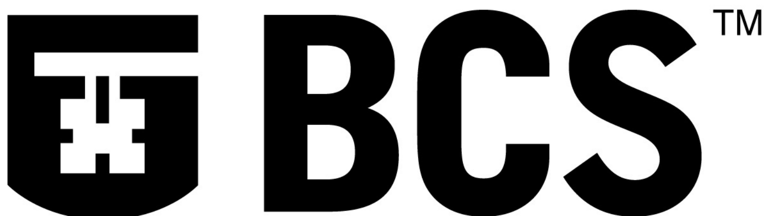
Newsletter of the British Computer Society
Heath Informatics (London & South East) Specialist Group



"LMSG News"

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Editorial

In case you hadn't noticed, it is now May. Or rather, as this has to be written earlier, it soon will be, and I just hope the weather has improved.

From famine to flood: from bust to boom. Regular Newsletters are desirable, but can be problematic. From experience elsewhere, I know that the presence of a copy date is often associated with the absence of any copy, which leaves the Editor to do a lot of thinking followed by the majority of the writing.

Anticipating this, I collected notes at many of the HC sessions which I attended. A major item was the debate sponsored by our group, and ably chaired by Keith Clough. That's ours and we can claim precedence in reporting it. Other sessions are summarised as personal recollections.

The March Newsletter went out to a mailing list which was drawn from various sources which may not have been fully up to date. With it was a membership information form which everybody should have filled in and returned by now. Of course, if your information was wrong on the address list, you may not have got the piece of paper about updating. But, all the documents were available at the very successful HIC stand (D2) at the HC2003 Exhibition. So, this Newsletter should be going to a new and up to date distribution list. Thanks to the BCS HQ staff (Barbara Porch et al) who organise the mailing.

I don't have to write all this. You could join in too. The Editor welcomes articles, letters, meeting reports, or anything else reasonably related to our objectives.

Mark Buckley-Sharp

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Group Names

The Health Informatics Committee (HIC) has an important role in the Society in that it manages external links to bodies such as IMIA and EFMI, and it runs panels coordinating expert opinions on healthcare informatics matters. However, although it assists them, it is not strictly in charge of the set of individual specialist groups within healthcare informatics. The exact formal status of HIC remains under discussion, and it will get fitted into the Society properly somehow. That may be as a forum, or an expert panel, or as something else.

The role and status of HIC is a different matter from the brand naming of the healthcare informatics specialist groups. Our new name of HI(L&SE)SG (and there may be an insignificant prize for the person who can expand that in full from memory) needs to be ratified by the Society: for example, it is not yet in use on the Society's website. An important purpose of our new name is that all the healthcare informatics groups should coalesce alphabetically in the Society's list.

Other Healthcare Informatics Groups

Other longstanding BCS specialist groups include, in their older identities, Northern Medical, Scottish, Nursing, and Primary Care.

New specialist groups include South West, North East, and Allied Healthcare Professions. The recent HIC meeting heard how these are progressing, although there are some difficulties. You would think that with all the interest in NHS IT, there would be more than enough interest and action to keep a full set of groups very active.

Contacts List

Chairman: Vacant, but an appointment is expected.

Secretary: Stephen Elgar, stephen.elgar@btopenworld.com

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Website URL at: www.health-informatics.org/lmsg

Other Committee members include David Hancorn, Andrew Capey, Elizabeth Hunter, Jas Weir, with Keith Clough continuing as President.

Membership of HI(L&SE)SG is open to anyone interested in its activities. It is not necessary to be a member of the British Computer Society.

To join the group, please e-mail your contact details to Mike Andersson (see above), including postal address, e-mail address, and BCS membership number if you are a member of the Society.

At present, there is no annual fee to join the group. A small charge to cover local costs is made when attending meetings.

To unsubscribe from the group, please also contact Mike Andersson.

Proceedings at HC2003

Registrants at HC have a copy of the Proceedings included in the cost. How much of HC appears in the Proceedings? The answer may surprise you. If you got the CD-ROM version, have you looked at it yet? If you paid extra for the book, was it good value? Seeing that HC is a multi-stream conference, which always means that you cannot go to most of it, perhaps you are looking forward to reading details of the sessions you could not attend. You could be disappointed, as the proportion of HC2003 reported in its Proceedings is only about 16%. What does this tell us?

[Counting the plenary sessions as one each; adding all the multi-stream options including the cancelled one; calling the posters one session; and excluding the commercial case history adducts; there were 48 sessions in the HC2003 programme. Allowing for partial reporting, there were 8 and a bit session reports in the Proceedings.]

What is in the Proceedings is what might be called the science bits. That's what is done by people on their own or in small groups trying to find out the more fundamental truths in our special interest area of healthcare informatics. In the swirling world of government targets, industrial reorganisation, and end-user confusion, looking for a bit of truth must be a reasonably good idea. When the torrent eases, it will remain as the sedimentary deposits which we can pan for nuggets in the future. That isn't to say that it all appears equally useful right now, or even very new. But, it's a stream of activity which needs to be kept going.

What then are we to make of the absence from the Proceedings of the vast majority of HC2003, and not forgetting the same for its predecessor events. It tells us that most of HC is taken up with commentaries on work in progress; policy statements; keynote speeches by people, some of whom arrived in post yesterday and will be gone tomorrow but who front organisations with a longer life. It tells us that a lot of the sessions are now effectively sponsored with a handover of editorial control. And, it tells us that there is a quite separate need to report all this activity. A lot of the content of HC now appears in sequel (and sometimes even in prequel) in BJHC&IM.

If you did not get to HC2003, or if having got there you could not be in more than one place at a time, all is not lost. Most of it will land on your desk sometime, and some of it right now.

Meeting Report
Tuesday 25th March 2003
at HC2003

The Group has sponsored a debate at previous HC events, and 2003 lived up to our lively reputation. About 70 voters assembled to hear passionate arguments, and to participate, on the motion – "This house believes that using ICT solutions determined at a national level is essential to support the delivery of 21st Century healthcare." This is a highly relevant and topical matter as recent announcements on the future progress of NHS IT have set out an agenda which differs significantly in its intentions for delivery from that which went before.

Keith Clough had recruited the lead speakers. For the motion, Richard Gibbs, seconded by Andrew Haw. Against the motion, Paul Cundy, seconded by Markus Bolton. When reading the following report of their presentations, note that they were specifically commissioned to collate and present views which would be biased to their allotted roles. The views expressed are not necessarily their own, or those of any organisation with which they may be personally connected. The record is that of your Editor whose intention has been to make a readable version of the proceedings. If this differs at all from the speakers' intentions, remember that the message is always what is received!

Keith Clough (KC) chaired and opened the meeting by explaining that this was an opportunity to explore the two sides of an important argument. Speakers would be limited to time so as to maximise participation. The session made use of electronic voting systems, and all the participants were invited first to vote and declare their prejudice. At this baseline, 65%:35% voted in favour of the motion: the majority starting from the premise that nationally determined solutions are essential.

Richard Gibbs (RG) proposed the motion. Generally speaking, the individual organisations which we have in healthcare need to decide on their own how they are going to meet set targets. But, the requirement in IT is different. Healthcare is a many to many plex of organisations: compatibility and interoperability need technical standards and national common specifications. That means national solutions.

Our history of local solutions is not good. The NHS has not fostered suppliers who are either leaving the market, desperately reorganising, or may not have adequate funds to continue. Large IT suppliers may stay out of the health market. They think health is fragmented; that the cost of procurement is too high and higher than in non-health markets. Health IT needs central mandated funding. We have tried encouragement, and we have tried hypothecated funding. Nothing short of top-sliced procurement may actually work.

Paul Cundy (PC) opposed the motion. The argument we are having is about getting IT solutions, and should not be only about procurement. The evidence is that such national systems as have been tried, have failed to deliver. Examples include Wessex, HISS, and READ-3. Attempts at centralised procurement have been no better. SW region put out their OJEC advert in 2000. Did it speed up procurement? No. National solutions have been tried outside health as well. Inland Revenue; National Insurance; electronic court records; air-traffic control have all fared little better.

The question to ask is whether design at the population/national level could really support direct healthcare given by all clinicians. The obvious complexity for the front-line user is not solved by removing all local ownership and by the consequential planning blight. But, even supposing that there could be national solutions, they would only have to be implemented by subcontractors with further overhead. And, how could a local health service ever evolve if its IT functionality is locked to a national solution.

Andrew Haw (AH) seconded the motion by posing a question. Is the local organisation-centric procurement process alive or dead? It is dead: even if not, it should be. Healthcare used to be delivered from organisations which occupy physical locations. But, healthcare is now much more fluid. NSFs, as standards of healthcare delivery, are not organisation bounded. Both the patients and the clinicians are highly mobile, and hardly wish to be confronted by different systems everywhere they go. How long does it take to learn the norms of a new system? Too many people in healthcare have had to do a procurement. This is a wasteful overhead with no benefit. It must be better to standardise. Whatever EHR eventually comes to mean, we will need it. Some common and lasting standards are essential.

Markus Bolton (MB) seconded the opposition. There are installed hospital EPR systems, and other local health systems, which are doing good work. The NHS is not like Tesco – much the same everywhere. Local health Trusts vary a lot – in the timing of their IT cycles; in their degree of specialism; in their specialty balance: and they are throwing up new ideas for progress at a huge rate. Common centralised procurement will just lose all local support. It is difficult to get major change but local ownership is a main driver. Ownership comes from the choosing process, and not merely from the choice outcome.

Centralised purchasing has obvious attractions: but does it really work? The halfway house of framework agreements can be offered, and has been: but do people then use them fully? The '21stC IT' report has stopped all new OJEC adverts. From the NHS side, this has blocked our local initiative. From the supplier side, this has blocked cash flow.

Comments from the floor were made by speakers identified here as S1, S2, etc.

S1	a) We have a proliferation of standards, NSFs etc b) Has the Microsoft NHS licence (as an example of a national solution) been proven to be value for money? c) Local ownership of projects is essential
S2	a) No local ownership leads to no local action. But local ownership does not have to be equated to local procurement.
S3	a) Project failure is not new. The reasons for project failure are common and well known, and they can be managed. It is not the case that a national project always means failure any more than a local project means success. b) A local view of a different requirement may not be true: it may just be ignorance. A national programme should be managed for economy of scale and for interoperability between individual products. c) Suppliers must be encouraged. Buyers must avoid scope creep in their projects.
S4	a) People at the point of care, who are the people we are trying to support, still need to be convinced that IT is really a workable solution. IT is not an end in itself and cannot be separated from the rest of the healthcare delivery process.
S5	a) Where there is high staff turnover (and where doesn't that apply) there is a need for standard systems to help with training and induction.
S6	a) We need to go even further than national solutions towards a single national system. Typically, 1 in 3 system developments fail. Would we prefer about a third of the NHS to be inoperative, or would we prefer a two-thirds chance of it all working? b) As examples. We (nearly) all use MS Office. We (nearly) all use the BT telephone network. Go to Columbia Health, and you will find a common system in use.
S7	a) Central funding is needed both to design common functionality, and to have all healthcare delivery catch up to a common level of performance.
S8	a) Staff on rotations need common systems. b) Local systems are highly valued locally, and that needs to be preserved whatever is procured.
S9	a) As a warning, national systems may restrict innovation. Big proprietary systems are being built without adequate ability to interoperate with others. What is required is national standards for systems, and not necessarily national systems as such.
S10	a) Within any need for national systems, there is a specific need for subsystems. These include patient index; master codes; etc.. Could national systems be created as fairly thin functionality on top of these subsystems?
S11	a) The NHS does not have common business processes, and existing Trusts work as federations of activity. A magic wand to deliver the same system everywhere seems like a nice idea, but what is to happen with existing locally good and useful systems?

	b) The total supplier resource in the market may be enough to cover the NHS expectations, but that is spread over many suppliers. Expecting delivery of a common national system from a few suppliers will be impractical.

PC then summed up for the opposition. The motion under discussion has been demolished as we do not need national solutions. Even if we did, we do not need national procurement. What we do need is evolution and interoperability between existing systems. One single system would only be a downgrade on the current situation, and future cost can only be constrained by maintaining adequate variety.

RG then summed up in favour of the motion. We seem to agree the need for national standards, even if only for interoperability: that in turn is a type of national solution. We must also consider how we have got to our present position. 'IfH', which was to work through local implementation, hardly led to lots of thriving local solutions. Banks, and the Pensions Agency, are national solutions which do function. Local support is still going to be needed, and can be covered by configurability. Local implementation can coexist with national solutions.

KC called for a final vote on the motion, which was 55%:45% in favour. In a secondary vote, 82% reported that their original view was unchanged, and 18% that they had changed their vote as a result of the debate. This allowed both sides to claim some successes. The motion was carried both before and after the debate. The debate caused a net swing away from the national solutions model, but some were still persuaded in the opposite direction.

NHS Direct

Newsletter 45 (March 2003) reported our meeting "Bringing Healthcare Information to the Public". As a follow-on from that, see www.doh.gov.uk
for press release 2003/0165, and www.doh.gov.uk/developingnhsdirect
for plans to expand NHS Direct, which include ideas discussed at our meeting.

Snippets of HC2003

Newsletter editors are always on the scrounge. Information, Information, Information is their stock in trade: and from anywhere it is available. So much of HC is not in the proceedings, and these snippets provide the briefest of notes from half a dozen unreported sessions.

Being somewhat techie, and interested in frontline use, I much enjoyed the session on **Integrated Clinical Systems** led by Liz Horkin from Southampton. Their premise is that clinicians want something that works for them and with them, but that there can be common infrastructure behind it all. Central systems include PMI, PAS, Reference Code Files; Pathology; Imaging; Interface Engine. All clinical systems are then built on top using a common web style. Clinical services are queued for development, with priority to clinicians prepared to commit seriously. Developments are quick and effective: and skills are developed with an outside contractor. With the growing list of applications, some wider clinical lessons are being learnt. Patients may have a care pathway; but they may also have a care meander (passing on through several clinical systems), and they may also have a care maze (simultaneous care in several systems). Implementing total care packages (like an NSF) becomes possible through mapping into available systems and hence identifying missing systems which require development. I thought this was a very effective managed process for ensuring that useful things do happen, and that external pressures can also be accommodated.

That takes me to the tutorial on **Avoiding National Service Framework (NSF) Silos.** We can and have built small systems with limited scope, whether these are departmental (like Pathology) or clinical. They can be linked by an interface engine, and we can put viewers on top of their data. We could build precise ways of collecting and collating NSF data. It is unfortunate that NSFs are sometimes equated with their minimum data set definitions, but there are a number of reasons against this. An NSF is not a boundary for the work of a clinician: cancer cases for a surgeon are only some of the surgeon's work: the surgeon wants a surgery system and not a cancer system. An NSF is not a boundary for a patient either: some may be within the scope of more than one NSF. An NSF is meant to be a definition of good clinical care without

organisational boundaries. Implementing a standard for an unbounded care process is much more than keeping an integrated care record, and also more than collating information from the care records. I thought this session was a useful reminder that IT, or data, or whatever it is that informaticians are interested in, only exists usefully for a different purpose.

Continuing the theme of integrating records, I attended the session on **Integrated Records and Diagnostic Service Procedures**. The session considered standards with an academic slant.
The clinical process is dependent on information, and clinicians must be able to access all diagnostic information from wherever it is held. Access must be fast and secure: data must be readable, understandable, and tailored to the end user's requirements. Straight away, this is a requirement for semantic interoperability between multi-supplier systems. While clinical expert review may require information in original form, others may get what they need by reports which are decimated, filtered or collated: and either pre-prepared or created on the fly. Those creating system specifications eg, for the Integrated Care Record Service, must include full interoperability. Otherwise, there will be an unsatisfactory default to restrict suppliers and limit usability. I thought that this session continued an important theme of HC2003: that we are making progress to understand our requirements better.

I grouped the three snippets reported so far with the theme of making frontline support really workable. The following snippets are no less valid, but they address a wider picture.

Reshaping Clinical Practices was a feedback session from the BJHC&IM Autumn Forum meeting. As this is a summary of that summary, it can only be headlines.
Whatever the plans and outcomes of national design and procurement activity, there will always be a need to deliver local change through management of and by local people. There are capacity and skill limitations with NHS IT staff. Even if numbers are up, turnover is too high and there is little workforce planning. Many clinicians are switched off by IT, although the difficulty can be overestimated and there are champions available. Expectations must be controlled, and clinicians need time to do the work. All the same, they tend to stick around (Ed – if only to complain!). The scope, timescales, and ownership of EPR/EHR remain unclear. The requirement for prescribing and booked appointments/admissions show that shared care interoperability is a must. But, they are knocking against the limits of communications, of confidentiality and consent, and of our understanding.

The **National Framework** feedback session was particularly useful for those who were not able to attend the whole stream on the previous day. It was billed as a partial view and this is a further level of summary.
Capacity. Recent surveys of industry capacity show that it is limited, with intellectual property spread in smaller companies without capacity. Our large scale IT record is poor, and available products may not be UK-friendly. But, there are many vendors who could meet the ICRS core now. On the other side, there are user capacity limitations as well, with a legacy of work in progress, and a lack of primary and community care focus.
Infrastructure: Technology creeps in, with networks improving availability, scalability, security, and quality of service. Mobile technology is becoming much easier. (There was no discussion of infrastructure applications eg, NHS number.)
ICRS: Healthcare organisation is changing fast. Despite the known needs, true patient-centric activity still eludes us. The ICRS design authority has its programme of work, but there are concerns. Will it really improve patient care; will it really enable improved access to healthcare; how will it deal with confidentiality?
Stakeholders: These include patients, clinicians, and management. Patients need to be involved in design, QA and accessibility (skills, language etc.) Clinicians need active involvement with better training and identification of responsibilities. Management must lead and develop service modernisation with integral IT. [Ed – This makes the idea of a ring-fenced IT budget rather pointless, as it's only part of the requirement.]
Appointments/Bookings: The aim is to give choice linked to compliance up to the standards of commercial booking systems, such as airlines. There is progress towards tough targets, but bookings are only a small part of the care pathway.
I thought that the session covered the issues realistically. It was part of a wider feeling that HC2003 was serious about the

opportunities and problems of significant implementation of healthcare IT.

If we are not caught out by the technology or the budget or the project management or the sheer difficulty of changing everyone's activity, then we might still be shot out of the water by **Confidentiality**. Nowhere else do law, ethics, personal preference, and ignorance combine to polarise the possible outcomes between success and failure. So quite a considerable audience assembled to hear a feedback commentary on the recent NHSIA public consultation process. **Background:** Confidentiality is a difficult question as society's' expectations are changing beyond the current law. Sharing information has benefits: patients recognise this through better healthcare and reduced risk. Sharing information has risks through inadvertent or deliberate leaks, and potential for harm. Trust for sharing information cannot be assumed, and can definitely be lost. **Consultation:** Some basic principles were considered. Everyone needs to be informed about the confidentiality model within which the NHS would operate. Data should only be identifiable when needed. The patient should have some control over access. The consultation documents, including staff code and patient charter, generally scored 80-90% acceptability for length, readability, and content: except that the staff code was widely considered too long. Although these are high scores, they are a long way from universal approval. Also unclear are how the 'sealed envelope' concept could be workable; how much time and training are required; how there will be accountability and overall confidence; and how to handle legal capacity for consent. There is more to be done on the business model for confidentiality and on information governance.
Requirements: There is a minimum legal requirement for fair processing and consent. The majority of people would be happy with a generic model which actively limits the use of confidential and identifiable information. But, a minority want very detailed individual consent applied to their personal data. Currently, there is too much implied consent, which really means no consent at all. At the least, we need a move to more but better implied consent (model based), with explicit individual consent where required. **Progress:** It was clear in the discussion that the NHS is barely, if at all, complying with minimum legal requirements. If complying is the objective, and stopping all current healthcare might not be in the public interest, then the NHS must have an active plan to transition to compliance. Plan stages need to include public communication; staff training; securing all the information flows; and overall support for such an important programme of work. A rather interesting point from the floor discussion was that the NHS will continue its work even though it may not be legally compliant on confidentiality. Compliance can only come from a relatively lengthy managed process. [Obviously, it is to be hoped that the Information Commissioner agrees that actively working towards a suitable standard is ultimately a better and more lasting outcome than stamping down hard immediately.]

Advertising Meetings

The Committee wishes to encourage an effective and lively series of meetings which should be suitable for those wanting a programme of continuous professional development.

There is a prime requirement to organise meetings which have a wide appeal of subject matter, and which have authoritative speakers and other contributors.

In support, there is a need for good and active advertising of the future meetings.

- Announcements should appear on our website.
- For members of the Society, meetings should appear in the regular e-Bulletin.
- For members of the Group, we have the Newsletter, but that may not appear with sufficient frequency.
- It would greatly help if Group members supply or confirm a personal e-mail address so that ad hoc posters can be circulated easily. That requires us to improve and collate our membership list, and Mike Andersson will be leading on this project.
- Notices of meetings will be sent routinely to members of other organisations such as ASSIST and IHM. Please would individual members of any of these organisations pass on advertisements to their colleagues at places of work.

Meetings of our Group are inexpensive. Where else would you get a professional meeting for the equivalent of about £10 per day?

Attending Other Meetings

Notices of meetings of other groups have been included in this Newsletter where they may be of interest to our members.

In many case, other organisations offer a discount on registration for HI (L&SE) SG members. That is a good reason to be a BCS member or to be on our mailing list.

HI (L&SE) SG makes a reciprocal offer to members of any other group, who are interested to attend our meetings. Advertising of our meetings in publications by other groups is positively encouraged.

Project Funding

BCS Health Informatics Committee is expected to make some funds available for project grants. Procedures are being considered, and any announcement will come from HIC. Anyone interested should watch the HIC website.

Contact: www.health-informatics.org

What's On Autumn 2003

Wednesday 17th September

HI (L&SE) SG

tba

Moorfields Eye Hospital, City Road
London EC1

Tuesday 7th – Wednesday 8th October

IHM Annual Conference and Exhibition

Telford

Contact: 020 7881 3291
enquiries@ihm.org.uk

Thursday 16th – Friday 17th October

International eHealth Association
and Partners

eHealth 2003

Conference and Exhibition, London

Contact: 020 7828 7777
krc@imf.co.uk

Wednesday 19th November

HI (L&SE) SG

Patients and Confidentiality

Moorfields Eye Hospital, City Road
London EC1

What's On Summer 2003

Wednesday 21st May

ASSIST Annual Conference

The Long Winding Road

Lakeside Centre, Aston University

Contact: www.assist.org.uk

Wednesday 4th June

HI (L&SE) SG

2010 – Healthcare Delivery and IT Support – some predictions on each.

Moorfields Eye Hospital, City Road,
London EC1

Wednesday 11th June

HI (Nursing) SG

Information & Litigation in Health Care.

Kettering Hospital

Contact: www.bcsnsg.org.uk

Tuesday 17th – Wednesday 18th June

BCS HI (Primary Health Care) SG

Dealing with uncertainty: the future of IT in primary care

Heythrop Park, Oxfordshire

Contact:
54 New Street, Worcester, WR1 2DL
+44 (0) 1905 727461
administrator@phcsg.demon.co.uk

Tuesday 1st July

British Computer Society
Healthcare Informatics Committee

More Radical Steps

By invitation

To ask for an invitation, apply to
radicalsteps@amiconf.demon.co.uk

Thursday 3rd July

Royal Society of Medicine Forum on
Telemedicine and e-Health

Telemedicine and Telecare in the NHS VI

RSM, London

Contact: RSM 020 7290 3943
telemed@rsm.ac.uk

Thursday 17th July

HI(L&SE)SG with ASSIST (Oxford)

Telemedicine in Practice

Chorleywood

Contact: krc@imf.co.uk

Health Informatics (London & South East) Specialist Group

Next Meeting

Wednesday 4th June 2003

2010 – Healthcare Delivery and IT Support – some predictions on each.

at The Board Room
Moorfields Eye Hospital
City Road, London

5.30 for 6pm until 8pm
£3 charge for refreshments
Please e-mail barrie.winnard@moorfields.nhs.uk if you will attend

The opinions expressed in this NewsLetter are given in good faith as a record of meetings and activities of the Health Informatics (London & South East) Specialist Group (formerly the London Medical Specialist Group). They are not necessarily opinions or policies of the British Computer Society or of any organisations employing the authors or speakers.

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