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

THE BRITISH COMPUTER SOCIETY

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Editorial

This edition comes to you following the Healthcare Computing 2005 conference and exhibition. Every one of these conferences has its own atmosphere, and this one felt curiously subdued.

Maybe that matches with the interest being shown in our own group meetings as they report progress with implementing systems under the national umbrella. The furore of procurement, and whether or not sufficient people were consulted 'in the loop', seems less relevant. The awful truth has dawned. We must deliver on what is acknowledged to be a huge project with huge investment and even bigger expectations.

What I call the scientific bits of HC – the people jostling for items to put on their CV – seemed distant, as we all trailed from one big announcement session to another. The NHSIA is dead – long live whatever it is called now. Even NPfIT is an acronym past its time. Now our vision is 'Connecting for Health'. Somehow I liked NPfIT. It was something about wanting to be fit for the purpose. Health and Fitness seem to belong together.

So, well done to Richard Granger for his inspirational chat. Scarcely any novel substance, but you'd hardly expect that from his strategic level. The detail came more from Alan Burns who seems to be putting some serious energy into the clinical champions' network. And, then there was Kenneth Robinson who outlined how Scotland is going about all this somewhat differently - in an incremental way: although he has the benefit of a more compact patch.

And, hooray again to Richard Granger for telling the photographer in the auditorium to go away. The conference organisers are responsible for the nuisance. Maybe they do want some shots, but not that many.

While I am at it, perhaps the organisers can do something about the lights which swing wildly about and flash in the faces of the audience. (I am not the only one heard complaining.) And then there is the inane 'music'.

But, enough of the trivia. This issue is really about reporting our annual debate session at HC. That's the one where a serious issue is deconstructed by presentations from good speakers who have agreed to make the best arguments they can on one side or the other, whether or not that is their current opinion.

The audience get to have their say as well. We must strike a chord somewhere as this debate was at least as well attended as those of previous years.

Elsewhere at HC, all the sessions I attended had a good audience of interested people. The exhibition was as extensive as usual. The big players were surrounded by the minnows trying to get themselves adopted by a bit of the national programme. Maybe that's going to be a good solution, with the creativity of smaller companies married to the brawn of the majors.

Mark Buckley-Sharp

The next group meeting is expected on Wednesday May 18th, when we get to hear about connecting up a hospital – wires and wireless. Speakers from LogicaCMG.

Debate

This House believes that the National Programme for IT will meet clinical needs.

As usual, the group devised a topical motion for debate, but one with some ambiguity. What are the clinical needs? And, might there be several ways of meeting them?

The session was opened by **Keith Clough** engaging in some comic business with a hat. He explained that the hat could be worn by anyone not entirely convinced of their own argument. This was important as the opinions expressed by the speakers in this report are not necessarily their own or those of any organisation with which they might be associated. The group had invited the speakers as advocates to research and enthuse on the two sides of the argument.

We used remote control voting machines, and some pre-votes were taken. First, population polls showed about 60% in IT; about 55% working within the NHS; and about 18% clinicians. The prior opinion in the motion was about 40% in favour (NPfIT will meet clinical needs), and 60% against (NPfIT won't meet clinical needs).

Sean Brennan is an ICT consultant and journalist. He writes the EPR Arms column in BJHC&IM. Sean proposed the motion.

Computerising the NHS is very very difficult. One answer to whether NPfIT will meet clinical needs is "Yes, but, No, but, Yes…..". Within the complexity, can we be sure that all the bits will work, as we seem to be starting from scratch and largely aiming to replace existing systems. At least IT really is on the national agenda. NPfIT organisation may or may not be best, or be the most likely to succeed. But the aim is absolutely right.

The NHS represents huge transaction quantity. 5M lab results a day. £1M spent every 7 minutes. 110 people die each day because of NHS accidents. The NHS is perceived to be benign, but how many of the serious errors are preventable. We need seamless integration because information is not properly shared, or is missing when required. The real answer is that NPfIT will probably meet clinical needs – eventually.

Roger Wallhouse is a health industry consultant. Roger opposed the motion.

NPfIT arose from political will. You only need to look at the service level in a travel agent to see that we don't have anything like that in the NHS. The political will should be applauded as it comes with the vision and the funds. NPfIT has framed debate, but for the biggest IT programme ever – how can it work in time. Even so, IT itself is not a clinical need.

There are assumptions that clinical need is unvarying, and that clinicians already know what is needed. How will common solutions fit individual cases? NPfIT is trying to drive through without time to consider, time to learn, or time for review and moderation.

Paul Cundy is a GP, and he seconded the motion.

Let's not keep NPfIT in the future. The evidence is that it has already delivered. For GPs, nearly all have computer systems assisting in care delivery. These systems are now extracting data to assess care quality, and patients are now benefiting.

N3 actually works! It delivers clinically useful knowledge now. There are some questions about ETP and C&B but they are coming. GP2GP will be useful too. So, NPfIT not only will meet clinical needs, it already has.

[Ed: You must keep up to date with the acronyms. N3 – New NHS Network. ETP – Electronic Transfer of Prescriptions. C&B – Choose and Book. GP2GP – GP to GP (transfer of records).]

Simon Dodds is a vascular surgeon and computer scientist. He seconded the opposition.

A cool view requires an assessment of what the clinical needs are. It's then a separate question whether NPfIT is a solution. If it seems to be a solution, then perhaps it should be tested, with pilot studies and review, followed by a robust implementation. NPfIT falls down on all these criteria.

Clinical support is waning, and even that is from a low base. There is a design, but clinicians are not told what it is. There is implementation, but how is not described. Despite that, there is insistence that it is used.

The timescales are slipping even at this stage. NPfIT could fail completely. We cannot assume that it will work at all – ever. We really have no idea of the scenery in 10 year time. To say that NPfIT will meet clinical need is too optimistic.

Keith Clough then invited contributions from the audience. These are listed A-M here.

A. A major plank of NPfIT is NCRS. This is supposed to be an incremental record [from a zero base] and SNOMED-CT coded. How can this be adequate for clinical use?

B. Implementing any typical system does not engage 85% of users anyway. But, systems go in and they work. The component parts of NPfIT will be a really significant improvement.

C. More clinicians have been involved in this project than in any previous clinical systems. It is difficult, but it will happen.

D. We have had a lot of poor system choices so far, but NPfIT is an improvement.

E. NPfIT is a good aspiration. But, there is a low probability that our aspirations will be met.

F. Consider sectors like mental health and social care. These are requirements not even in the NPfIT programme content.

G. To meet every clinical need would be too broad now. But, NPfIT should meet a lot of needs.

H. GPs largely have systems that work. NPfIT threatens that.

I. The problems of putting in the required amount of information at the clinical level will break the system. Is this a clinical system at all?

J. There have been no demonstrations of clinical diagrams. There is more to clinical records than codes and text.

K. We must think of the patients' clinical needs, and not just the needs of clinicians.

L. The programme needs direct involvement between clinicians and suppliers. If so, then it should succeed.

M. Private sector IT developers (outside health) do not necessarily discuss with users before announcing a product.

The proposers then summed up.

Roger Wallhouse (against). A supplier has a problem when the customer just wants to buy: the defects don't seem to matter. There is a big assumption with NPfIT. How do we know it can complete merely because it has started.

NPfIT is based on the NHS stepping up its IT spend to 4% of revenue. Will it? NPfIT is not fully funded on top of existing spend. Ultimately, it is not an IT project – it's an undesignable culture change.

Sean Brennan (for). We have been promised so much in the past that even now we cannot quite believe in NPfIT. But, don't forget that we are not buying a box, we are buying a service.

The closing vote was then taken. Quite a lot of people has come in late so there were extra votes available. Had one side or the other sent out for some lobby fodder? The result was 55% for and 45% against. So, a swing from previous scepticism to cautious optimism.

To wrap up the meeting, a number of straw polls were taken on suggestions from the floor.

NPfIT is value for money. 36% agreed.

Doesn't matter if clinicians not consulted. 60% agreed.

The public doesn't care about NPfIT. An interesting question but we ran out of time.

Keith Clough thanked the speakers and the audience for their useful and interesting contributions.

Comment

I thought the debate session captured both the mood and content of a lot of HC2005, and I hope we can think of another appropriate topic for next year.

As the reporter, I am too busy scribbling to contribute, but I strongly support person 'K'. I don't need to consult a lot of clinicians to know where the problem is. Everywhere I go, and from every friend and acquaintance, I hear about the organisational chaos which the NHS persistently displays towards its customers. That is despite the earnest and well-meaning endeavours of clinicians to be knowledgeable, and caring, and efficient.

So, I want NPfIT to create a better, more integrated, more patient-responsive delivery system for clinical care. That really would be satisfying the principal clinical need. As was said when NPfIT started, we weren't getting anywhere using our previous procurement and implementation methods. Now, we must do a lot better.

Report by Mark Buckley-Sharp

