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

THE BRITISH COMPUTER SOCIETY

March 2006

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HealthCare Computing 2006

Another successful HC event completed. Three days of multiple streams of presentations, and the usual extensive exhibition. HC is subtly different every year. What are my impressions of HC2006?

First, my profound thanks to the organisers for getting rid of the swinging spotlights in the main auditorium, and also for turning down the 'music' to an absolute minimum: only just enough to know the sound system was actually working. Also for keeping out the photographer with his flashgun, except for disrupting one speaker.

We are into the implementation phase of CfH now, and a useful range of speakers described how they have made the leap.

I took the masochistic route of listening to speakers from Apira Ltd (Stream 2, Wednesday morning) describing implementations at Queen Mary Sidcup and at Hillingdon. Einstein is said to have defined madness as endlessly repeating the same experience while being fated to suffer the same outcome. Fresh from my ringside seat at UCLH, it was like reliving the nightmare all over again.

Not content, I then went to hear a slick performance from University Hospitals Birmingham. Anyone yet to implement an LSP solution should pay attention to these experiences. There is a common pattern in how to break down the scope effectively: at UCLH we called them streams of work. The Birmingham presentation was very honest about what went well and then what could have been improved in every area.

In between, at a thinly attended case history session, I heard about computers on wheels in wards at Gwent. When we heard last May (News #55) about the wireless LAN at UCLH, we didn't get the follow-up that the LAN remains unused at UCLH as the carts were not funded. Maybe it is time to reiterate the benefits.

For some reason I am working my way backwards through the HC programme, as my next comment is about the Ministry of Defence procurement. There was a good audience for this on Tuesday. While the affected MoD population and staffing equates to a PCT, the geography is much more challenging. As you would expect from the military mindset, the requirements analysis and procurement had been approached thoroughly. I did just wonder, if you stripped out the geographic complexity, whether there is still some lesson about how much resource each PCT really must deploy to get the CfH vision in place. Maybe not an admiral to head it all up, but certainly something vastly more serious than we tend to see.

There were useful updates on progress generally with the England CfH, and with the Scottish and Welsh equivalents. Richard Granger filled his now regular slot with very effective multimedia coverage of the main strategic issues. It can't be that easy when, back at the shop, the chief executive has just departed. (I might have said disappeared, except that I am finding it hard to imagine anyone less visible.)

The Exhibition was as full as usual. I tend to look down the list of exhibitors while ignoring the claims that every single one is the leading supplier of everything. I tick off the stands I really must visit, and mark them on the map. Then, when I have done

those, I can wander amongst the rest and hopefully be surprised. Except that I went through the list and ticked nothing. So, without preconceptions, what were my impressions?

Dictation systems were prevalent. You can dictate to a digital card, upload and have your letters typed offsite - even abroad. You can dictate to a speech recognition system and tweak the results yourself. And there are a few other possibilities in between. All these help to manage the problem of either lack of skilled staff or the space to put them in on your own site.

There were some equipment manufacturers. I had an interesting discussion on PACS viewing stations with the requirements for resolution and calibration. I picked up lots of pens, but the free mini-mouse has proved to be defective. And I caught up with the folks I know from IDX - now GE.

I will conclude this review by returning to the conference session on the Monday afternoon. I have long thought that the NHS is full of people working their socks off, and yet failing to provide the patients with any sort of satisfactory process. My idea is to turn the vision round and give each patient a sort of air traffic controller who marshals all the required people and facilities in the right order, and to a sensible timescale. I thought this might best be run by a nurse. From Oracle now comes just this idea, but automated. Care process management is just what we need, and if automation means we can do it without too many people, then I'm in favour.

Mark Buckley-Sharp

Debate Session at HC2006

This House believes that real innovation using ICT in Healthcare delivery is driven by clinicians rather than informaticians.

As usual, a completely vague resolution had been devised by **Keith Clough** who also chaired the debate session and had dragooned the speakers.

Also as usual, the speakers had been employed on either side of the debate without regard to the official views of anybody, and often not even of themselves.

Before the debate started, a prior vote was 18:4 in favour.

Simon Dodds is a surgeon at Good Hope Hospital, and he proposed the motion. Innovation means doing something entirely new. Real innovation also involves something which works. Perhaps no more than 2% of any group could be considered innovators. Successful innovators display several properties. They 'feel the need' - in this case the need of patients. They 'create the environment' usually involving a team. They have 'confidence', and clinicians are selected for this. They 'anticipate' well, and guess the likely outcome. And, they 'spread the word' so that innovation gets into use. Clinicians have all these skills, and they have the opportunity in healthcare IT to make the difference.

Ian Herbert describes himself as a consultant health informatician, and is also vice chairman of BCS-HIF. Clinical training requires some self-belief as well as knowledge. Clinicians may own the requirements, but they may have tunnel vision, which limits their ability to make lasting solutions. They need an outside view. The abilities to design, build and deliver are essential to effective innovation, and each of these requires particular skills. Much of GP computing is a success. But, only some of it is by GPs, and the rest is with GPs. Most innovation is teamwork, without which it is ineffective.

Mark Outhwaite of Outhentics Consulting seconded the motion. There is a need to think critically about why clinicians must be so closely involved in IT innovation, and to note that clinician definitely does not equal doctor. At a low level, there must be a change in the relationship between the patient, the clinician and the technology. Only clinicians can effectively question this relationship, and only they can do it. At the organisation's process level, ICT and process change are interdependent, and require new ways of working. At national level, leadership must embrace new ways of working, and these are the ways of clinical process.

Colin Jervis of Kinetic Consulting is also a member of the group's committee. Healthcare really needs IT support. Clinicians may innovate with clinical care, but informaticians innovate with IT. IT innovation requires detailed knowledge - of IT. Clinical systems may turn out to be good, but can be narrowly focused. The real need is for IT to be totally patient centric, and not devoted to any one clinical service. Clinicians and patients may inspire innovation, but delivery is now much more complex.

Following the opening presentations, individuals from the floor were invited to make their own comments. This is an important strength of the group's sessions, as it is one of the few opportunities during HC for everybody to have their own say. Contributors are listed here as A-H.

A. There are only a few clinicians with IT skills, and they are the only ones who could innovate in IT. This is not enough.

B. The motion promotes a polarisation. The best innovation comes only from teamwork. (The motions proposed and debated by the group are always planned to be ambiguous so as to allow for free discussion - Ed.)

C. Real innovation is quite rare. The clinical professions are so closely regulated that innovation gets squeezed out.

D. The key is 'using' in 'delivery'. While clinical leadership is required, it is rare and informaticians are anyway not the only alternative.

E. We need clinicians (not always doctors), and informaticians, but especially also the patients.

F. Having the idea and having a successful implementation require very different skills.

G. Innovation is high risk. Innovation requires some freedom eg, from targets. Patients may be the main driver for innovation.

H. Innovation may be hard to pin down. Clinicians are definitely required to either kill off ineffective ideas or to spread effective ones.

Following contributions from the floor, there was a brief summing up.

Ian Herbert remarked that ideas may come from anywhere, but ideas still need to be worked out and implemented.

Simon Dodds considered that only the front line can drive innovations of any sort.

By this time the debate had degenerated into an argument about which word of the motion required most emphasis: almost a method acting session. The final vote was 18:9 in favour, which at least indicated that five more people had arrived late.

As usual, the group's debate session was enjoyable and a chance for people to meet and air their views.

Keith Clough handed out HC ties to all those who had contributed, although ladies present considered this might be discriminatory! With this level of agreement at least, the meeting closed.

