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

THE BRITISH COMPUTER SOCIETY

"LMSG News"

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Editorial

Since dragging ourselves back from the limbo of obscurity, the Group has begun to make some serious progress.

Our new venue in the Board Room at Moorfields Eye Hospital saw an attendance of active participants for the meeting of November 21st entitled – "We Need to Take Really Radical Steps". The meeting report appears in this Newsletter.

Having a Newsletter issue and one meeting under our belts, the Group hosted its belated AGM and a second meeting on January 23rd. Again, a good turnout, and the meeting report for "Bringing Healthcare Information to the Public" appears here.

The new Committee held preliminary discussions under the temporary chairmanship of Keith Clough, and the discussions reconvened on February 5th. The immediate aim is to get another Newsletter (this one) to our members, and get through our badged session on Tuesday 25th March at HC2003 in Harrogate. Longer term, the Group wishes to continue its regular series of professional meetings. There are now provisional dates of 4th June, 17th September, and 19th November. Those who check diaries will see that this changes the normal weekday of our meetings from Thursday to Wednesday, mainly to simplify room booking.

This Issue comes to you from an editor who has volunteered to do the job regularly, and who was consequently appointed unopposed!

Mark Buckley-Sharp

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Name Change

The formal committee of the Society which represents health informatics is the 'Health Informatics Committee' (HIC). (Contrary to the note in the last Newsletter, HIC is not constituted as a specialist group.) Our Annual General Meeting on 23rd January agreed to recommend that our Group changes its name to help coordinate all those specialist groups which come under the health informatics umbrella.

HIC coordinates the activities of the Society's relevant specialist groups, which are either geographical or related to a healthcare profession. These specialist groups have been asked to adopt consistent naming, and the London Medical Specialist Group agreed to become the Health Informatics (London & South East) Specialist Group.

This change will be taken to HIC and the Society for ratification and implementation. Meanwhile, we can start to practice the new name which appears in the masthead of this edition. The subheading of LMSG News is retained to connect with our ISSN number.

Other geographical groups include South-West; Northern; and Scotland, and more may arise later.

AGM 23rd January 2003

All the best AGMs are short and to the point. We did reasonably well against this standard.

Andrew Capey provided the Chairman's Report which mainly confirmed the events reported in Newsletter 44.

Barrie Winnard provided the Treasurer's Report where activity has been low, and reserves maintained. It was noted that members had not been asked for subscriptions this year (ending 30th April).

Barrie is also now the organiser of our host location, and participants appreciated the available facilities and refreshments.

The Group agreed to change its name, for the reasons given above in this Newsletter.

Keith Clough chaired the meeting, and spent some time twisting arms to maximise volunteering for the new Committee.

It was announced that the next meeting of the group would be in March at Harrogate as part of HC2003. Thereafter, the new Committee would re-establish regular meetings of the group.

Committee Meetings 23rd January 2003

Available Committee members met briefly before the AGM, and the new Committee met after the presentations on the same evening – 23rd January.

The Secretary continues as Stephen Elgar, stephen.elgar@btopenworld.com or stephen.elgar@bah-ha.nthames.nhs.uk

The Treasurer continues as Barrie Winnard, barriewinnard@quista.net or barrie.winnard@moorfields.nhs.uk

Mike Andersson, contact at e-mail bcsgroup@andstrom.co.uk will bring together the membership information and lead on transferring this to the Society for future centralised management.

Mark Buckley-Sharp will be the Newsletter Editor, mark.buckley-sharp@uclh.org

A volunteer will be sought to be the Website Editor. The existing website is at www.health-informatics.org/lmsg, which obviously now needs a pagename update.

Other Committee members include David Hancorn, Andrew Capey, Elizabeth Hunter, Jas Weir, with Keith Clough continuing as President.

The post of Chairman remains vacant. The Committee will consider this urgently and make an appointment.

Committee Meeting 5th February 2003

The Committee met to progress discussions started at the AGM, and to outline a programme of meetings in 2003/2004.

The various sources of membership lists are being gathered, and may already have reduced to two sets – our own, and whatever is held at BCS HQ in Swindon. These will be collated by Mike Andersson, bcsgroup@andstrom.co.uk and used to circulate this Newsletter with a letter asking everyone to confirm a wish to stay on the list and update their contact details.

No subscriptions have been requested or collected for the current year, ending 30th April 2003. The Committee decided that there will be no subscription next year either, so that members' renewal of contact details will be free.

We want to get as much attendance as possible to our meetings, which will include people not on our main mailing list. Therefore, instead of subscriptions, there will be a flat fee of £2 per person at every meeting. This will pay part of the refreshments costs.

The Committee may have found a new Chairman, but watch this space.

Neville Vincent has agreed to feed our web-site, although he is not on the Committee. Information maybe sent to him at nevillevincent@bcs.org.uk.

The Committee then spent a considerable time sifting through many suggestions for programme topics in 2003/2004. In the following list, the dates and locations are fairly definite, and the topics are proposals subject to recruiting speakers.

Tuesday 25th March 2003, at HC2003. See the enclosed advertisement for our debate session at the conference.

Wednesday 4th June, at Moorfields Eye Hospital, City Road, London EC1. "Providing the public with web services."

Wednesday 17th September at Moorfields Eye Hospital, (as above). "2010. Where will we be?"

Wednesday 19th November, at Moorfields Eye Hospital, (as above). "Patients and Confidentiality"

Wednesday 21st January 2004, at Moorfields Eye Hospital, (as above). "ICT. Benefit and Risk"

There is also the possibility of an away-day meeting for an on-site demonstration. No more details, as this surprise has not been sprung on the demonstrator yet!

Meeting Report
21st November 2002

We Need to Take Really Radical Steps

There is a widespread view that use of technology has improved greatly over the last ten years as seen in the impact of the Internet and the requirement for effective corporate information systems dominating the commercial world. The NHS, however, appears to have been left behind. A worthy strategy, "Information for Health", was insufficiently resourced and a new, more centrally driven version "Delivering 21st Century IT" is at least a year off making a difference. Why do we appear to have got it so wrong? Perhaps more radical steps should be considered. Two speakers were invited to help us in considering alternative approaches:

Paul Johnson, John Radcliffe Hospital, paul.Johnson@obs-gyn.ox.ac.uk
www.tmr.ox.ac.uk

e-Health: is use of technology to place the individual at the centre of our vision and has a number of aspects. The most important is the arrival of the "informed patient" with access to and use of information at the right time and in the most appropriate way for that individual. Another aspect is better use by healthcare professionals of evidence to inform the development of management of clinical care. Monitoring of medical conditions is also open to transformation through cheaper and less obtrusive equipment, and use of telemonitoring. This allows measurement in the individual's normal habitat, the home and work place, rather than in the hospital, and for longer periods. These opportunities illustrate how technology will allow the medical model to be turned upside down with the informed individual placed in the centre.

The informed patient: The increase in use of the Internet by people to seek information on illness and health is a common experience of healthcare professionals. Patients and their carers arrive with bundles of information about their condition printed from the web. How should professionals respond to this? Paul suggested that there needs to be a far greater co-ordination of intervention in terms of education. Professionals within the formal sector need to work with the patient and carer.

For patients who feel excluded from society, other approaches are required. In Britain, an example of an issue is the rate of teenage pregnancy, which continues to be one of the worst in Europe. Present approaches are failing to improve the situation. Paul described a community-based project in which young pregnant women can be monitored in familiar environments and learn about pregnancy together in an informal way. As part of this project they are preparing a glossary of medical terms in their own idiom and publishing this on a web site. Professionals are addressing health needs of the excluded though use of technology intended to bring about changes of behaviour.

Professional use of the evidence base: A paradox is the slow speed of change of professional practice in some clinical areas despite the greater ease of access to information in electronic formats. It is as if we are going into the Information age without using the rapidly expanding evidence effectively. Perinatal mortality rates in Cuba are better than in the US and Britain – why? Unexplained perinatal deaths are known to be related to slow growth of the foetus. In the US and Britain monitoring of the foetus is the norm and yet although circadian rhythms are known in the foetus, this is not taken into account when monitoring takes place. It may be better to undertake such monitoring over a longer period and in the home. We find it difficult to identify individual cases where problems are likely, and then to focus attention on women with the greater risk.

Reversing heart disease: Paul described another clinical area in which new ways of monitoring and more appropriate, non-invasive interventions can be combined to considerable effect. For heart disease, it is better to set up monitoring over a 24-hour period. Then, for patients with proven heart disease, combinations of changes in diet, exercise, and lifestyle have been proven to be as effective as surgery for some cases. Are we focusing on these low cost approaches based on empowering the patient? How should healthcare be conceived and organised to bring about such a focus?

Paul suggested that radical change in medicine must occur. At the two ends of life, when medical intervention is usually concentrated, more continual and sequential monitoring, with intelligent systems triggering interventions, should produce improvement in outcomes. The rise of e-health is unstoppable. We should seek to understand and use it to best effect.

Q Is it always better to have more information about a patient than less?

A Yes, as long as an effective context exists. There can be prompts for the significance of particular hazards through the application of more complex, automated logic in support systems.

Q There are known examples of self care (e.g. for Diabetes and Heart Disease) in which tasks are badly done by some patients – what do you make of this?

A For some people, the provision of information is not sufficient to bring about change in behaviour and engender positive habits of self-care. To bring about change, a context for communication may have to be found that is appropriate to the individual and makes participation more likely. Language is important in this.

Q How do medical colleagues respond to these views?

A Doctors on the whole don't receive this message well perhaps because of their vested interest in the medical venture and its perpetuation. At the same time, it is as if patients and nurses are already in collusion to make this change of focus come about.

The second speaker was David Kwo.
david.kwo@westminster-pct.nhs.uk

David has just been appointed as Chief Information Officer for London, having previously been seconded to the NHS Integrated Care Record Service (ICRS). David outlined the new approach being adopted for the purchase and implementation of ICT infrastructure and corporate applications across the NHS in London and the rest of England.

David explained that four ICT pillars underpin the present drive to modernise the NHS:

Broadband networks.

Use of direct booking systems by GPs into Hospital services while the patient is in the surgery.

Electronic prescribing within the Hospital and between the GP and the high street pharmacist.

Purchase of an Electronic Record – now called the Integrated Care Record Service.

Money will back this relaunch of strategy, with £400M to be available in 2003/4, and £700M and £1,200M over the succeeding two years across England. A small number of Prime Service Providers (PSPs - organisations leading consortia of suppliers) will be selected nationally to provide the ICRS and London will have a single PSP. Finally, the new layers of management, the Strategic Health Authorities (StHAs), of which there are 5 in London, will each have Chief Information Officers who will be responsible for managing the relationship with the PSP. David gave four scenarios to illustrate his thinking of what options lay ahead for progress of the implementation of the PSP across London and selected one of these as a radical approach for discussion tonight:

Electronic Health Record: Placed as a data repository by the PSP, it receives clinical data from the separate systems of hospitals and GPs which is then available for browsing by all. The problem with this approach is that, although it provides access to information, it does not support transactions across the separate systems.

Best of breed: Accumulated by the PSP selecting from different suppliers, who provide the best functions in the different clinical areas, and which are then integrated through a series of interfaces. How much cost and time would this approach take to implement, and is it really practical?

Accreditation of output and input: Legacy systems would be used but modified to ensure a common output and interface. Again, is this possible or practical?

Single system and one supplier: A single enterprise would re-engineer the entire functionality of ICRS across all clinical environments in one system for all healthcare organisations in the area. This was the radical approach David asked participants to consider.

To illustrate the potential for technology to transform the NHS, David showed a video of Visicue, an American development in which remote clinical management of a number of ICU units is supported through telemonitoring and video cameras. Here use of technology offers improved quality of care and lower costs of scarce resource of clinical expertise.

Q For hospitals already having a developed EPR function, what is the benefit of migration, particularly as there will be extra costs, and less specific tools available to clinicians?

A Any migration to the ICRS will take 5 – 10 years. In this timescale most existing EPRs will need replacement.

Local EPR can serve individual organisations well but as a whole the health community has a fragmented set of records and functions and this should not be perpetuated.

Q The best place for the patients record is in the home and the EPR has one purpose within a medical environment – to enhance the patient's treatment.

A Supporting the informed patient is an essential requirement for the ICT services of the NHS. The EPR must support the wider care pathway across separate medical environments rather than in isolated ones. For this to happen, my view is that a single system shared across clinical environments is a necessity.

Q Is there not a danger of extending the EPR beyond the ability of anyone to use it effectively? The EPR may support the medico-legal venture better than the patient.

A Current systems are not well used by clinicians and this has to be addressed. Across 28 acute hospitals there are currently 11 different EPR systems and this fragmentation cannot be good for patients, although it may benefit some clinicians. The rise in the number of legal cases associated with medical practice is regrettable and I would suggest not directly related to the presence or absence of good information systems.

Q Perhaps we need to rethink the concept of the EPR from being a composite record of care for the patient to being functions and services to be delivered to patients by different agencies, i.e. scheduling as a linking concept as happens with the airline, hotel industries and stock exchanges.

A We need to use existing information flows and services to better effect at the same time as progressing with the ICRS.

Q Won't the selection of a small number of PSPs depress innovation in the market?

A We need to figure out a way to manage the market so that there is true competition for the benefit of the NHS and the patient. This will be difficult but the present market is already dominated by a small number of large suppliers who are not, on the whole, innovative.

Q The ICRS specification documents lay out a requirement for functional integration with social care. What will the PSP mean for the present 33 Social Service department and the possible successor Trust organisations formed with the NHS?

A It is essential that each implementation of the ICRS is local in focus and managed by a multi-disciplinary and multi-agency team with Social Service included.

Q Taking the example of Visicue, the importance of the "front-end" of systems for the clinician and user will become very important – rather like the control panel of atomic power stations.

A Visicue does not use complicated technology and is a proven solution.

Other Meetings
Autumn 2003

Wednesday 17th September

HI (L&SE) SG

2010. Where will we be?

Moorfields Eye Hospital, City Road
London EC1

Tuesday 7th – Wednesday 8th October

IHM Annual Conference and Exhibition

Telford

Contact: 020 7881 3291
enquiries@ihm.org.uk

Thursday 16th – Friday 17th October

International eHealth Association and Partners

eHealth 2003

Conference and Exhibition, London

Contact: 020 7828 7777
krc@imf.co.uk

Wednesday 19th November

HI (L&SE) SG

Patients and Confidentiality

Moorfields Eye Hospital, City Road
London EC1

See the Note on page 8 about attending meetings of other groups.

Meeting Report
23rd January 2003
Bringing Healthcare Information to the Public

So much of the discussion within health informatics is about how healthcare professionals can do their jobs safely and effectively. Turn that around, and there is far less discussion about the benefits for those other important participants in healthcare – the public and where individuals need to act the role of patient.

A start was made on this alternative perspective by our two speakers.

Alasdair Liddell described the Living Health Project and the pilot work in the West Midlands area involving TeleWest.

Living Health was a DH funded pilot to make use of digital interactive home television. £3.8M was provided in November 2000; the pilot ran from May to November 2001; after a short extension, the pilot closed in May 2002.

UK has quite a lead in the coverage of digital television, with up to 8M households capable of receiving such a service. The timescale of takeup has been even faster than internet connection.

The main resource for the users was upwards of 22,000 pages of healthcare information. Provided by television, the content of a page has to be limited to about 50 words, but navigation between pages can be standardised and made simple for the user of a remote control. Navigation by menus, or by Prev/Next buttons, or by A-Z indexes is easier than using a browser and mouse.

With the main information resource, the pilot set out to evaluate the feasibility of consumer use. The target population in the Living Health pilot was 54,000 customers of TeleWest Birmingham.

By the end of the pilot, nearly half the target population had used the service; the service was receiving about 9K page hits per day; and the average visit was 12 minutes with 30 pages.

Besides the main resource, there were two subprojects.

Users could logon using a PIN and make appointments in primary care. The full possibilities of such a service were not explored as only a few practices and users took part.

In-Vision provided a telephone call-back service with a one-way video link from NHS Direct to supplement the usual telephone-only consultation. The video link could just show the NHS Direct nurse, or could show diagrams or video clips.

Television is very inclusive with high user familiarity. Compared to internet use, the Living Health television pilot showed access skewed to higher age and lower socio-economic groups. Television was not merely duplicating other services.

Besides the achievements of the pilot, there are some clear future expansion possibilities.

More could be done with a return circuit from the user eg, by cable.

There is more scope to carry transactions, such as bookings and reminders, on such a service: a television alternative to e-mail. Once information can be person specific, it become possible to replace appointments whose only purpose is to hand over information.

And, more telecare could be enabled as bandwidth increases.

Lesley McCourt is general manager of NHS Direct for NE London, and she described the wider role of the NHS Direct service.

NHS Direct is a 24-hour available service for home or anywhere access. It is provided from 22 sites, with load sharing of calls if the most local centre is overloaded.

Calls are handled by nurses using a triage with standard algorithms but including their professional knowledge as well. The algorithms are subject to ongoing review and updates under change control.

Besides the telephone service, there is also the internet NHS-OnLine, which can be accessed from a personal PC or from public access points. OnLine has a health encyclopaedia and takes 250K visits per month. A visit averages 10-15 minutes and 30-40 pages. OnLine is delivered from two mirrored data centres.

NHS Direct has developed rapidly, and continues to change. Fairly immediate requirements are for NHS Direct to relate more closely to other NHS services, and to become more integrated with the NHS IT family of applications. The initial takeon of clinical content relied heavily on US sources, and this needs to be revised for UK practice and UK clinical databases.

There is considerable potential for a much better service through much closer integration.

All NHS Direct sites need to be running a single version of their software. This is part

of being really consistent across the service.

There would be financial benefit, if nothing else, in sharing many operational databases eg, with A&E departments.

With standardised triage, it should be possible for everyone to get the same response whether that is from NHS Direct, or a practice nurse or GP, or an A&E department. At present, these sources play against each other in the public's perception.

More intelligent telephony and call routing would for example allow scarcer resources such as interpreters to be deployed as required.

When there has been a contact with NHS Direct, there should be better information flows to other carers. At present, the default route to primary care is using fax, with limited takeup of EDI messages.

Ultimately, it really should be possible to make one call to access all services. NHS Direct could become the standard route to emergency ambulances.

NHS Direct, Primary Care, and A&E are not set up to compete, and NHS Direct was not set up merely to save money elsewhere. The objective is to change the relation between the public and the health service, and to assist the public to access the most appropriate part of the service as may be required.

Health Informatics Committee

HIC - Honorary Secretary

The post of Honorary Secretary to the BCS Health Informatics Committee is becoming vacant (vice, Neville Vincent). A new appointment will be made by HIC on nominations received from the constituent specialist groups. Those interested in being nominated via HI(L&SE)SG should contact Keith Clough, via krc@imf.co.uk

The Secretary is one of the Committee's Officers, and provides administrative direction.

You will already be a member of one of the BCS Specialist Groups within HIC. To become an Officer of BCS HIC you will already be a member of the Society, although an exception may be considered.

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.

- Annoucements 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.
- It would greatly help if Group members supply or confirm a personal e-mail address so that ad hoc posters can be circulated easily. That requires us to improve and collate our membership list, and Mike Andersson will be leading on this project.
- Notices of meetings will be sent routinely to members of other organisations such as ASSIST and IHM.
- Individual members of any of these organisations could then help by passing on advertisements to their more immediate colleagues at places of work.

Considering the horrendous prices charged by most organisations in the conference business, meetings of our Group are really inexpensive. Where else would you get a professional meeting for the equivalent of about £10 per day? Please consider cheap as shorthand for excellent value.

Meetings
Spring/Summer 2003

Wednesday 21st May

ASSIST Annual Conference

The Long Winding Road

Lakeside Centre, Aston University

Contact: www.assist.org.uk

Wednesday 4th June

HI (L&SE) SG

Providing the public with web services

Moorfields Eye Hospital, City Road, London EC1

(see Meetings List on page 2)

Tuesday 17th – Wednesday 18th June

BCS HI (Primary Health Care) SG

Dealing with uncertainty: the future of IT in primary care

Heythrop Park, Oxfordshire

Contact:
54 New Street, Worcester, WR1 2DL
+44 (0) 1905 727461
administrator@phcsg.demon.co.uk

Thursday 3rd July

Royal Society of Medicine Forum on Telemedicine and e-Health

Telemedicine and Telecare in the NHS VI

RSM, London

Contact: RSM 020 7290 3943
telemed@rsm.ac.uk

(Meetings in Autumn 2003: see page 5)

When at HC2003

Come to the Debate session organised by our Group

Tuesday 25th March
16.00 – 17.20
Stream One.

"This House believes that using ICT solutions determined at a national level is essential to support the delivery of 21st century healthcare."

Have your say on this contentious issue of the moment.

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.