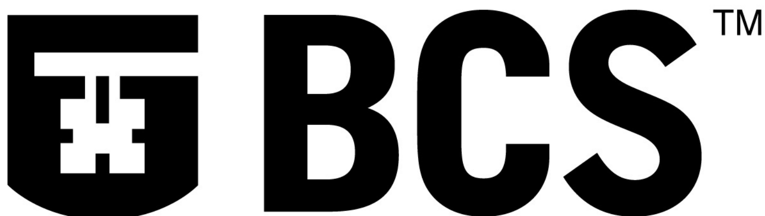
Report from the British Computer Society
Heath Informatics (London & South East) Specialist Group



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Committee

The Committee met on 20th July and heard that we remain 'solvent' and our membership is growing slowly. Members can only join electronically so that we know e-mail announcements can be sent to all.

The Committee agreed to support the new HIF magazine (opposite). This may become the main route for publishing our meeting reports.

Attention was given to the forward programme. These plans are always subject to the recruitment of suitable speakers, but we hope to have:

Thursday September 21st. Robotics.

Wednesday November 15th (note change of day). Voice Recognition.

Thursday January 18th. Informatics in the Independent Healthcare Sector.

And we have ideas for the next of our popular debate sessions at HC2007 in March at Harrogate. As usual, the topic should be highly ambiguous, and is meant to be enjoyable.

Annual General Meeting

In one of the quickest AGMs on record, Barrie Winnard agreed to continue as Chairman, and the rest of the Committee agreed to continue as well. Except that Keith Clough has retired as Vice-Chairman due to his commitment to the Interactive Care group.

Any more volunteers to join the Committee should apply to Barrie.

Magazine

A new magazine is to be published by BCS, sponsored by the Health Informatics Forum. Direct submissions are invited, and the magazine is also likely to include meeting reports from HIF groups.

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An Update on Connecting for Health in London

Introduction

When I was at school, we spent a lot of time writing précis. This involved summarising a long piece into something which, while brief, retained as much as possible of the original meaning. We did a lot of other things like grammar and parsing, which still have relevance in formal computer languages, but précis comes to mind when considering Connecting for Health.

'CfH'. What a tiny tag to encapsulate all our hopes. A ten-year programme reduced to an acronym. Like Shakespeare fitting Henry V's exploits into 'this wooden O'. But, is it an adequate précis alone.

Do we all know and share in both the strategy and detail of CfH. On the one hand, it is suggested that more front-line staff (not just clinicians, please) should have been on board with the plans at procurement. On the other hand, how many people does it take to make a strategy which can survive scrutiny. (The answer to that question is - about 30).

It is surely right that the NHS is dragged up to the IT standards of even the most backward of today's consumer-facing

organisations. This will take some time: whether more or less than 10 years is hardly important. But that is a timescale which we know will encompass huge change in IT capability, and we must adjust the programme as we go.

Over such a long period, there will also be big changes in understanding, as we learn what IT can really do for healthcare. We must be prepared for a spiral of invention, discard and invention again. No single bound. Taking it in steps is the only way to create and expand the user knowledge base, which in turn will truly enmesh IT with working practice.

So, CfH faces huge issues. It is already fairly clear that NPfIT didn't procure many useful end products - only some large-scale commitments from suppliers with deep pockets. CfH now has to act as broker between suppliers who must develop and deliver (or be replaced), and NHS organisations who must be persuaded that those products are really a feasible progress worth the risk of change.

The National Audit Office has recently reported on NPfIT. If you have only read the press comments, then I suggest you look at the full report, if only to accept that the press has an ongoing anti-NPfIT bias which should be resisted.

All of which tells us that CfH can hardly be a static project. It can have no fixed aim if only we can agree. It must, has and will be a continually evolving programme, with targets and timescales adjusted, as required, so as to get to the strategic end point: if possible within time and budget.

In that light, the Group was extremely pleased to be able to host a presentation on July 20th by Kevin Jarrold, London Director for CfH. In a previous role, Kevin was Director of Information at University College London Hospitals, from where he visited the Group to talk about the Implementation of IDX-CareCast at UCLH (see News #52, of Nov-04).

Mark Buckley-Sharp

An Update on Connecting for Health in London

Meeting Report

Kevin Jarrold is the Regional Implementation Director of CfH London Cluster. With the recent replacement of sectoral SHAs, he is also interim Chief Information Officer of the London SHA.

The scene in London is of a population of 8 million; an NHS staff of 150,000; and 74 NHS organisations ranging through acute, primary, mental health and ambulance trusts.

London Cluster has already achieved a number of IT implementations. (A list is with the copy of the PowerPoint slides which will be available alongside this report.) Over 1500 GPs are enabled for Choose & Book, and there have been installations of PACS (acute) and of Vision (GP).

The strategic compass of London Cluster is to recognise the vision of the whole programme; to develop that into a route map for implementation; and to engage the end users so that the implementations are agreed, accepted, and really used. That raises a number of more detailed issues.

Delivery of products is clearly important. But equally it is clearly not enough. For products to be deployed effectively, there must be good preparation. Predeployment work must be thorough and users need early visibility of proposals.

Implementation of CareCast at QMSidcup involved quite significant changes in the product right up to the implementation date. This is not early visibility, and it does not allow an organisation to design new procedures to use the product effectively, let alone train staff in those new procedures. (Relevant, but not stated, was that the same applied when implementing CareCast at UCLH.)

Staff don't just need to use the product, they need to know how to use it for the organisation's business requirements. That is key to planning and realising the benefits on which the whole programme is based.

Early visibility and the ability to plan benefits amount to giving the accepting organisation and end users a governance control on their part of the project, which is not dissimilar to what would be done if the organisation procured the product contractually in the first place. That places CfH as an intermediary enabling and requiring users and their plans to be matched to suppliers and their plans.

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A condensed history so far shows:

Dec-03: NPfIT lets London contract to BT with IDX.

Mar-04: NPfIT lets Southern contract to Fujitsu with IDX.

Jun-05: Southern contract changed to replace IDX with Cerner.

Oct-05: London agrees interim products such as RiO for community and mental health.

Jul-06: London expecting a new BT route map to implementation.

The new route map will recognise a need to speed up acute implementations, and to resolve uncertainties such as the GP solution (given the choice agreement), and any longer term use of RiO. There is also a return to the discussion as to whether users will work directly into a single London database, or whether sharing data on demand is either more feasible or more desirable.

The use of interim solution has been pragmatic, and has brought forward IT benefits to users. The GP system choice agreement may mean that existing suppliers are retained for longer. The goal might still be reached by ratcheting up the standard requirements and allowing any supplier to match those changes.

There are some 'must have' and 'do not lose' aims. The products must support the clinical process; they must be safe for that purpose; and they must be patient centred. Also keep in mind that health and social care must be joined up effectively.

There is a balance to be struck between urgent need - whether that is to meet the programme aims or gaps in a user organisation - and due diligence to maintain organisations as going concerns. Advance has to be feasible. Part of the new route map will be a set of work streams which include scheduling detail and an assurance overview.

Also ongoing is a refresh of the strategy around NHS organisational changes, NHS financial flow changes, and policy developments such as Patient Choice. The current work between London CfH and BT is expected to lead to a formal change control notice (CCN2) which therefore repositions the programme contractually.

On 1st July, the London sectoral SHAs were replaced by a single London SHA. Besides avoiding a lot of duplication, it brings London CfH into a 1:1 relationship with the SHA. The SHA can take more ownership of London CfH, of the health strategy for the whole of London, and London CfH is tied to NHS operational governance. Clearly the SHA will have an IT structure, and London CfH will have a project structure mapped to its SHA and to its LSP supplier (BT).

The London CfH project structure overall will slice the work several ways. The life cycle slice deals with individual implementation projects. The geographical slice balances the workload by area. The product slice maintains in-depth expertise to support all users. Looking forwards this should improve confidence both on the NHS side and the LSP side, enabling them to plan and deliver more effectively.

There are always risks. Expressing those risks is meant to be a way of managing them and not resigning oneself to them happening. The LSP might not deliver suitable products. NHS organisations and/or their users might not engage, or might be unable to engage, with the CfH programme. Benefits might not be realised.

But there are opportunities. The CCN2 review will give a new baseline to the programme. London CfH can work with a single SHA. The strategy for London can be refreshed. Business transformation - what the IT programme is really about - should become more robust.

Following Kevin's presentation, there was considerable discussion which it is not possible to fully summarise here.

One point worth noting was the need for a much greater standardisation on the implementation processes so that there can be some degree of replication efficiency. Data migration was cited as a major headache in many projects. There are also deep complexities in the interfaces between numerous local systems, which threaten operational viability as systems are changed. Kevin reiterated the point that the local organisation should have a governance role in any implementation as similar as maybe to a direct procurement.

The meeting was well attended, notably including those from some distance. A recognition of the importance attached to CfH and its effectiveness.

Next Meeting

The next meeting of the Group is on Thursday September 21st, 5.30 for 6pm, at BCS London Office, Southampton Street.

The topic is expect to be Robotics in Medicine, and we are hoping for a visit by a robot !!

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