this upgrade, GPs will be able to update the listing for their own surgery on the NHS Choices website later this year, a spokesperson told E-Health Insider.

The move follows criticism that the website contains out-of-date and inaccurate information on GP practices. At the moment primary care trusts are responsible for updating information on the site.

In the future, GPs will also have their own webspaces where they can upload a picture and background information such as where and when they qualified.

Military records start to become joined up

The roll-out of a new IT system that will allow military medical records to be accessed by medical professionals across the UK, overseas and on the battlefield, has begun.

Coimcleghe Medical Reception Station was the first large military medical centre to implement the Defence Medical Information Capability Programme, following piloting at two small sites. The system is now being rolled out to all UK Army medical facilities, before being extended to the RAF, Royal Navy, Defence Dental Services and permanent overseas bases and was due to be completed in August 2008.

After 2008, a deployed version of the system will be available in field hospitals, on board ships and on the battlefield via laptop and other portable equipment under development. The system will allow casualties to be issued with a chip loaded with their health records as a back-up until they reach a military medical or NHS facility.

All military medical and dental records will be available in a single electronic database. Any medical professional who is involved in a patient’s care will be able to access and update the individual’s health records, even on operations overseas. It replaces the current system of military medical records being held on non-networked computers or on paper.

From 2010, the system will be connected to NHS information systems. NHS medical records of new recruits will be able to be imported directly into the Defence Medical Services, and records exported back to civilian GPs on retirement.

Key systems raise concerns

NHS foundation trusts are concerned about the functionality of key systems from the NHS National Programme for IT, according to a survey by E-Health Insider.

The foundation trusts reported in a survey on their experience of the National Programme for IT (NPfIT) that they are regularly finding that nationally developed software is incomplete or less capable than their current systems. Out of 54 trusts, 48 took part in the survey carried out by the Foundation Network, part of the NHS Confederation.

The reports says “most trusts have opted out of certain parts of the national NHS IT system, including the CRS software for electronic patient records. National systems, including e-booking and digital x-ray communication and storage, are widely used, according to E-Health Insider. Trusts have been told they risk incurring penalty payments if they opt out for other systems.

Twelve trusts reported ‘major’ problems in the PAS with one having identified 60 areas less efficient than its current PAS where new processes will need to be introduced at significant additional costs.

N3 becomes VoIP-enabled

The National Network for the NHS (N3) can now carry phone calls using voice over internet protocol technology (VoIP), enabling NHS organisations to converge voice and data over a single network.

N3 has largely been used so far to accelerate the transmission of clinical data. Through voice-enabling, two new services have been added: the N3 Hosted Voice and N3 Hosted Video.
Getting the educational ducks all in a row

The players and offerings in the health informatics educational field are somewhat fragmented, suggests Jean Roberts, senior lecturer in health informatics at the University of Central Lancashire and a member of the BCS/HIF strategic panel. She believes that communication must improve.

To get the education informatics ducks successfully in a row we must first recognize a ‘duck’. The educational field around informatics to support health (HI) has many players with many offerings, the challenge is to describe them all and harness the most suitable for each potential student. These educational initiatives are driven from a variety of sources, with a plethora of content elements at many nodes. In this article I will attempt to highlight types only. I am bound to omit some, such is the diversity and complexity of the field.

Each of the home countries has educational HI initiatives that meet their own priorities using in-house courses and seminars, higher and further education offerings, core courses and commission provided courses and professional society registration/qualification requirements for entry and continuing personal development. With the increase in e-learning, the provision is now becoming non-territorial. The challenge is determining what vehicles suit which needs of an individual and the demands of the service.

The boundary between training and education is blurred – learning to operate the functions of a new software application or device configuration is one thing. Understanding, for example, the data quality issues, ethical implications, relevant legislation and impact on your organisation is another. The tactical and the strategic perspectives of the business per se also come into play. ‘Federated’ organisations like the NHS need to address competencies to do today’s jobs effectively and to upskill (land increase) the workforce to meet future demands within the overall care domain and governmental/public sector direction.

There is a well-recognised requirement for information handling skills for the majority (approaching 1 million) of NHS staff and those who work closely with them, whether estates staff, senior clinicians or managers from ‘porters to professors’ to quote the now defunct NHS University prospectus. How to facilitate health informatics concepts and their application into personal development and improved practice is not straightforward.

There is sometimes a dilemma between management needs and individual aspirations. Flexible learning models are breaking down barriers to personal development and facilitating life-long learning in parallel with work and family commitments. Actions that quantify the knowledge and skills needed to deliver particular service outcomes provide blueprints for making decisions about worthwhile educational activities. So with known individual needs and quantified organisational requirements the goal is to enable the creation of a range of pathways that meet both bottom up and top down objectives. This activity is confounded because we are only now getting to grips with what constitutes the necessary and sufficient across all levels and disciplines.

To make it easier to roll out education is employer buy-in. Initiatives to complement the activities of the Qualities Assurance Agency (QAA) and the University Vocational Awards Council (UVAC) to specifically recognise and accredited educational HI courses are in progress at present. This is being done both from the NHS perspective for example the NHS in England’s Quality Mark, and via mappings in terms of National Occupational Standards, academic learning objectives and the Knowledge and Skills Framework. Watch this space on both the HI and IT fronts.

There are a number of group interconnections already in part because the same people are wearing different hats and partly through logical groupings. For instance, the Institute of Health Records and Information Management (IHRIM), Chartered Institute of Library and Information Professions, BCS Health Informatics Forum and others collaborate on events, professional development and registration/ accreditation initiatives. IHRIM also works with universities to ensure that academic HI courses will also meet their professional HI requirements.

Collaboration is vocations-based as well – a collaborative comprising The Health and Social Care Information Centre, NHS Institute for Innovation and Improvement, NHS Connecting for Health and three strategic health authority authorities is piloting a graduate training scheme from this autumn. Informing HealthCare In Wales has a graduate trainee already in post. On Merseyside they have a number of years’ experience in NHS HIcaptionship. Other schemes currently in planning include a programme of activity around personal and professional development of HI trainers, support for foundation degrees in HI and Apprenticehips in HI/CT. The new HI Quality Mark will supersede the individual NHS in England IM&T Awards and be attached at modular level to academic courses, regardless of geography.

Real world information

Educationalists need to know what is going on in the operational world and there are various ways that this is being addressed in practice – from the e-news and commentary sites such as e-Health Insider, BJHC Online and the IT trade press feeds to excellent local health economy websites. In England, the NHS Health Informatics Community eBulletin – wwwinformatics.nhs.uk – and, in Wales, the HI Professional Development site – www.wales.nhs.uk/hi-profile – highlight news and events of interest amongst other items. Many of the academic institutions operate links lists and reading repositories in their virtual learning environments. There are distinguishing criteria that single out health informatics from any other form of IT, however focussed that may be. The BCS offshoring report ‘Embracing the Challenge, Exploiting the Opportunities’ states that HI includes: activities for which distance and/or proximity is crucially important; functions that require employee agility; and initiatives that form a sustainable centre of expertise over time.

Different initiatives will require collaborative actions or specificity, and this will determine how, when and where the myriad of potential contributory bodies work together or stand alone. Communication between the educational providers, employers, and the potential ‘student’ body does go on all the time, but is currently somewhat fragmented and relies significantly on personal relationships.

This will become more productive over time. It must do in order to provide the rapidly changing and volatile health domain with the ever increasing number of appropriately skilled and ‘fit to practice’ health informaticians required to support patient care, operational management and strategic planning.

So while we can probably now recognise most of the ducks when we see them, it is still a challenge to know where to find them and to be able to describe the whole community in its entirety, gaps and linkages included.

The wider BCS picture for IT professionals

By Gillian Lovegrove, manager, BCS Education and Training Forum

The BCS Education and Training Forum (EdTrForum) was established to work for the people in both these important communities, which have a huge part to play in the support, instruction, and ongoing development of computing professionals in its broadest sense. The current priorities for the EdTrForum are to:

- Build on discussions regarding the supply and demand for IT/CSI graduates. What skills are needed, what will the next IT professional look like?
- Continue to investigate the existence of networks of other bodies in education and the partnerships with those bodies. These include the HealthCare IT, Qualities Assurance Agency (QAA), the University Vocational Awards Council (UVAC) to specifically recognise and accredited educational HI courses are in progress at present. This is being done both from the NHS perspective for example the NHS in England’s Quality Mark, and via mappings in terms of National Occupational Standards, academic learning objectives and the Knowledge and Skills Framework. Watch this space on both the HI and IT fronts.
- Focus on the 16-19 age group and support for educational practitioners for this group.
- Continue to realise the potential of the Forum as a knowledge community by encouraging communication and the cross-fertilisation of ideas and activities.
- Promote the value of BCS membership and improve the support for BCS members in education and training.

Details of the main areas of activity are on the website but in summary are:

- School IT, IS, computing and ICT;
- teacher training and supply;
- further education;
- higher education;
- public understanding;
- gender and widening participation;
- publications;
- support for members in education and IT Training.

Some of these are undertaken directly but are more often in collaboration with other organisations.

The EdTrForum originally consisted of a Strategic Panel and an Expert Panel which was particularly active in the schools arena. The Forum is at last able to claim it covers training too with the newly formed Information and Technology Training Specialist Group (ITTSG) bringing fresh ideas and new outlooks.

The Education and Training Expert Panel consists of eight working groups, watching briefs, and external liaison. The working groups are called:

- careers;
- teacher Education, E-Learning, Data Management, Inclusion, Educational Members Support Information and the Website: www.bcs.org/forums/edt
Healthcare added to ECDL portfolio

ECDL has been widely adopted in the UK as a way of training clinicians and a wide range of healthcare staff to handle technology. However, it became apparent over time that the basic IT skills taught in ECDL did not address some fundamental subjects specific to health, such as patient confidentiality and data security.

That gap is now being filled by ECDL Health, a new module within the ECDL portfolio. Its content has been designed so as not to duplicate either the basic health professional education on ethics and record keeping, or the basic computer skills of the ECDL.

BCS, which awards ECDL in the UK, introduced the module as part of the NHS Connecting for Health (NHS C4H) made ECDL Health available to its staff at the end of March 2007. There are 250 NHS ECDL test centres that could potentially access the new module including centres in Wales and Northern Ireland. The Royal College of Nursing is also considering whether the new module could be included as part of pre-registration training for nurses.

The introduction of the module was the result of an initiative by NHS Connecting for Health and the BCS, which created an international expert panel, representing six European countries, plus the USA, to develop a core syllabus. Proponents represented included medicine, nursing, health informatics, administration and health policy. The core criteria for the syllabus were:

- information processes that were different in healthcare to other domains.
- candidates passed the course-end test.
- candidates took an average of ten hours to complete the learning section of the unit and 90 per cent of candidates passed the course-end test.

Feedback identified some weaknesses of the interim testing framework but no criticisms were made of the content of the syllabus.

Claire Adams, ECDL service manager within NHS Connecting for Health, said: ‘The outcome of the English NHS pilot has been highly successful in validating the appropriateness and the importance of the core syllabus. The input from the NHS pilot sites in terms of the creation of the learning materials and endorsement of the syllabus at a local level has been critical to the success of the project and its subsequent roll-out.’

The UK was the first country to introduce ECDL Health, and has backed it by commissioning electronic training material and a test engine. Others countries may follow – Italy is already conducting a pilot, and the US is seriously interested.

ECDL Health is not about technical skills, but rather concentrates on explaining how electronic systems differ from paper ones – for example, with a paper record you can see where it’s originated from easily, but with a computer you need to take specific steps to understand who wrote it. For instance the significance of a previous raised blood pressure reading taken by a GP can be different from when it is taken in A&E.

The other aspect is about how using computers in healthcare is different from other environments. For example, if an incorrect clinical finding has been recorded, it’s not good enough to simply correct it. Both the initial item and a dated annotation with the correction must be kept.

‘It’s also about interpreting the data – a benefit of electronic records is that they can search for group items, but in so doing the facts may lose their context. Breathlessness, for example, is a term which is unambiguous, but without the nuances of context has much less meaning, such as whether it was after going upstairs or while sedentary. Users of electronic systems need to understand how to identify the authorship and context of items relevant to them.’

The unit has been designed for all staff working with healthcare systems, including clinicians and administrative workers. Candidates do not need advanced computer knowledge to take the qualification, they simply need to be able to use a computer keyboard and mouse.

‘It complements the existing topic areas covered by the ECDL,’ said Carol Hulm, special projects manager at BCS, which awards ECDL in the UK. ‘It provides candidates with an understanding of the key principles and policies relating to healthcare information systems and the practical skills needed by users. As well as enabling users to read, retrieve, update and store patient records accurately, the unit also provides candidates with a thorough understanding of the key issues regarding patient confidentiality and data security.’

The introduction of the module was a lengthy process which dates back to a 1999 paper to a European conference on effective application of electronic health records. When developed a little further, the idea attracted the interest of the NHS through the then NHS Information Authority, which supported UK and European consultation.

The proposal was then adopted by the International ECDL Foundation, which created an international expert panel, representing six European countries, plus the USA, to develop a core syllabus. Provisions represented included medicine, nursing, health informatics, administration and health policy. The core criteria for the syllabus were:

- breathlessness, for example, is a term which is unambiguous, but without the nuances of context has much less meaning, such as whether it was after going upstairs or while sedentary.

The seven modules are:

1. basic concepts of IT;
2. using the computer and managing files;
3. word processing;
4. spreadsheets;
5. database;
6. presentation;
7. information and communication.

www.ecdl.co.uk

About the European Computer Driving Licence

ECDL dates back to 1996 when it was introduced in Sweden. It was the brainchild of The Council of European Professional Informatics Societies when its members sought to raise IT skills in Europe in the mid-1990s. They created a syllabus based on the already existing Finnish Computer Driving Licence.

ECDL was rolled out in 1998 in the UK with BCS as the agency licensed to award the qualification. There are now more than 1.5 million participants in the UK and BCS has formed a major partnership with the NHS in England to deliver the ECDL.

In 1999, the ECDL syllabus was introduced beyond Europe as the International Computer Driving Licence. It can now be taken in 125 countries.

The ECDL syllabus, excluding the health unit, breaks down into seven modules, each of which must be passed before an ECDL certificate is awarded. The health unit is independently accredited by the BCS, i.e. it is not necessary to hold the ECDL to be able to take it. The seven modules are:

1. basic concepts of IT;
2. using the computer and managing files;
3. word processing;
4. spreadsheets;
5. database;
6. presentation;
7. information and communication.

www.ecdl.co.uk
Home carers train on hand-held devices

Mobile home carers in Glasgow have typically had little exposure to IT, so training them was a vital part of a BlackBerry roll-out. Brendan Murphy, head of ICT and marketing, Direct and Care Services, Glasgow City Council, explains their approach to the task.

On a daily basis more than 15 Glasgow hospitals assess and discharge patients to care in their own homes. This care often starts with a mobile home carer being assigned to ensure that the person has a safe return home and is helped for the first four weeks after hospital discharge. Consultants can release a patient late afternoon with very little notice to implement effective home care for that evening’s cover.

In the past, mobile home carers were required to visit one of nine local offices throughout the city looking for detailed fax messages with details of the client to attend and provide a home care service. This method was prone to errors, was costly and inefficient and both the home carer and client were often provided with little useful information, making the first few visits to a new client fraught with difficulty. Direct and Care Services of Glasgow City Council has now rolled out more than 400 BlackBerry devices to assist in delivery of this key service, principally to allow mobile home carers to quickly respond to emergency new referrals and ‘home from hospital’ requests which can be made at very short notice. The benefits of these units include instant, accurate client data being made available to home carers, leading to the provision of a better service to clients. Managers also have instant email access to a frontline workforce who were often difficult to engage with.

Lone workers brought closer

This initiative has had a huge effect on services, bringing managers closer both to clients and to lone workers. Lone worker groups feel less isolated, helping improve the service provided, and the skill level in IT of this staff group has increased greatly.

From the outset, the difficulties in training a manual, part-time, largely female workforce were not underestimated. A focus group of six home carers were initially brought together for an informal meeting to assess previous exposure to technology and to determine the best way to train and deploy over 400 units.

From this group, it was obvious that the principal IT exposure was to mobile phones and this was generally only for voice usage. One week after this meeting the same six home carers were brought together and the strategy for implementation explained to them and, crucially, at this meeting a hands-on session with the BlackBerrys was conducted.

This was highly successful and the home carers themselves decided that implementation should be supported by bringing staff together in small groups to offer a hands-on experience, allowing them to take away their new BlackBerry immediately after the training session.

Modules lasting one hour

A one-hour training module was devised and delivered to a maximum of five home carers per session. This short session ensured frontline delivery of services was maintained and also that there was little chance for attendees to become bored.

Delivery was by a general member of the ICT support team, a decision taken to help ease any tension that the manual workers may have had when being confronted by a ‘boss’. Sessions were set up to be particularly humorous to ensure that a positive message went round the teams that the training was fun and enjoyable – essentially delegates sent and received messages to each other and were encouraged to help and support each other during the session – this worked.

At each training session a simple fact sheet was issued detailing very basic BlackBerry functionality (receive, read, send, store emails). Post-training, home carers also have access to an ICT support team member and drop in sessions are available daily – these are used as ‘how do I do this?’ type sessions or to change BlackBerry configuration or repair broken units.

The training of this very unusual workforce has been highly successful, a blue print for the training of operatives who have low IT skills. Hands-on sessions allow a focus on usage to take place and immediate post-training deployment ensures that important skills learned are not forgotten. Direct and Care Services will use this method in future ICT implementations.

About Direct and Care Services

Direct and Care Services is the second largest department within Glasgow City Council, employing some 9,000 manual workers with a turnover of £129M per annum. School meals, school cleaning, janitorial services, home care services and a range of commercial catering activities are among the principal services of Direct and Care Services. The department works in 10,000 homes each day and has a daily presence in over 300 public buildings.

Southern training approach gains national accreditation

By Andrew Raynes, education training and development programme manager, Southern Programme for IT.

The Southern Programme for IT (SPFIT) has recently received accreditation for its new qualification framework, designed to equip end-users of systems rolled out through NHS Connecting for Health with a recognised award.

National awarding body, NCFE, has accredited the Southern Programme for IT’s qualifications with the Care Information System Investment in Quality (CIS IQ) licence for its suite of courses, which include: Information governance, care systems training, CRS, Choose & Book and PACS. The licence demonstrates the high standards applied to training delivery, allowing the Programme’s materials and certificates to carry the awarding body motif.

The Southern Programme which covers NHS South Central, NHS South East Coast, and NHS South West has spent 10 years developing the Care Information System User Competencies and Qualifications (CIS UCQ) with input from health communities within the Southern Programme to ensure optimum use of the new systems, and the realisation of benefits that will follow implementation. The accreditation provides a unique opportunity for strategic health authorities and trusts in the south to deliver accredited competency-based training on a portfolio of programmes. The qualification is expected to raise standards and deliver good return on investment by achieving cross community memory, knowledge and skills retention, standardising processes and enabling consistent transferable and trackable skills.

In addition, CIS does not replicate other important standards, including qualifications such as the European Computer Driving Licence, rather, CIS builds on skills and competencies in order to complement skills required for their specific roles.

For more information about CIS, email Andrew.raynes@nhs.net
Electronic records require nurses to upskill

Most nurses feel a need for further training before the introduction of the electronic patient record, according to the 2007 survey by the Royal College of Nursing (RCN). The research also looked at IT use, training and education more generally, as Sharon Levy, RCN informatics advisor, explains.

Delivering professional nursing requires not just caring hands or a kind heart but also a sharp and inquisitive mind, one that enables the practitioner to utilise ‘…clinical judgement in the provision of care’… (RCN 2003).

‘Information is at the heart of professional care and nurses, midwives and health visitors are the largest group of clinical information users. Through skilled therapeutic interaction, nursing professionals obtain, record, share, use and store sensitive information, in both paper-based and paperless formats. They must, however, have the knowledge and skills to manage information within ethical, professional and legal frameworks, placing the needs and preferences of the patient at the centre of their care.

Record keeping, information governance, effective communications, critical thinking and information appraisal are all topics that should be included in the pre-registration education of student nurses, in the view of the RCN.

Furthermore, basic IT skill is a core competency that should be taught to those who are entering the profession, as well as to those who are already working in the health service. Enabling clinicians to know how to use and maximise the potential of clinical IT is key to successful implementation of all UK national IT programmes. The recent Royal Society report on Digital Healthcare 2006 noted ‘…the single most important factor in realising the potential of healthcare ICTs is the people who use them.’

Survey results online

Over the past four years the RCN, the largest professional body and trade union for the nursing professions, has polled its members to identify attitudes, readiness and concerns regarding IT developments in the NHS. Earlier reports are available on the RCN website.

Members were asked to complete the 2007 survey on Nursix.com during the month of June. 2,635 nurses responded to it, including a few non-RCN members.

We are not claiming the sample is representative of the nursing professions workforce across the UK. Our survey used a convenience sample of self-selected nursing professionals who are more likely to be interested in and aware of NHS IT developments.

Also, the participants completed an online survey, which relied on a degree of IT competence.

An overwhelming majority (94 per cent) of respondents had heard of the electronic patient record (EPR) before taking part in this survey and two thirds of them welcome its introduction.

However, many respondents noted lack of information about their National IT Programme with 17 per cent having received none and 56 per cent ‘a little’ information about it.

Nearly all respondents (92 per cent) feel that it is very important or fairly important to have consultation about IT developments in the NHS remained a key risk to successful implementation of UK national programmes. Notably, the perceived effect of the EPR on clinical care continues to show a downward trend with now only 42 per cent of respondents believing it will improve clinical care compared to 70 per cent in 2004.

We included some open-ended questions to capture some qualitative data. Whilst this analysis is still underway, a comment gives an insight to the clinical ‘reality’ that many nurses face:

‘IT training, as well as ECDL, is needed. Improving my IT skills would help me to do my job more effectively and also a sharp and inquisitive mind, one that enables the practitioner to utilise ‘…clinical judgement in the provision of care’… (RCN 2003).

It is, however, widely recognised that at present nurses are not adequately prepared for the incorporation of care technology into nursing practice, and in particular into nursing documentation, and that the solution to this deficit may lie in nursing education.

We, at the RCN, endorse the recommendation made in the Royal Society report, which suggests that: ‘…higher education institutions and professional bodies responsible for the different disciplines adapt their curricula to integrate the use and understanding of healthcare ICTs into the basic training and continuing professional development of healthcare professionals’.

Products under development

We are currently working with the BCS to develop ‘products’ which should enable students and qualified practitioners to attain a level of competence required to maximise the potential of clinical IT.

Such development enables learners to grasp core nursing practice and information management concepts and skills and support the need of the profession to move beyond the role of computer operators to data entry activity into the realm of a knowledge workforce. Current and past surveys are at: www.rcn.org.uk. See www.bcs.org.uk for full links. For more information, email: Sharon.Levy@rcn.org.uk.
Patient records could support research

The research community has been looking into how electronic data collected by the Care Records Service could be harnessed to clinical research. Such use of the data would ultimately benefit patients, explains Ngozi Okwudili-Ince, UKCRC programme manager, National Programmes for IT and Sarah Harrop, UKCRC science writer.

There is great potential to benefit health through careful use of the IT systems that underpin healthcare management. Our National Health Service is a valuable asset for this because it can gather coherent data on the entire population, and means that the UK should be in a position to take a global lead in this area.

Earlier this year, a team of researchers conducted four simulations on behalf of the research community to examine how the NHS Care Records Service may be able to support clinical research, and their findings have been published in a new report. The impetus for the report was in 2005, when the government committed to develop the capability within the NHS national IT system in England to aid recruitment of patients to clinical trials and data gathering. Of crucial importance was that this would be done strictly within the bounds of patient confidentiality, and for the benefit of patients. The overall aim would be to support groundbreaking work on the health of the population and the effectiveness of health interventions.

In response to this, the UK Clinical Research Collaboration (UKCRC), a partnership of the major UK research funders and organisations involved in clinical research, established an R&D Advisory Group to Connecting for Health. The Advisory Group's remit was to ensure that research would be a priority during the ongoing development of the NHS Care Records Service (NHS CRS). The first step towards this goal was to provide the supporting evidence for this by conducting simulations on behalf of the research community. These simulations also offered a unique opportunity for the research community to engage with NHS Connecting for Health in England.

Four research applications for the electronic patient data were investigated: interventional clinical trials, surveillance, prospective tracking of a known cohort, and observational epidemiology. The research simulations identified several required characteristics for data and systems. These included access to comprehensive data covering as wide a population as possible; strict governance of data access and a capability for supplying data and associated services from a federated system of linked medical records.

All four research simulations highlighted the technical, regulatory and governance issues raised by use of the NHS CRS and considered the advantages of the approaches in England, Scotland and Wales to routine data collection. The report of the simulations also provides some compelling examples of the benefits of enabling access to this routinely collected data for research purposes. One such benefit could be the development of an advanced, world-leading pharmacovigilance and disease surveillance system. The NHS's 'cradle to grave' cover provides key advantages over e-health systems under development in other nations, such as the USA.

The report pinpoints the data needs of the research community, differentiating between requirements for information about groups of patients rather than individuals, and anonymised or pseudonymised data versus identifiable data. The requirements to enable data linkage, quality and completeness validation are addressed and the honest broker role is examined as a possible way forward. This approach would ensure patient data confidentiality and security as well as scientific integrity of data delivered to the research and public health communities.

In summary the report’s main recommendations are to:

- Communicate the relevance of research to healthcare. At the heart of this is recognition that research is a core, not secondary, component of the development of the NHS Care Records Service because it directly benefits patients.
- Federate existing databases to ensure that the data made available are as comprehensive as possible. This could function as a data switchboard linking NHS Care Record data to other data sources and also provide an effective infrastructure with optimal governance systems in place. Services such as removal of identifiers and data quality checks could also be delivered.
- Improve data quality to ensure that data are accurate and based on a set of standards for recording and processing. Incentives may also be required to ensure data are complete and of high quality. Initiate governance discussions to ensure appropriate access to, and use of, data for research purposes. Data governance must be both robust yet capable of facilitating research.
- Engage key stakeholders to communicate the joint benefits of using patient data for research and clinical care. Engagement of professional audiences is key to enhancing data quality and improving data access.
- Fundamental to the report’s recommendations is that research is integral to patient benefit: clinical services and research share the same mission of improving patient care and patient safety.

Incentives may also be required to support the research community to engage with Connecting for Health. The research community with Connecting for Health.

The report also strongly recommends the development of a UK-wide approach in coordinating efforts to support better use of existing resources. The next steps will include work to explore the federation of data sources, in order to ensure a consistent approach across the UK and build on the extensive experience with record linkage already in place. These recommendations were welcomed by Lord Hunt, the then minister of state for quality at the Department of Health, who sanctioned a formal programme of work to take the recommendations forward. This will be carried out in the context of other developments in e-health, and in tandem with measures to strengthen the governance of health information used for wider purposes. In parallel, members of the UKCRC advisory group and simulation teams gave evidence at the House of Commons Health Select Committee’s third evidence session on the electronic patient record. They used this opportunity to draw attention to the messages in the report of the UKCRC research simulations.

Maintaining momentum will be important if the UK is to take advantage of its current position. In May 2007, the Wellcome Trust and the UK Clinical Research Collaboration held a frontiers meeting to discuss the potential of using electronic patient records to improve the health of the UK population and to look at what has been happening in other countries.

Speakers at the event estimated that the UK has a window of just three to five years to set up a working system of linked medical records. The next few years should see some exciting developments in this field which are set to benefit patient health and further engage the research community with Connecting for Health.

Further information

For more information, and to download a copy of the report, look at the UKCRC website:  www.ukcrc.org/activities/ infrastuctureinshns/nhsprogrammes.aspx

A video and report of the Welcome Trust Frontiers Meeting on The Use of Electronic Patient Records for Research and Health Benefit can be found at: www.flyonthewall.com/ FlyBroadcast/wellcome.ac.uk/UKCRC/ FrontiersMeeting/

Proceedings of the House of Commons Health Select Committee’s third evidence session on the electronic patient record is at: www.patient.uk.parliamentary_ committees/health_committee/ currentinquiries.cfm
Architecture sets out how services fit together

How and why NHS Connecting for Health (NHS CFH) is creating a service-based enterprise architecture was explained by Jagdip Grewal, chief technical architect of NHS CFH, at the BCCHSF’s April meeting.

Helen Boddy reports.

services fit together

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Helen Boddy reports.

'An enterprise architecture (EA) based on a service based model allows stakeholders to understand how everything fits together in the NHS,' said Jagdip. 'It means we all also use a common language; suppliers often have different terminology to us and this standardises what we mean.'

In drawing up the enterprise architecture, NHS CFH defined a set of architecture domains for integration, security, channels, local and enterprises services. Across these domains are a set of principles, standards, policies and guidelines (PSPG), and each domain consists of a set of conceptual services. These define at a high level what NHS CFH is trying to achieve for the customer in terms of business (e.g. care management) or technical services (e.g. technical integration).

'We’ve taken our services and assumed the key thing is the customer,' said Jagdip. 'When we give the customer in terms of business (e.g. care administration) for specific areas. The physical instances of these logical applications are the systems deployed by our suppliers. Once the way forward has been modelled, suppliers can be mapped onto the architecture and their conformance to PSFG evaluated. Standards are key for the technical service level. ‘We have to have standards that allow interaction between suppliers’, systems,’ said Jagdip. ‘We will never just have one supplier so we need a way of joining them up. By including guidelines and standards in the architecture, it is also possible to easily see which suppliers are not up to speed yet.’

All supplier contracts are around standards, which have been chosen so that it is possible to achieve interoperability. That means:

- use of eXtensible Markup Language (XML),
- use of Simple Object Access Protocol (SOAP),
- use of Simple Network Management Protocol (SNMP),
- use of Home Health Language V3 (HL7 V3) and HL7 CDA v2. Once the standards were set, it was possible to give detailed specifications to the systems’ designers.

'We have adapted Health Language 7’s Clinical Document Architecture but using an evolving strategy that aims to get everyone to the end point,’ said Jagdip. 'We are using a set of templates to tell suppliers how to code the information. Not all suppliers will be able to fully code the information from day one, but over time all will reach the required standard. We will be in a mixed economy for many years, with thousands of systems going through upgrades. Thus using standards will enable us, over time, to increase the compatible coding of clinical information flows, which are necessary between systems in different care settings.'

He gave the example of GP Systems of Choice (GPSc) where this is a national framework using standards. The NHS has to make sure it sets the right standards, and then encourage suppliers along the maturity path to achieve certain points over time. ‘The use of open standards (ebXML and HL7) has enabled us to expand the number of suppliers to the programme. We have now integrated hundreds of suppliers through open standards implemented by our national service providers,’ said Jagdip. ‘There are 13,900 instances of systems integrated to national services, which produce 120,000 prescription messages per day, 17,000 bookings for Choose & Book and 1.4 million demographic queries. Integration of a huge number of deployed web services presents certain challenges as suppliers are often interacting with different versions of web services. ‘We therefore have to be careful how we define the services and get the versinng right,’ said Jagdip. ‘You can’t expect everyone to upgrade all at one time. We need evolution of services, not revolution.’

Focus of conference to be patients’ control of records

‘Patient Controlled Worldwide Health Records – Putting the Patient at the Heart of Care’ will be the theme of this year’s annual conference organised by the BCCHSF.

Jill Riley, group administrator, reports.

The idea that a patients’ longitudinal health record should be held by a trusted third party, chosen by the patient and then shared with those care providers with whom the patient chooses to engage, is one that is attracting much attention across the globe. This model takes control of the record from healthcare providers and shares it with the patient and solves many of the issues associated with records bound within a particular care provider or single healthcare community.

This year’s conference will focus on those issues – technical, cultural and ethical – that will need to be addressed to enable this vision to be realised. It will be held on 28-29 September in Eynsham Hall, Oxfordshire.

The conference will include a stream for peer-reviewed academic papers and poster presentations, as well as providing an opportunity for less academic presentations from those engaged in contemporary activity relevant to the conference theme.

As in previous years, this event will include high-profile invited speakers and peer-reviewed academic papers.

Programme details on website

Following the closing date for papers and submissions, the programme committee will work their way through these and further programme details will be available on our website. The prices for the 2007 conference are unchanged from those for 2006. The conference is open to all, and the registration form is on the website. Places are limited to 100 delegates, and are allocated on a first-come, first-served basis. We have a limited number of sponsorship opportunities. If you would like to know more, contact me as below.

Members of the specialist group are eligible for a discount of £70 over the two days. If you are interested in attending both days of the conference and wish to take advantage of the discount, it’s worth joining. Individual membership costs £55 per annum. The venue, Eynsham Hall, is a fine Jacobean mansion house with stunning gardens and parkland. The Hall has an academic, yet informal, feel. www.eynshamhall.com

Further information

Group website: www.phcsg.org
Or contact Jill Riley on 01905 727461; email jill@phcsg.org.

Programme website: www.eventcentre.com

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ASSIST is run by health informatics professionals for health informatics professionals.

The association was established in 1993 and became a member group of the BCS Health Informatics Forum (BCSHIF) in February 2006. It currently has over 1,500 members, from public and private sector health and social care NHS organisations across the UK, academic institutions, and commercial providers of informatics services.

ASSIST aims to develop professionalism and professional standards, and to work with other bodies, including government, to provide a voice for informatics specialists. While maintaining its independence, ASSIST seeks constructive relationships with private sector bodies: current formal partners include Tribal Age (SFIA) and Agenda for Change consultancies; appraising a software tool against the Skills for the Information Professionals; for assessing practitioners’ skills for the Information Age (SFIA) and Agenda for Change Knowledge and Skills Framework; and developing an NHS management trainee scheme for informatics.

ASSIST routinely contributes to national consultations. It sees its role as one of ‘critical friend’, providing informed, constructive, independent comments from the perspective of informatics practitioners. The most recent submissions were to DH consultations on payment by results and on proposals for a national information assurance scheme, and to a joint CFH/IC review of services supporting the work of health informatics staff.

The association’s strength lies in its national network of regional branches. These run programmes of high-quality and cost-effective events, supporting the continuing professional development of ASSIST members. Roadshows have been run in multiple branches on, for example, Agenda for Change and the National Programme for IT.

ASSIST members also regularly contribute to national conferences and workshops. Examples include: a two-day workshop on the 18 weeks Referral to Treatment target for the Faculty for Healthcare Computing and BCSHIF events.

ASSIST publishes a quarterly newsletter. The most recent edition included topics ranging from five years of the National Programme for IT, to professionalism and the UK Council for Health Informatics Professions. ASSIST is also a regular contributor to this newsletter and the British Journal for Healthcare Computing and Information Management.

Further information about ASSIST, its activities, membership benefits and how to join: www.ASSIST.org.uk

Who’s who on the committee

Chair: Brian Derry
Honorary secretary: Pam Hughes
Member: Tony Eardley
South West Branch rep: Jason Bradley

Immediate past chair and professional development board: Andrew Haw
Treasurer: Rupert Davies
North West Branch Rep: Adam Dury

Vice chair (2): Adrian Purcell
Membership liaison officer: Carole Archer
Thames Valley Branch rep: Mik Horswell

Vice chair (3) and joint communications & marketing: Ian White
Member: Dave Miller
West Midlands Branch rep: John Thornbury

Vice chair (1): Simon Anderson
Trent Branch rep: Mark Janvier

Member & joint communications & marketing: Siobhan Roberts

Co-ordinator: Elly Stimpson-Duffy

Meet the member group

ASSIST

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 ASSIST, the Association for Informatics Professionals in Health and Social Care, and is written by its national chair, Brian Derry.

ASSIST is an active role, representing health informatics practitioners, on:
- the Government IT Professional Initiative;
- professional development, through a multi-agency Professional Development Board;
- the NHS Connecting for Health Capability and Capacity programme;
- Informatics workforce planning;
- the board and council of the UK Council for Health Informatics Professions;
- the NHS Faculty of Health Informatics;
- a number of government committees and working groups.

ASSIST has positive relationships with a number of government agencies, including NHS Connecting for Health (CFH) and the Information Centre (IC) for Health and Social Care. Joint activities include: a major survey of the health informatics workforce, with the fieldwork carried out by Tribal consultancy; appraising a software tool for assessing practitioners’ skills against the Skills for the Information Age (SFIA) and Agenda for Change Knowledge and Skills Framework; and developing an NHS management trainee scheme for informatics.

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The alcoholic

NHS commissioning data sets (CDS) have evolved in a generally unplanned way over the past 25 or so years, writes Brian Derry, chair of ASSIST. In this article he calls for a fundamental redesign to create a new NHS data model, which would lift the current restraint they place on key government policies.

CDS have their roots in the Körner review of the late 1970s. As such, they are characterised by a strong emphasis on acute hospitals, consultants, care settings (A&E, outpatients, in-patients on acute hospitals, consultants, care on demand) and measures of activity and waiting times. There have been continuous piecemeal additions to the CDS, as a long series of ad hoc responses to (not always joined-up) Department of Health (DH) policy imperatives. The time has come for a fundamental redesign of the underlying NHS data model to meet the needs of a patient-centred NHS, with choice, plurality of provision, closer integration of health and social care, multi-agency, multi-professional 18 weeks referral to treatment pathways, care pathways from initial diagnosis to resolution / the end of chronic care, and a strong focus on quality of care and patient safety. The current data model is a major constraint on the development of key government policies, including payment by results, practice-based commissioning, 18 weeks referral to treatment pathway management and the assurance of efficiency, clinical quality and patient safety. As the foundation of virtually all DH central information requirements, the data model is a design constraint for the next generation of NHS information systems. This risks perpetuating the archaic shackles of the present. The time has come to stop building ever more complex structures on crumbling foundations. There is an overwhelming case for a ‘Körner Review for the 21st Century’. This context and objectives for such a review should be:

- Patient/client-centred information, independent of care sector, setting, professional group, etc. This is essential if any solution is to be proof against future changes in the delivery of care, including shifts of service provision from acute to primary/community sectors; from NHS to private sector; consultants to GPs, nurses and other practitioners; physical contact to telemedicine, etc.
- DH and commissioner information requirements should be a by-product of operational clinical systems, in line with one of the original care Körner principles, which since its inception has been honoured more in the breach than the observance, relentlessly adding to NHS costs.
- The rigorous assessment of the informatics consequences of government policy proposals at an early stage. This assessment should include the information requirements of the NHS to deliver policy, as well as the central requirements of DH for monitoring and performance management.
- A robust process for assessing the business case, costs of compliance and practical implications of any new central demands. The current Review of Central Returns (RCR) and Information Standards Boards (ISB) mechanisms need to have greater authority and be better integrated. The CDS concept needs to move from being the specification of additional data items to one of collating existing information for commissioners from established data sources and flows.

A clear distinction should be kept between:

- Data items, comprising the data sets – the ‘content’.
- Technical messages and their structures – the ‘messages’.
- Routes by which information is transferred between agencies – the ‘flows’.
- Collation of data for secondary processing and analyses – the databases/data warehouse (including SUS).

‘The NHS data model is like alcoholism. It is insidiously addictive and accepted as a given in polite society, yet carries substantial direct and indirect costs and is ultimately destructive.’

The first step to redemption is a positive recognition of the problem and the determination to do something serious about it. The disconnect between the NHS informatics strategy and DH policy was raised in the BCS/HSIF report ‘The way forward for NHS informatics’ published at the end of last year. ASSIST is therefore working on an initiative to involve informatics practitioners across the country in developing national thinking on these issues. We hope also to engage DH and NHS Commissioning and the Information Centre for Health and Social Care. Watch this space!

Next steps should include:

- A prohibition on further ad hoc developments to existing CDS.
- Focused effort on developing a new NHS data model. This should be augmented by fully documenting existing CDS to establish current baseline.
- A review and strengthening of the RCR/ISB mechanisms intended to control the burden of bureaucracy on the NHS, including in relation to non-DH demands from bodies such as the Audit Commission.
- A robust mechanism for assessing the informatics consequences of business cases, processes, costs, timescales etc. for the NHS and DH of new policies. The focus should be on supporting NHS operational delivery, as well as central performance management and public accountability. This mechanism should be an integral and early part of policy development and options appraisal; it should not be left until policy implementation.
- Trying to establish likely future policy direction – short, medium and long-term – for health and social care, to help form up DH and NHS business requirements. These should be translated into a formal information strategy, to augment the national strategy.
Smart garments will have patients covered

Smart garments are being used to improve healthcare and have the potential to become much more sophisticated, according to Paul Beatty from the University of Manchester. His talk on the subject delivered to the Northern Specialist Group is described in this article by chair Tom Sharpe, based on a meeting report by Phil Paterson.

About smart garments

The speaker on this topic, Dr Paul Beatty, was a senior lecturer in the School of Cancer & Imaging Sciences at the University of Manchester (JoM), with a background both in anaesthesia and physiological measurement. The rest of this article is a digest of the main points raised in his talk to the group on 6 June, and the ensuing discussion.

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A Philosophy of Information
Bernard Smith
Trafalgar Publishing
£17.50
Score: 10/10

Project Management in the Real World
Elizabeth Harrin
BCS
ISBN 978-1-902505-81-7
£24.95
Score: 9/10

Networked Neighbourhoods
The Connected Community in Context
Patrick Pauwels (Ed.)
Springer
ISBN 978-1-84628-267-6
EAS
Score: 7/10

Letter to the editor
Has common sense returned?

Dear editor,

Last month I spotted the headline ‘£711m hospital project is scraped’ and wondered whether it was seen by your readers. It related to the rebuilding of three hospitals run by the University Hospitals of Leicester. The cancellation followed a review of the PFI project after the estimated cost had risen to at least £921m. There were doubts that the project provided value for money – a view of PFI schemes expressed by some of us about 15 years ago. Perhaps more importantly, it was also thought that the scheme would strangle any attempt to modernise services by forcing patients into hospital, simply to pay back loans, when they would be better treated elsewhere – a view expressed by those of us involved in telemedicine, 10 years ago.

When will others follow the Leicestershire lead?

Keith Clough, vice chair HJIC SG

Please send letters to: helen.bobby@hq.bcs.org.uk

Tuesday 2 October, BCS London
Public health: private data?
An event hosted by BCS Health Informatics Forum and BCS Security Forum

Programme
12.30pm Lunch and networking
1.30pm Introduction by Ian Herbert, vice chair; BCSHF
1.40pm Dr Fleur Fisher: data disclosure
2.10pm Brian Derry: data practicality
2.40pm Short break
2.50pm Phil Cracknell: data breaches
3.10pm Tom Parker: data confidentiality
3.40pm Round up by Prof Brian Collins, chair Security Forum
4.00pm Close

Speakers
Dr Fleur Fisher is a former GP and former BMA head of ethics science and information; she is now a consultant in healthcare ethics.

Brian Derry is director of informatics at Leed’s Teaching Hospitals NHS Trust (LTHT). He is also national chair of ASSIST and on the board of the Faculty of Health Informatics.

Phil Cracknell is regarded as one of the UK’s leading information security specialists. He has over 20 years experience gained in a variety of high-profile technical and managerial security roles.

Tom Parker is NHS Connecting for Health’s information governance architect for London, with special expertise in patient confidentiality controls.

This event is open to all associated with the BCS Health Informatics Forum and BCS Security Forum.

To secure your place email: christine.mayes@hq.bcs.org.uk, giving name, organisation and any special requirements (diet, access, etc.). Venue: BCS, First Floor, 5 Southampton Street, London, WC2E 7HA

Has common sense returned?
Forthcoming events

September

Northern Specialist Group
Connecting for Health: ‘The Road not Taken’
Presenter: Prof Rajan Madhok, CSC Alliance /Manchester PCT
26 September 6.15 for 7pm
Manchester Conference Centre, University of Manchester
www.bcs-nmsg.org.uk

Primary Health Care Specialist Group
Annual conference
Global health records – putting the patient at the heart of care
28-29 September
Eynsham Hall, Oxfordshire
www.phcsg.org.uk

ASSIST, London and South East Specialist Group
and NHS London Programme for IT
Workshop to learn about SNOMED CT and how it will provide a foundation for the NHS Care Records Service.
28 September 9.30am – 4.30pm
BCS, 5 Southampton Street, London
www.assist.org.uk

October

BCS Health Informatics Forum seminar
with BCS Security Forum
Data security in the health sector
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

ASSIST North West Branch
SNOMED CT Pilot
4 October 3 pm - 4.30 pm
Speaker: Dr Bob Young
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
Looking to the future for the national programme and introducing some real clinical benefits.
9 October 9.30 am - 4.15 pm
Numbers are limited for this event; advance booking is required and places will be restricted to people actively working on HI projects across the North West.
Platinum Suite, Reebok Stadium, Bolton
http://northwest.assist.org.uk

November

Nursing Specialist Group with RCN Wales
14 November
Cardiff
www.nursing.bcs.org/events.htm

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

ASSIST Yorkshire and Northern Branch
21 November
Tribal House, 6 - 7 Lakeside, Calder Island Way, Denby Dale Road, Wakefield, WF2 7AW
http://yorkshire.assist.org.uk/

ASSIST North West Branch with the NHS North West Strategic Health Authority
Conference: assistive technologies: state of the art developments. AGM: 4.30 pm
29 November
Stirling University
www.scotshi.bcs.org.uk/Events.htm

BCS and the British Institute of Radiology
Workshop on IHE XDS Cross Enterprise Document and Image Sharing in UK Healthcare – £60 (plus vat)
BCS, 5 Southampton Street, London, WC2E 7HA
15 October 10am – 4pm
www.ihe-UK.org
For a booking form, contact christine.mayes@hq.bcs.org.uk

ASSIST Yorkshire and Northern Branch
17 October
Meeting Room 1, 1st Floor, North Wing, St Mary’s House, St Martin’s View (also St Mary’s Road), Leeds LS7 3JX
http://yorkshire.assist.org.uk/

Northern Specialist Group
Electronic Transmission of Prescriptions
17 October 6.15 for 7pm
Presenter: Tim Donohoe, NHS Connecting for Health
Manchester Conference Centre, University of Manchester
www.bcs-nmsg.org.uk
IHE XDS is an internationally agreed method of using an ebXML registry to share stored electronic documents which has been defined by the Integrating the Healthcare Enterprise (IHE) and is rapidly being adopted around the world.

IHE XDS supports a wide range of documents including CDA documents, pdf, rtfl and DICOM images and supports the use of documents that may include a coded section allowing an easy progression to automatic information search while supporting existing clinical practice.

Come and learn about XDS and how to implement it at this workshop led by the IHE-UK Demonstration Manager.

Participants will receive guidance on:

- XDS, XDS-I (images) and XDS-MS (medical summaries);
- Use of the relevant IHE technical specifications;
- Participating in UK demonstrations of XDS;
- Preparation for the IHE-Europe connect-a-thon.

This is an excellent opportunity for healthcare software suppliers, information officers and those involved in electronic information sharing across the healthcare enterprise to learn and participate.

Come to the workshop and explore ways to use IHE-XDS in the UK.

For further information visit:

www.ihe-UK.org
www.ihe-Europe.org
www.ihe.net

Contact Nicholas Brown IHE-UK Steering Committee chair on 07717 626360

Integrating the Healthcare Enterprise is an international not-for-profit organisation that enables healthcare IT system suppliers and healthcare IT system users to work together to obtain interoperability of systems.

Cost is £60 (plus vat)

FOR A BOOKING FORM, CONTACT christine.mayes@hq.bcs.org.uk.