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

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Editorial

I have only ever had to miss one of the Healthcare Computing (HC) series of annual meetings. As a result, I have a nearly complete set of the books of proceedings. I rather like the books: they seem more robust and permanent than the CDs.

Or, rather, I did have a nearly complete set. Preparing for a departmental move has involved serious consideration of the usefulness of my library, leading to a procession of full rubbish sacks. I checked through the contents of my HC books, and I thought I would share the outcome of my review.

It was nice to recall some of the papers which I had listened to directly so long ago. But that's not the same thing as finding the content useful today. Although the material always seemed relevant at the time, I concluded that it all got replaced (and that's more than just updated) on a cycle of about three years. So, I have kept the last three years, and will in future run a policy of add-one and throw-one annually.

Of all the content older than three years, and to prove that I did look at it all, I will pick one item as highly relevant to today's situation, both by topic and by the prescience of its content.

"The electronic transfer of clinical records: suggested rules to control access and confidentiality." by Griew AR, Darley BS, Mcloughlin KS; Healthcare Computing 1994, 137-143, has 14 rules and rationales which are as close to the ICRS requirements as you could hope to get. I recommend it.

Mark Buckley-Sharp

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Committee Report
Wednesday 17th September 2003

The group now has about 145 members, and registration continues by e-mail to Mike Andersson (see Contacts) or on-line at our website. Recently, the addresses were loaded onto central BCS systems, with telephone and e-mail data being added now. This progress is all about moving our membership administration entirely to head office where those who want to be involved with the group will be logged either via their BCS membership or in a BCS non-member category of specialist group affiliate. Longer term, all will be able to maintain their affiliation on-line. Although the not so good news is that BCS will become able to charge an administration fee centrally, this will be balanced by simplification of payment collection which the group alone could not achieve.

Continuing with administrative matters, the group is an early adopter of BCS Connect where our financial affairs can be managed

centrally, and there will be list servers for broadcasts to members, for free discussion groups, and for restricted discussion amongst Committee members. We hope to hear more about this initiative at a meeting on October 15th.

The Committee heard that the group's website, which is a directory within that of the Health Informatics Committee may have to be reorganised and resited. David Hancorn will be investigating how the plans may affect us.

Otherwise, The Committee fell to planning the future programme for which announcements appear elsewhere in this Newsletter.

Our Stand at HC2004

There will be a stand at HC2004 for the various BCS groups. Ideally, this should be staffed on rotation by some group members who can advise visitors about our activities. Anyone who would be prepared to give a little time by joining a panel of volunteers is asked to e-mail Keith Clough at krc@imf.co.uk . Keith will pass on the list to whoever becomes the stand manager.

e-Health Innovation

The e-Health Innovation Professionals Group is launched in October 2003 to facilitate networking between fellow professionals and organisations.

The group supports and contributes to IHM, ASSIST, BCS-HIC and others, and supersedes the IHM and ASSIST Telemedicine and Telecare Programme.

To join the mailing list or offer help contact Keith Clough, krc@imf.co.uk

And at www.assist.org.uk/links/ihm

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Other Committee members include David Hancorn, Andrew Capey, Elizabeth Hunter, Jas Weir; and the Committee has welcomed new members Sandra Evans and Moira Watkins.

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.

If you receive a copy of this Newsletter either by post or e-mail then you are a member of the group. There is no need to reconfirm membership unless any of your details have changed.

At present, there is no annual fee for being a member of the group. A small charge to cover local costs may be made when attending meetings.

There are two easy ways to join the group.

1) E-mail to Mike Andersson at
bcsgroup@andstrom.co.uk
advising your postal address, e-mail address; and include BCS membership number if you are a member of the Society.

2) Go to our web-site at
www.health-informatics.org/lmsg
and fill in the on-line form.

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

Meeting Report
Wednesday 4th June 2003
at Moorfields

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

For this meeting the group took a look into the crystal ball with the help of Ian Jardine (an independent Health consultant) and Murray Bywaters (Silicon Bridge Research Ltd) and considered the shape and form of healthcare over the next 7 years and the role IT will make in its transformation.

Healthcare in 2010:

Ian started by stressing the importance of gaining "hearts and minds" in leading any change, and quoted the example of Ahkenaten, an ancient Egyptian ruler who changed the state religion and the capital. Following his death the capital was returned to its original location and worship continued as before. There are profound change in motion in how medicine is practiced, in part to do with the relationship of the patient and the healthcare professional, in part due to organisation of delivery of care and the contribution of technology.

There is a development in the relationship of patient and healthcare professional as the patient becomes a more active participant in their own care and as the practitioner is trained and responds to this need for dialogue in consultation and empowerment of the patient. Home monitoring and patient measurement is shown to produce better results and compliance to treatment. Surveys and active trials of access to medical records and second opinions on-line also indicate enthusiasm and better outcomes. (It should be noted that the legal status of on-line notes and consultation is not yet known.) In response to these trends, the present NHS procurement of an Integrated Care Record Service (ICRS) includes functions providing patient access to a subset of the record that will be built up.

Within the professions there continues to be movement towards greater specialism both within Medicine and in terms of the expanded role of the para-medic and nurse. Many GPs are becoming specialists in subjects such as dermatology and the assumption is that the chain and pattern of referral from Primary care will result in changes in casemix of patients and their practitioners in secondary care. Specialist hospital services are becoming more significant with Day Care Treatment and Specialist Surgical Units. Associated with these changes in hospital, use of Telemonitoring, call centres and NHS Direct, the growth of Home-based care, Intermediary care and Walk-in centres are increasing.

Significant changes in disease management are also in progress with attention moving to carefully controlled regimes of care for chronic disease such as Diabetes and Asthma and, for children, developing attention to early intervention in family and behavioural problems such as child abuse and severe personality disorders. In terms of the delivery of care, genetic knowledge and manipulation will become more significant. Other trends are likely to include continuous monitoring, near patient testing and individual titration and minimal access (or key hole) surgery; all of these within a context of protocols and guidelines for more explicit pathways of care. For practitioners, Computer-based training and decision support will play a significant part as care is provided within a more general knowledge management environment. Self-help groups for patients will become more common and, for the practitioner, multi-disciplinary teams in clinical networks.

A practical issue for all practitioners currently is the pressure on their time for meetings - Ian assumes that video conferencing and electronic consultations and communication through more powerful networked computer desktop will become normal practice.

Trends in technology:

Murray drew our attention to a comparison of spend by staff numbers in different sectors of commerce: whereas Banks in Britain spent £8,790 per head, Government in general spent £2,920 and Health £979. The conventional wisdom is that this parameter has a strong relationship to productivity. This belief in the leverage effect of IT spend on productivity is shared by the current Government and is behind the enormous reinvestment in progress of £2.3B in the NHS over 3 years. Another concept is relevant to this investment effort, that of the potential of IT to support extended relationship management, that technology can grow complicated business (or clinical relationships) across organisations. For the wider business world "e-commerce" can support complex and flexible supplier relationships, for health this can be translated as seamless care across multiple clients.

Why is the business of healthcare different to other commercial sectors? Murray suggested that there is a general lack of specification of process, arcane and complex professional structures that underpin expertise and that Government is compelled to intervene when the population becomes dissatisfied with services. There is a growing pressure on services from an ageing population, a pressure common across the Northern democracies and that productivity increases do not necessarily result from increased investment. There are tensions in the various approaches available to IT investment in healthcare, for example between the devolved and market driven, to one that is science and technology driven, to an incremental approach. The present phase of investment in the NHS in England, led by the highest paid civil servant Richard Granger, can be seen as a centralised, Big Bang.

Murray introduced the concept of a transition in progress from an installed base of systems for healthcare, and a market structure, that can be characterised as being focused upon organisational-centric functions to one that will be transaction-oriented and cross organisational. These transactions will be centred upon clinical and business processes relevant to the citizen, patient and healthcare professional (e.g. I can see all my booked appointments and tests needed for the next week). IT can be seen as providing an active infrastructure to support shared patient information based on protocols and pathways with standard interfaces in the background underpinned by enterprise-wide applications that can speak to each other across consistent and fast networks.

The NHS reinvestment has a number of features that Murray introduced. A procurement process is being held to identify a set of National Applications Service Providers (NASP) - to provide services such as a spine or summary record for every citizen - and for the 5 regions, Local Service Providers (LSP) - suites of integrated systems across GP, Community, hospital and mental health services. The first phase of investment to the end of 2004 will see national email and directory services, an initial implementation of the spine, results reporting 1/3 of communities with PACs, eBooking and the citizen view of our record - "myhealthspace". By 2006, the range of functions available across the NHS will have increased to include referrals, requests and orders, complete coverage for PACs, clinical decision support and patient scheduling. By 2010, this should include "everything else you could dream of for the NHS"!

Murray continued by suggesting that the current scale of reinvestment in IT within the English NHS was likely to be followed by other countries as they sought to transform the delivery of healthcare. A new set of suppliers would come to dominate the market within a more devolved service. These companies will provide a bundle of health services such as build, equip and manage. The present set of NHS IT suppliers would provide components within this set of services.

In conclusion, and returning to thoughts of Ahkenaten, Murray reminded us that the cost of IT is 25% technology and that 75% is the effort of implementation.

Discussion opened to the floor:

Q: Who will be the big players in this changed market place?

A: These suppliers are likely to include current big players in Medical equipment such as Siemens, General Electric, Philips and Agfa.

Q: It can also be said that many organisations have overspent on IT and maybe the NHS has got it right to date?

A: Whereas other industries can be seen to have been "over-engineered" in terms of IT investment, but with its reliance on use of information, it is suggested that it is difficult to sustain that view of health. It is possible to say that the absence of an effective information service can kill patients.

Q: Will there be a convergence of Medicine and IT?

A: Yes but IT can be seen as providing a new set of tools, just as pen and paper did in the distant past. However, if, in the past, efforts of implementing IT have been characterised as technology being fitted around Medical Practice, increasingly, it will be the other way around. This relationship is already accepted in use of medical equipment (e.g. "to use this monitor you do this, this and that…"). The relationship is most creative when IT can provide opportunities to do things differently.

Q: What contribution can IT make to better health?

A: Health can be seen as being a product of 20% genetics, 20% life style and 10% intervention (and 50% random variation? – Ed.). As stated earlier, IT can be seen as supporting the trend toward patient empowerment.

In conclusion the observation was made of similarities between recent changes in the rail industry and this phase of investment in the NHS ie, the complexity of relationship, the scale of outsourcing, speed of investment and the reliance on new private partnerships. Would we see another Hatfield disaster?

(report compiled by Stephen Elgar)

Meeting Report
Wednesday 17th September 2003
at Moorfields

Providing the Public with Web Services.

Three guests presented this topic to the group, and an on-line demonstration followed. Besides a general introduction, the specifics concentrated on progress at Southampton PCT which is being transferred also to Ealing PCT.

Michael Bone of Health Systems Consultants gave the introduction. As more and more people, both at work and at home, gain access to web services using simple browsers, so information and process opportunities are opening up within the NHS service providers and for the wider public.

For the NHS, there are web opportunities in booked admissions, in joined up care meeting NSF standards, and for the future Integrated Care Records Service (ICRS).

For the public, access to the internet via dial-up, broadband, and in Cafes and public libraries, will enable reading general information, receiving personalised information, and return channel participation in health management.

There are still some concerns. For the NHS there is a need, common to many applications besides just web access, for accurate ID, secure person to person links, and management of patient consent. For the public, there are similar concerns about confidentiality, and some about speed of access.

But, for all, there are considerable technology benefits from use of a consistent interface, with a low cost of ownership; from solutions already on-the-shelf; interoperable, and multimedia if required.

David Deakin of Interactivhealth talked about how their products have been developed for Southampton PCT to improve data access using web technology.

There is an assumption that the current model of delivery will remain, with the local general practice functionality remaining central to primary healthcare. Within that, PCTs provide a new level of coordination for groups of primary care providers, and become relevant as a level at which the next wider stage of collaboration can occur. For example, PCT-wide web publishing enables common clinical engagement; collaboration on coordinated care; a consistent message to the public, and shared development of self-care packages.

Within Southampton PCT, there is a PCT web portal and an intranet (actually an extranet) for all professionals in the area. The 'Modifi' system allows local content management; the 'Matrix' publishing system includes centrally sourced news items; 'Portico' is web information for professionals; and 'SePAS' is intended to become a secure patient access system.

Content management is set up to be simple and is scaled to PCT size at an affordable cost. Roles and training are provided for content management down to practice level; similarly there are roles for news and content areas, with about 12 dispersed areas.

SePAS is not yet implemented, but the intention is to make it secure for the patient to the same standard as current internet banking. That requires no new technology and familiar procedures.

Glen Griffiths of Interactivhealth ran the demonstration directly on-line to the Southampton PCT site.

Practices retain their own web sites (if they want), and there are links to practice sites which can be their own URL on the common PCT server. Each practice maintains its own content using Modifi which has passwording to protect

publication down to the individual page level.

The systems were rolled out to practices, where all agreed that the web system was worth doing and all were keen to join in once it was offered. Whatever previous web publishing capacity might have been available the PCT system increased it and made content management more flexible. Ongoing positive criticism suggests that the systems are being actively used by those trained.

Besides static publication, progress on some on-line forms had shown how much more efficient these can be than paper.

Generally practices publish demographics about staff; appointments availability, leaflets and health promotion information. Much of this only needs occasional updating for definitive changes.

Professionals using the intranet have to be authenticated. The collation and management of staff ID and access profiles is essential for the project. In discussion it was agreed that the same applies to many NHS applications, and that ID should not have to be linked to any one application.

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.
- 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.

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

Thursday 16th – Friday 17th October

International eHealth Association
and Partners

eHealth 2003: Implementing the change

Conference and Exhibition, London

Contact: 020 7973 4700
www.ehealth2003.org

Thursday 30th October

Royal Society of Medicine
(Telemedicine & eHealth)

What the ICRS has to offer the modernisation of health care. Why clinicians should engage now.

Contact: 020 7920 3943
telemed@rsm.ac.uk

Wednesday 19th November

HI (L&SE) SG

Patients and Confidentiality

Moorfields Eye Hospital, City Road
London EC1

Wednesday 10th December

BJHC Ltd

Caring for older persons at home in the 21st Century

Conference & Exhibition, Birmingham
www.bjhc.co.uk

What's On
Long Term in 2004

Wednesday 21st January

HI (L&SE) SG

ICT, Benefit and Risk

Moorfields Eye Hospital, City Road
London EC1

Tuesday 27th – Wednesday 28th January

FC Group (Healthcare Division)

Effective ICRS Implementation Moving forward into 2004

Conference, London
psimms@firstconf.com

Thursday 29th January

Royal Society of Medicine
(Telemedicine & eHealth)

Modernisation of A&E services

Contact: 020 7920 3943
telemed@rsm.ac.uk

Monday 22nd – Wednesday 24th March

BCS – HIC

HC2004, Harrogate

[at which HI (L&SE) SG will host a satellite session for another of its lively debates on the topic – "ICRS – We Have Liftoff".]

Thursday 20th May

ASSIST

Annual Conference

Lakeside Centre, Aston University
www.assist.org.uk

Wednesday 23rd – Saturday 26th June

Computing in Clinical Laboratories – 15th International Conference

Guildford
Contact: ian.wells@royalsurrey.nhs.uk

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Next Meeting

Wednesday 19th November 2003

Patients and Confidentiality

Presentations by
Dr John Wright
Dr Fleur Fisher
followed by discussion

at The Board Room
Moorfields Eye Hospital
City Road, London

5.30 for 6pm until 8pm
local charge may be made for refreshments
Please e-mail barrie.winnard@moorfields.nhs.uk if you will attend

Your Debate

The Group's debate format at HC is always well received. For HC2004 we are going again for something topical, and for an angle which should be timely. Proposer, Opposer and Seconds will be asked to present for and against the resolution, with comments from the floor.

"ICRS in England – This House Considers that We Have LiftOff"

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