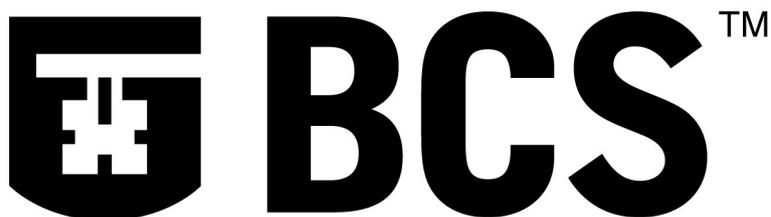


# Report from the British Computer Society Health Informatics (London & South East) Specialist Group



THE BRITISH COMPUTER SOCIETY

**September 2005**

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## Editorial

Our last meeting report was in May, which has been an unplanned gap. The July meeting had to be cancelled on the day, due to the bomb attacks on tubes and a bus. London has had its share of bombs before, and this was an unwelcome reminder that anything can happen.

The July meeting topic, on RFID, has been rescheduled to November.

Meanwhile, there is some progress on using the IDX CareCast EPR system in London, as UCLH went live with its Phase 1 PMI and PAS in mid-June. There were some interesting little glitches during the changeover, but it finally worked. A data migration issue meant that new outpatient appointments could not be given out for a couple of days as the slot availabilities could not be confirmed. Three months later, after some holidays for the participants and some data quality issues managed through, CareCast is still going, and UCLH is looking to consolidate and get on with future phases.

Kevin Jarrold, IT Director at UCLH, is moving to head the London region. I am sure we wish him well, and hope his success will be facilitated by at least knowing in which cupboards the skeletons are hiding.

The Committee has continued planning the future programme, and has settled on a suitably ambiguous resolution for our annual debate sessions at Harrogate in March: one which also takes us away from perennial discussions about NPfIT/CfH. Wait and see.

**Mark Buckley-Sharp**

## Dates of Future Meetings

Thursday 17<sup>th</sup> November. RFID (Radio-frequency Identification) in Healthcare.

Thursday 19<sup>th</sup> January 2006. Best Practice.

A Debate session at HC2006, Harrogate, in March. Refer to conference programme.

Thursday 18<sup>th</sup> May 2006. A joint meeting hosted by us, updating on Telemedicine and eHealth.

Thursday 20<sup>th</sup> July 2006. tba

Thursday 21<sup>st</sup> September 2006. tba

Thursday 16<sup>th</sup> November 2006. tba

All the Thursday meetings are at BCS, Southampton St., and that should be our new permanent day of the week and meeting base. We also prefer use of the third Thursday in the month if you want to plan ahead.

## New Group

There is a proposal to form a new group, provisionally called the BCS Health Informatics (Interactive Care) Specialist Group., which would fit within the Society's Health Informatics Forum.

This group is expected to hold an inaugural meeting on Thursday 27<sup>th</sup> October

More information from Keith Clough at [krc@imf.co.uk](mailto:krc@imf.co.uk)

## Meeting Report September 14<sup>th</sup> 2005

### GP Views of NPfIT

Primary care handles far and away the highest share of all patient contacts, and efficient organisation in primary care is clearly key to effective delivery. The uptake of IT systems in primary care is extensive, and is more clinically rich than in secondary care.

Over the past year or two, considerable concern has been expressed that the National Programme had not paid sufficient attention to the need for primary care to continue their activity as enabled by current IT, rather than impose significant detriment by forcing supplier changes.

Two speakers presented their views on the current and future plans for primary care (GP) IT, and particularly how policy changes are affecting the outlook.

**Philip Posner** is a GP in Kentish Town, and has long experience of developing IT in his practice. **Gillian Braunold** is a GP in Kilburn and joint clinical lead for primary care within the National Programme / Connecting for Health. To say that one is the sceptic and the other is not would be only partially true, as it became clear that considerable convergence has happened over the past nine months, since the clinical leads came into post.

**Philip Posner's** practice in Kentish Town has 16 thousand patients, served by 17 doctors and a wide range of other clinicians. There is a large education programme, including undergraduates of UCL. The practice has been paperless since 1993, which is to say that any paper received is scanned and stored, but is not used in the clinical process.

GP systems in the UK have led the world for their clinically rich functionality in support of the business of primary care. IT is not confined to the practice staff, but is linked to other organisations, and is used by healthcare practitioners from other organisations.

Links to the PCT deal with registrations; item of service claims; and new data for the clinical quality framework of the GP contract. These requirements drive the need for excellent data quality. Although the GP2GP transfer of records is worthwhile (avoiding printing records in one practice and rekeying in another), there may be problems in just allowing a transferred electronic record to

drop into the receiving system. There may be inaccurate data collectively within GP systems, which is a clinical risk if it is just accepted as true.

Links for laboratory data were developed a long time ago. A lot of work was done on mapping codes for tests, but there have been improvements using national standards for codes within messages.

Most GP systems have wide clinical functionality which continues to develop. Kentish Town has scanning of paper; clinical notes; decision support; intranet for forms and guidelines; with moves towards direct patient access for both appointments and for viewing records.

Some local projects have been instructive, if not always successful. Integration of district nurse and health visitors (who have a different employer). Diabetic data shared between GP and hospital clinic. Out of hours access to the system using Psion palmtop. Use by social services.

Some national projects are in progress, and may have better outcomes. GP2GP, except that data quality remains an issue. ETP is coming. Referral and discharge summaries now moving forwards to Choose & Book. Quality Framework data is being provided satisfactorily.

There are some important opportunities:

- Really sharing data in a multiagency care centre.
- Better national standards for systems and data.
- Improved communications via an IT infrastructure also tending to improve personal contacts.
- And, the opportunity to reduce clinical errors.

Then, there are some challenges:

- Changing IT with changing working practices is never simple.
- Data quality (again).
- New requirements for privacy and security as sharing increases.
- Training and more training, and more training, is vital.
- Patients will want, and should have more access to all this IT.
- And, arching overall is the need to communicate and manage the vision of what is intended and what is possible.

Threats to primary care IT must be recognised and addressed:

- NPfIT was a real threat to GP systems, confronting existing suppliers.
- The forward plan cannot include a period of reduced functionality or speed or reliability.
- Responsibility for the records must be agreed.

Current problems lie around:

- Whether GPs are really on board with the National Programme.
- The way targets are changing.
- Uncertainty about the Spine.
- And, how all this change is to be funded.

A GP perspective of the National Programme might be that they still need to be fully convinced; that inevitable work changes must be facilitated; that Choose & Book needs to be incentivised somehow; that the cost of change must be recognised; and that we need to build on current IT rather than just threaten to take it away, to be replaced by something which does not yet exist.

**Gillian Braunold** started with an audience brainstorm of topics which had arisen and need to be considered:

- Changing systems
- Training.
- Data Quality.
- The Spine
- Security & Confidentiality
- Communications (about the projects)
- Funding
- Reliability (of systems)

There are definitely challenges for the National Programme / Connecting for Health. Patients both demand and require a truly common and patient-centric record which can be used effectively for care. This will require all care sites to be linked on a secure network with shared applications. A summary of the care record needs to be clinically safe (adequately complete and accurate) as well as available. While sites catch up, this must not stop innovation by the leaders. And, there is more explaining to do regarding patient data confidentiality.

The National Programme (NPfIT) was and is about a procurement, and its role is reducing. Meanwhile Connecting for Health is about implementation and its role is expanding. We need to think about the big picture where the wasteful costs of moving and managing paper need to be eliminated

and reinvested in better methods enabling better care.

Clinical leads were appointed less than a year ago, and they have the dual facing roles of championing the programme within their clinical base, but also of championing the requirements of their clinical base within the programme.

The national/spine care record is supposed to be a summary of significant clinical events, but the incoming leads got few answers on its real purpose. The purpose has now been rescoped by a working group of clinicians.

There are good reasons for a linked national record. It must be accurate for when it is needed. It must enable better decisions. And, now is the time to get a more general consensus. Trust by both the professionals and public has to be built up. The national record must actually be got running, at least in a simple way which will allow us to learn as we proceed.

In general, patients should have records at two levels. One on the spine (NCRS) which is a summary, and those at one or more local sites which will have full detail.

To access the summary will require a legitimate care relationship with the patient, and will be under patient control. Local records need to be shared as required, but also under patient control.

The plan is to populate the national record starting in 2006 with simple extracts of historical data, taken from GP practices which have reached an accredited status for their data quality. Clinically sensitive data will be excluded anyway. The patient will be able to prevent the upload.

How the national record develops is yet to be seen.

Previously, there was great concern about supply of future GP systems, and how this might be disrupted by the national programme. GPs will now have choice of system, provided that the supplier is in contract with the LSP, and the supplier is committed to ongoing development with the national programme, and the system is capable of being hosted centrally. The latter point being specifically intended to improve system management and continuity.

There was a lively discussion, and the speakers were thanked for their most useful background and update of primary care IT developments.