Newsletter of the British Computer Society
London Medical Specialist Group

THE BRITISH COMPUTER SOCIETY

LMSG News

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November 2002

Editorial

Welcome back to our Newsletter and, no, you haven't missed an issue since last January. Running groups, organising meetings and speakers, and even writing Newsletters, is a time-consuming business. The job demands for anyone working in healthcare IT are ramping up at an alarming rate as the NHS seeks to close some of the gap between its operational culture and that of even the humblest, most backward looking, consumer oriented service industry.

So, it is time for us to thank and even apologise to Andrew Capey who got left in the hot seat with not enough people to take on the tasks involved in running the Group, and with escalating demands in his day job.

This Issue comes to you from an ad hoc editor who has fortunately been fed all the background, not to say backlog, information so that we can clear the decks and start again.

Mark Buckley-Sharp

Contents:

Meeting. Thursday 21st November

Members should have received notification from various sources about a joint meeting mainly organised by the IM&T Group of the Institute of Healthcare Management, but jointly credited to our London Medical Specialist Group.

5.30pm – 8.00pm
The Board Room,
Moorfields Eye Hospital
City Road
London EC1V 2CD
(Just north of Old Street station)

The meeting is free but please advise your attendance, for catering purposes, in advance to Mik Horswell, 01494 463601, or at mikh@micklefield.demon.co.uk

The meeting title is

We Need to Take Really Radical Steps

Speakers will include Paul Johnson, of the John Radcliffe Hospital; and David Kwo, now an independent consultant. There will be ample time for discussion.

The title is obviously related to the recent Radical Steps meeting organised by the BCS Health Informatics Committee, and for which the report is now available at: www.health-informatics.org

Our WebSite Updated

A website is only any use if it is kept right up to date and linked from other appropriate sites. LMSG had acquired at least two sites, both with maintenance backlogs, and this has now been corrected by the sterling efforts of Neville Vincent.

Bearing a current date, you can now see improved information about LMSG at:

www.health-informatics.org/lmsg

and you can also get there easily from our organisational host www.bcs.org.uk

Ad Hoc Committee Meeting Report

It should not have escaped the attention of members that LMSG did not hold its expected professional meetings in either July or September, and did not hold a formal AGM in May or subsequently.

One of the quirks of the BCS structure is that LMSG is a specialist group, and the Health Informatics Committee is equally a specialist group, but HIC acts as a federation leader for all the separate health groups in the Society.

The difficulties of LMSG had not gone unnoticed. Glyn Hayes, Chair of HIC, offered his services and convened an extraordinary meeting of available LMSG Committee members on October 18th. Eight members of LMSG were also joined by Mik Horswell of IHM. Minutes will be reported formally in due course, and what follows here is a commentary on the decisions and actions.

The first question addressed was whether LMSG should be wound up, or whether it should be relaunched. In the context of the increasing national activity in health IT, and the reformulation of other BCS geographical health informatics groups, to wind up LMSG would be completely inappropriate. There are geographical groups in Scotland, Northern, and now South-West. Obviously, London must not be vacated. A likely suggestion will be to rename all the groups under the Health Informatics banner eg, BCS Health Informatics (London & South-East) Specialist Group, and so on for the other groups.

For information, besides the geographical groups, there are the functional groups of Primary Care, and Nursing, both of which are very active. They will soon be joined by Allied Health Professionals. (Why are secondary care doctors apparently disinterested? – Ed.) HIC banner names could be used for these groups too.

A number of actions were identified which are critical to the relaunch of LMSG, or perhaps we should already practice saying HI(L&SE)SG.

Membership: BCS is moving towards web enabled membership services, and members will then be able to maintain their own details. It is not necessary to be a BCS member to join the activities of a specialist group. BCS may create a class of 'Specialist Group Affiliate', probably with a centrally collected administration fee, which would allow anyone to attach to any specialist group. This would hugely simplify our membership administration and enable electronic dissemination of information. Meanwhile, steps are being taken to confirm the membership list, and move it to manual administration at Swindon HQ. There will be no group subscription requests at least for the current year ending 30th April.

Newsletter: There is a backlog of information to give to LMSG members, and no way of reconvening them without a mechanism for publicity such as via the Newsletter. Mark Buckley-Sharp agreed to collate information into a new Issue of the Newsletter, with copies available for members at least by the joint meeting with IHM on 21st November. (Here it is. – Ed)

Website: There seemed to be two sites, with either the editors or even the servers disconnected from the Group's activities and information. Neville Vincent agreed to get all but one site deleted, and to upgrade and relink the preferred site. This has now been done (see above).

Committee: This must be reformed and legitimised by an AGM. It was agreed that this should be done in January after members had all received the Newsletter in late November. An announcement appears below. Meanwhile, Stephen Elgar continues as Secretary; Barrie Winnard as Treasurer; and Keith Clough (our President) as a temporary convener.

Future Meetings: There must be an effective programme of professional meetings. A short topic will be arranged for January. A satellite meeting at HC2003 will carry the LMSG badge. Otherwise, a new Committee will need to meet and organise a longer term programme.

Wider Help: This works both ways. We need group members to help at meetings like HC and staff the BCS stand from time to time. In the opposite direction, we should be able to get more help with our own organisation from BCS HQ for membership, financial services and information handling: making our own Committee tasks different but easier.

Other Groups: LMSG also needs to recognise and work with other relevant groups. These include ASSIST, IHM (as in our forthcoming joint meeting), and BMIS, where there are common interests and a lot of cross-membership.

ANNOUNCEMENT

ANNUAL GENERAL MEETING

Your attendance is requested at an Annual General Meeting of the BCS London Medical Specialist Group.

Thursday January 23rd 2003

at 5.30pm for 6pm

The Board Room,
Moorfields Eye Hospital,
City Road,
London EC1V 2CD.
(Just north of Old Street station)

The meeting will

- Receive reports for the year ending 30th April 2002.
- Receive reports of recent ad hoc discussions.
- Consider the future name, activities and programme of the Group.
- Elect Officers and a Committee.

Officers means a President, Chair, Secretary, and Treasurer. These are normally expected to be corporate members of the Society, but the Society may permit exceptions. Other Committee members need not be corporate members of the Society.

The recent review of the Group's organisation suggests that two important Committee functions requiring individual volunteers are:

- A Newsletter Editor, responsible for collating meeting reports and for delivering a Newsletter for physical and electronic circulation.
- A Website Editor, responsible for maintaining the content of the Group website.

Otherwise a Membership Secretary is also required, to complete the move of records to BCS HQ and for maintenance thereafter at least until the Society has on-line maintenance of records by members.

The existing Committee requests maximum attendance at the AGM so that there can be a realistic and comprehensive review of the future role and programme for the Group within the wider Health Informatics community of the Society.

Ideas about the Group and its future may also be sent to the current Secretary at: stephen.elgar@btopenworld.com

Congratulations to Steven Kay of the Northern Group and leading organiser of the HC conference who was recently elected to the Society's Council, where Brian Layzell is also a member.

Forthcoming Event

HC 2003

Harrogate Conference Centre
24th – 26th March 2003

details at
www.healthcare-computing.co.uk

MEETING REPORT

8th November 2001

"Managing the Social Care Information Agenda"

Roger Stanton, Head of Social Care Information Strategy, Planning and Development, Department of Health

Nick Davey, Information and Planning Manager, Brent Social Services, Portsmouth City Council – seconded to Department of Health

The LMSG BCS has, for the most part, focused attention on the workplace context of the NHS. With the shift in Public Sector policy of this Government toward provision of "joined up" services, an alignment of health and social care is being sought. In this session Roger Stanton gave an outline of how an information strategy has been developed for Social Care, Information for Social Care (IfSC). This development has been built on collaboration with Social Services departments and within the context of both the e Government and NHS information strategy (Information for Health / Building the Information Core).

The context: Good information is seen as fundamental to developing high quality "citizen focused" services. There are a number of related drivers behind the need for a strategy such as public expectation of improvement, a series of "Modernising" initiatives of the Government and the "Best Value" context of local Government – the need to market test internal service provision against potential external providers. Social Services are managed and, in part, resourced locally. There is far greater variety, autonomy and less central direction compared to the NHS.

Framework report: The IfSC strategy is consistent with Quality Strategy for Social Services and the e-Government programme, a national framework was established for information management and local actions required to support this and an investment programme was established for future work. A national Road Show allowed the framework to be shown and to support a local understanding of what is required of Social Service departments.

The Electronic Social Care Record (ESCR): The key building block for the strategy is an electronic record for the client. This is a computer index linked to letters, emails, pattern of visits, social worker case notes and any other relevant material. A conceptual pyramid is build on this with a shared minimum data set for local and national use supporting, at its tip, Performance Indicators to allow comparison between different Social Service departments.

Strategic development programme: The ESCR is seen as closely related to concepts of the Electronic Patient Record and the same framework of explicit client consent and managed information transfer and use is intended (as for the NHS Caldicott Guardian).

Demonstrator programme: Just as the NHS has a small investment programme to develop early demonstrations of how we can all work in the future, so there is an even smaller set of 6 centrally funded local Social Service projects. These are set to report quickly and cover subjects such as VPNs, encryption and a Borough-wide information exchange agreement – further details on www.doh.gov.uk/scg. For Leeds and Cambridge an integrated health and social care record is being sought.

Local information plans: Each Borough and Social Services produced a response to IfSC.

Investment programme: Funding has been made available (2001/2 £2.5m and capital funding over 2002/3/4 of £50m). This will be distributed on the basis of the plans and progress of the demonstrators.

Suppliers market: There is a even smaller number of Suppliers for Social Service departments than for the NHS.

Nick Davey continued with the "worms eye view" from underground in Social Services departments.

IfSC is widely seen as inspiring, however the barriers to change are seen as greater than within the NHS. Funding and local installed IT base, for example vary greatly and local accountability means budget cycles are even shorter focused. Legacy client-based applications present great barriers to change being organisation specific. It is also unclear which NHS patient / Social care client or groups offer initial or greatest reward, but Mental Health is the area where most shared work is in progress. It may require the development of a new generation of systems across health and social care without these inherent barriers if service transformation is to be achieved.

There are similarities to the policy overload experienced within the NHS (multiple NSFs

for disease and patient groups) and a strong prioritisation is sought.

Prior to IfSC, innovation was localised and we now have a shared framework with a devolved approach to meet local complexity. With the new NHS structures of Primary Care Trusts (Borough based) and with explicit formal frameworks for openness of systems (the eGIF standards) and for the re-engineering of the care process for patient and client care across organisational boundaries, the scene is set for a renewed phase of co-ordination and partnership. Patient care pathways and citizen focussed care can be seen as linking concepts. This will doubtless start with a shared search for additional funds!

Nick opened up discussion across the group and this is summarised below:

Q: Where can we find out about the best practice / demonstrator sites?

A: A database is being prepared and will soon be available – see web site above.

Q: For the NHS in terms of the development of information strategy, there is a tension for any player between waiting uncomfortably for central definition of standards and going early with a local standard, what of Social Services?

A: The "centre" is less prescriptive than the NHS and only now is guidance sought from it. Also Social Services are more like "greenfields" so there is less to through away in any move to a centrally defined standard.

Q: The emphasis tonight has been on Social Services, but where does Education, Housing and other Local Authority functions fit?

A: Although the man focus for IfSC is Social care (e.g. Children), all client groups cannot really be separated in terms of functional use of services. Social Services is not self contained.

Q: We have seen a history of "dead" pilot projects in the NHS as funding dries up – what will happen to the IfSC Demonstrators?

A: They will either have transferable lessons and some solutions can be distributed if successful. There will also be failures and these will be welcomed again for the lessons offered to others.

Q: Where is success in use of ESCR likely to be first seen?

A: Where data quality on systems is already good, probably where scheduling of care is already "electronic" and where sharing of information with the client is already routine, since both uses are dependent on and foster gathering and maintaining high quality information.

Q: Are client participation in Care Plans the key concept for Social Service systems?

A: Social Care has led in the development of individual care plans and client participation, they are at the heart of present systems.

Q: Data quality is essential for success with all information systems, the NHS has great problems in this respect and is at present starting a new initiative, what of IfSC?

A: IfSC is included within the new data quality initiative.

MEETING REPORT

31st January 2002

NHS Direct
Putting the E into E-Health

Unfortunately our invited speaker, Dr Nick Robinson, Medical Director, NHS Direct West London couldn't be at the meeting. Self reliant and informed as ever, members present took the subject themselves and, based on an introduction by Simon Midlane (Senior Manager at Redbridge and Waltham Forest Informatics Service) and Stephen Elgar (Director of Health Informatics at Harrow PCT), on how NHS Direct worked on their patch, they launched into the evening's subject.

NHS Direct North East London: Nurse delivered telephone advice to the public is linked to the Ambulance service. Nurses use a new national system which allows client records to be created as the Nurse is guided through a series of questions for the caller, underpinned by decision support algorithms embedded within the system. Although all NHS Direct Centres use the same software (AXA), client records are not shared between centres and there is no link from the NHS number Tracing service.

Calls are local for the most part but can be "switched" to and from other centres when a centre is too busy. Mobile call routing also means that many callers are not local.

Decision support is nationally consistent (overseen by a national Clinical group) but the callers records can be fragmented across different centres and some callers will have multiple records within one centre.

The outcome of most calls is advice for self-management with self-referral to A&E departments and to GPs as an alternative. If the caller consents, a summary of the call can be Faxed to the GP.

NHS Direct West London; is run by a GP Out-of-Hours co-operative (GPs have grouped together so that individual practices don't have to provide evening / night / weekend visits). This had meant that collaboration with GPs is stronger. As well as faxing a note of a patient contact, an XML-based message can be sent to GP applications as an email (un-encrypted at present) which can then be viewable (free text) within the to GP application just as Pathology results are handled.

Plans are under also under development to set up a web-based area for the public, linked to NHS-OnLine (self advice system), to allow the individual to provide a narrative that would then be available to the NHS Direct Nurse. This could hold anything but there is discussion of providing a series of "tick boxes" to allow a client to make a consent statement for their prospective information exchange. There is also discussion of how Care Direct services can be developed in conjunction with NHS Direct to receive emergency call services from clients' homes and potentially to monitor particular conditions.

Once significant components of the health and social records is available in browsable form over NHSnet (e.g. Care Plan for Mental Health patient and Single Assessment Process for Elderly clients), it is expected that the NHS Direct Nurse can call this up and that this information can inform dialogue with the client.

Nu Care; at Northwick Park Hospital, one of the many innovative projects to remodel A&E services is now live, based on:

- GPs working in the evenings and at weekends in the department – GPs have a more general training and a greater range of clinical experience than the A&E team and, it is often said that, many patients attending A&E would be better treated by GPs
- An integration of NHS Direct services with the A&E portal
- Emphasis on making services and information available to patients so that they can manage themselves or receive services other than medical.

As discussion widened, the following were included:

- NHS Direct and OnLine fit within this Governments interest in improving accessibility of Public Services (set against a perception of services as being slow, difficult to access and comparing badly with other sectors and the commercial world).
- Both Direct and OnLine can be seen in terms of a models of participation of citizens in making choices about services they receive, of empowerment and active engagement in choices.
- They can be criticised as being dramatic initiatives and as a diversion of funds and distraction from the long-term work of improving quality and consistency of NHS provision and resulting health outcome. Has Direct and OnLine increased or decreased pressure on GPs and A&E?
- Also do they play on anxieties of the worried well? Are they relevant to building and maintaining health and quality of life? Are they another part of a Sickness rather than a Health service?
- Great opportunities for innovative service redefinition will follow for NHS Direct and its successors as the clinical and social care Electronic Records begins to become usual rather than exceptional. Anxieties on the management of Members expressed concern on management of confidentiality and of the exercise of the citizens' / clients' / patients' right of consent as interoperability, and openness of systems becomes more significant.
- Some members thought that a key development is the individual managing their own information and rules of exchange – an internet-based record, for the most part, owned by the citizen. Such as approach can be compared to the present fragmented and often chaotic and inaccurate institutionally owned and managed record.

MEETING REPORT

16th May 2002

"London-wide encryption"

Peter Gill, Assistant Director of IT, Ealing, Hammersmith and Hounslow Health Authority

Peter explained that his interest in use of encryption within the NHS started when he became responsible for providing internet access and email to clinicians in GP practices and hospital settings. Once the clinician has the email tool the advice from people like Peter and the Royal Colleges is against use of the new email tools for communication concerning patients. Email is by its nature insecure – you cannot be certain that it is authentic, has not been altered or unlawfully disclosed. The way to make it secure is to use an encryption tool. The NHS Information Authority appeared to have no urgency in providing a strategic context for encryption.

It is like giving someone a car and telling him or her they cannot drive it. In the absence of national leadership Peters' local health community started an email encryption pilot. As this developed it became defined as one of a series of national trials of use of such tools.

What is encryption? This is a way of "scrambling" a message before sending it and then "unscrambling" it when it is received at the other end. Just like the one of those codes games that children play (e.g. a=b and b=c etc…).

The significance of Public Key Infrastructure (PKI); this is a particular mode of encryption in which participants share a public key while an individual private key is held securely. Both sender and receiver share a way of working, a model of trust. The trust model requires a common set of policies and procedures to be followed by all, with careful vetting and training for all that join. The model is deployed as a "Certificate Authority" and is available as a package to prospective users. They have to present personal ID (e.g. passport), in addition professional registration and employment contracts are checked. Then the new user sign an acceptance of the policies and procedures to be followed. They are then given a private key which is stored on the PC and access to the shared public keys.

How does PKI encryption work? The user may use encryption from within the email package of their desktop. One analogy is of a multiply boxed and padlocked trunk – one box within another etc…. The content of the email message is within the smallest box. There are three layers of security for the message: the senders' (created using the senders' private key), another is the shared layer (use of the public keys) and finally the recipient's padlocked layer (based on the recipient's private key). The sender can access the public key of the receiver and use it to encode the message – but cannot decode with the recipient's key.

Progress with the West London pilot; 50 subscribers are signed up including 6 consultants and 18 GPs at present involving 1 hospital and 2 Practices – small scale at the moment but clinical data is being communicated. RSA Keon is the technology Supplier. There is now a package for groups of 50 NHS users available from the West London Certificate Authority.

Extending this to a London-wide encryption service? There are 2 other pilots in the capital, one based in the Merton and Sutton health community and one in Camden Borough services. There is outline agreement to work together and to extend a common Certificate Authority across London. The NHS Information Authority supports this development but much work has to be done to make this happen

The discussion that followed was summarised as:

Q: Why was the NHS Information Authority (IA) unable to provide strategic leadership?

A: The IA until Sir John Paterson's arrival had appeared reluctant to lead on large complex and developmental projects such as encryption of personal email. It is perhaps significant that the IA has been active on system to system or organisational boundary to boundary encryption – the Pathology result message from laboratory to GP. This has a deployment model, which is better understood involving fewer parties, and is largely automated.

Q: Encryption at the boundary of the organisation or within an organisation as well?

A: The logic of encryption of email can be seen as moving attention for security from the boundary to the internal network and individual workstation. Should all email be encrypted? At present email

encryption is intended for communication between rather than within organisations and system to system encryption can be seen to start at the boundary of the organisation. It was suggested that the greatest threat might be from Government rather than malicious individuals or groups. With this in mind and the powers available to the State, the predication of a need for encryption in the form discussed may be misplaced.

Q: Encryption and authentication / non repudiation in terms of access to widely shared access to Electronic Records?

A: The key to establishing who is using Electronic Records when it is widely available may be to link the user to the session so that an audit trail of viewing and editing is created. Perhaps all users will have a single identity / authentication device similar to that used in this encryption tool and maybe this will incorporate a body recognition device, a biometric (e.g. iris or thumb print).

Q: Is encryption worth the effort?

A: Finally, any security effort has to be balanced with appropriate to gravity of threat, cost and scale of benefit. So far there have been millions of transactions taking place over NHSnet and no law suits yet. Is encryption of personal email worth the effort.

REMINDER

ANNUAL GENERAL MEETING OF THE BRITISH COMPUTER SOCIETY, LONDON MEDICAL SPECIALIST GROUP.

23rd January 2003

See Announcement on Page 3 of this NewsLetter.