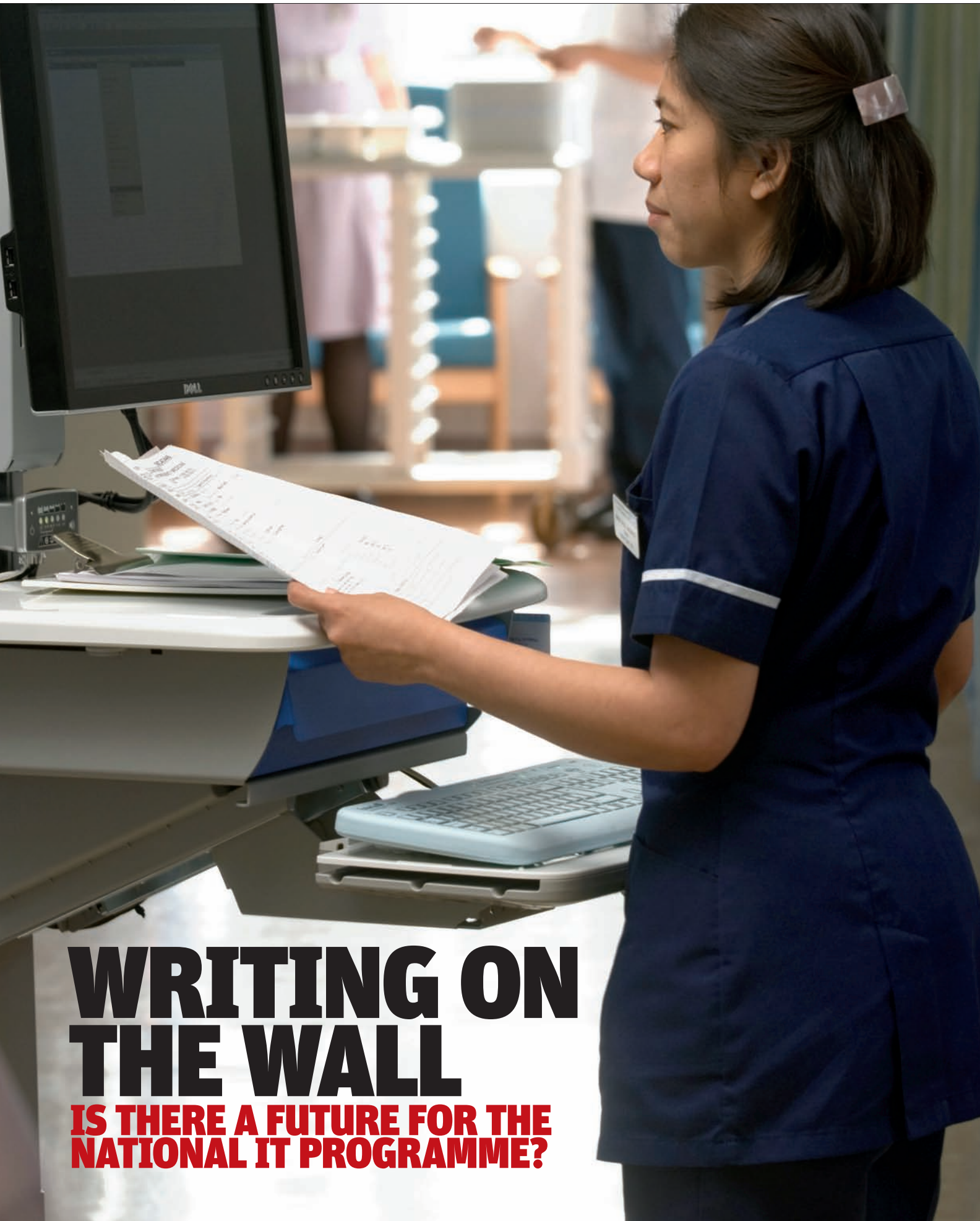
HEALTH SERVICE JOURNAL hsj.co.uk

HSJ HEALTHCARE IT

AN HSJ SUPPLEMENT/10 JUNE 2010



WRITING ON THE WALL

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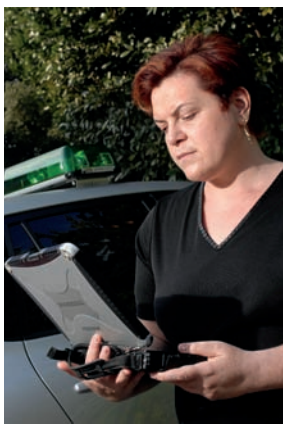

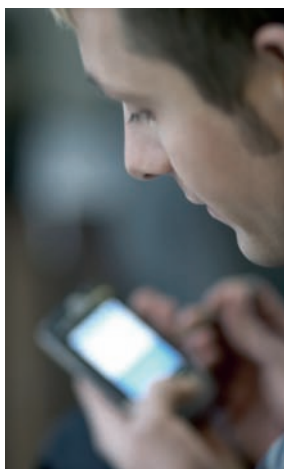

THERE MAY BE TROUBLE AHEAD...

One of the most ambitious IT projects in the world, Connecting for Health has been hit by delay and criticism. Does it still have a future? Helen Mooney investigates

The Labour government's Connecting for Health programme has been a long time in the making with the latest estimates optimistically putting roll out across the NHS by 2012, but does it really have a future?

As it stands the Liberal Democrats have said they want to abolish Connecting for Health, while the Conservatives have pledged to make significant reforms, giving more control to individual NHS trusts.

So what has gone right and wrong with the programme to date and what could and should be done to rescue and revive it?

There were hints that all was not well with the developments in the programme, with IT company Computer Sciences Corporation (CSC) missing its end of March deadline for implementing iSoft's Lorenzo software suite at University Hospitals of Morecambe Bay trust.

Speaking to *HSJ* in April, Department of Health director general for informatics Christine Connolly explained she had refused to sign renegotiated contracts with CSC, worth about £3bn of the troubled £12bn national IT programme and added that if CSC could not now put forward a convincing plan for Morecambe Bay, it could lose its contracts for all hospitals in the North, Midlands and East of England. She said: "Given they have not delivered, that obviously affects our confidence."

However, the contentious IT system finally went live at the end of last month and CSC and sub-contractor iSoft will now be able to ask for payment from the NHS IT programme.

The Morecambe Bay implementation is meant to show that the new Lorenzo software can work across the whole of a complex NHS trust rather than just departments or sections of trusts.

It will be Connecting for Health's core software for the Care Record Service (CRS) in the North, Midlands and East cluster, covering 60 per cent of England.

New agreement

BT's new agreement with the Department of Health in London may provide a better indication of the programme's future.

The company, which met its deadline to implement Cerner Millennium at Kingston Hospital last year, agreed to cut £112m or 11 per cent from its £996m local service provider contract to the NHS in London. It will do so by abandoning the idea of uniform software; if London hospital trusts already have fit for purpose IT, BT will connect those systems rather than replace them.

'What has gone right and wrong with the programme to date and what could and should be done to rescue and revive it?'

This means the Connecting for Health programme currently has three models for its three regions with exceptions for foundation trusts, several of which have chosen alternative systems.

Trusts in the southern cluster, which does not have a local service provider, are meant to have completed choosing software suppliers from the DH's Additional Supply Capability and Capacity (ASCC) list.

Acute trusts in London will get Cerner Millennium from BT – unless they already have a working system in place. Those in

the North, Midlands and East cluster run by CSC are committed to iSoft Lorenzo.

In March, think tank 2020health.org published a report on how to reform the programme. *Fixing NHS IT* says if the new government is to plough on with the programme it must judge contractors against criteria including whether they will deliver "value for money".

If not, it says that other providers should be allowed to deliver acute electronic health record systems and the programme should refocus on elements such as community and primary shared records, which potentially could save £1bn.

The report's author, NHS IT consultant John Cruickshank says: "Both the Conservatives and the Liberal Democrats have talked about localisation and the way forward is local ownership. By and large I don't see the programme being completely dismantled – that would be a retrograde step given that there have been notable successes with NHS Mail, PACS and Choose and Book."

However, he says the new government will need to look at how the programme has grown in terms of summary care records and the IT infrastructure it has attempted to implement for the acute sector. "It has grown in scope and lost clarity of purpose," he says.

Colin Sweeney, director of ICT at London's King's College Hospital foundation trust, says that his trust implemented the original iSoft package over 10 years ago and has for the time being opted out of the Connecting for Health programme.

"One size does not fit all, particularly in the acute sector, which is what the Connecting for Health programme is trying to do. The suppliers involved don't really understand the NHS," he says.

"Generally the idea of connecting up NHS trusts electronically was a good one but forcing people to use systems and not giving them any choice meant that there would be resistance," he adds.

However, Mr Sweeney agrees that, whatever the government decides, it is unlikely to scrap the whole programme.

In the Southern region, Bill Flatman, director of IT at Portsmouth Hospitals trust, admits that his trust was not ready to volunteer to trial the Cerner Millennium system.

He explains there are a "large amount of local costs" with implementing any centrally procured software system, despite government funding.

"From a financial perspective, it did not seem to be worth it for us in terms of value for money," he says.

Mr Flatman agrees there is no one model that will be a perfect fit for all acute trusts and that local procurement within current budgets constraints has to be the way forward.

"We are looking at very specific products and making the best use of what we have to connect up locally," he says.

The Connecting for Health programme has come under increased scrutiny

ACTION PLAN

Key recommendations from *Fixing NHS IT: a plan of action for a new government*

- **The elements of Connecting for Health that are a valuable platform for the future should be developed. These include N3 – the NHS broadband network – and PACS, the capture and communication of radiological and other images**
- **National action and investment is needed in areas where IT is under exploited, notably telemedicine and collaborative technology**
- **The roll-out of the controversial summary care records project should be halted and reviewed**
- **In combination with a consolidation and strengthening of IT provision at the local level, a radical reorientation and downsizing of the central IT organisation is needed, making it more transparent and accountable to the NHS.**

One thing is for sure, the current coalition government must make crucial decisions about the Connecting for Health programme.

With NHS chief executive Sir David Nicholson warning that £20bn must be saved from NHS budgets in the next two years, IT spending must be heavily scrutinised.

Any perception that NHS IT can be fixed just by axing projects or renegotiating contracts is to vastly oversimplify what needs to happen as would adopting a localised-only approach to IT, which would lead to fragmentation and a worse position. ●

Find out more

www.2020health.org
www.connectingforhealth.nhs.uk

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UPWARDLY MOBILE

Weighing up the benefits and risks involved in new high-tech kit can be a minefield, but there's no denying its potential to radically change the way we work

As home and community-based care increases, primary care trusts will need to develop more advanced mobile solutions to enable clinicians to access up to the minute patient information and data on the ground.

Transforming Community Services has placed more emphasis than ever before on the need for NHS community services to work more efficiently with patients and the wider public in their own homes and communities. Yet the NHS currently under-exploits telemedicine and collaborative technology.

Why are we so far behind other countries and what is being done to change negative perceptions of such technology?

Steve Pashley, an NHS management consultant and director of Health2Works, says the traditional NHS approach to such technology has left it behind the times. "The NHS has often gone for big contracts and big corporations in IT. Managers are used to it being something that costs millions if not billions [of pounds], and is done by IT people," he says.

"The NHS has the mistaken idea of the need for economies of scale which does not [always] work in software. Big software products are too risky and often don't really deliver," he explains.

Dynamic technology

In the North West, Health2Works is working with several trusts and the strategic health authority on the Web 2.0 Accelerator Programme to build a series of low-cost responsive and dynamic technology products for clinicians to use in the community. Any products created through the programme will be owned by a social enterprise governed by the NHS and offered at cost price to the NHS in the region.

'We wanted to show people in the NHS that this is not rocket science and that it does not need to cost millions of pounds'

Examples of products in development include Peter Piper, which will allow speech therapists to remotely monitor patients' progress and help them to better plan which patients they also need to see in person. Another product, Help Decide, means commissioners will be able to openly engage the public in remote discussions on service change plans.

"We wanted to show people in the NHS that this is not rocket science and that it does not need to cost millions of pounds and it can give value for money to patients and the public," says Mr Pashley.

Elsewhere, on a national level, the use of assistive technology to help PCTs develop self-care models with their patients has been piloted. Using this new technology can mean people are able to live independently for longer. That is where the whole-system

New technology can prove a massive boost to healthcare

demonstrator sites come in. They were proposed in the white paper *Our Health, Our Care, Our Say* to test the benefits of integrated care. In December 2006, the Department of Health invited NHS and local authority partnership bids for schemes for combined telehealth and telecare (remote social care), covering their whole population. Throughout the summer, the winners set up project boards and sub-groups with the aim of delivering a framework to the DH in early autumn 2007.

Control trial

Meanwhile, a research and evaluation group was set up to evaluate their effectiveness. The Labour government supported the randomised control trial of this equipment through three whole system demonstrator sites in Kent, Cornwall and Newham. With a total cost of around £30m it is the largest of its kind in the world.

The evaluation of each has been designed as a randomised control trial, focusing on individuals with chronic obstructive pulmonary disease (COPD), heart failure and diabetes, as well as adults with health and social care needs who are at risk of hospital admission. The evaluation will look at the impact on emergency admission rates and bed days, patient and carer experience and quality of life and the impact on primary care. All three sites have recruited GP practices to take part in the programme, through targeted information, practice visits and roadshows.

In total, there are 7,000 telecare and telehealth installations in individual homes, making the programme the largest such trial in the UK to date. Each site has recruited more than 1,000 patients to use telehealth and 1,000 to use telecare.

Andrew Forrest, programme director for the whole system demonstrator in Cornwall, explains: "This is about helping people to stay in their own homes so they don't have to go to their GP or to acute services, but it is more than that, it is about helping people manage and understand their own conditions better."

'It's the service redesign that's tricky. It's the staff training and helping community matrons to understand where it fits as a tool'

He says people using the telehealth system with high blood pressure, for example, are given "parameters" to start to understand what their blood pressure level should be. Mr Forrest says the trial has been received very positively within the PCT, so much so that the organisation's community stroke team has decided to use telehealth to monitor its patients at home as well.

"Because we have put the systems and infrastructure in place, this telehealth can potentially be rolled out to lots of different areas of the services we provide," explains Mr Forrest. "Ultimately, because of our geography, this type of technology saves time and is cost effective for the trust, clinicians and patients."

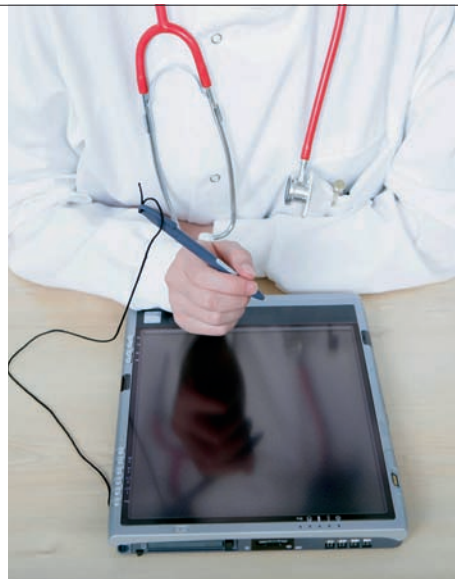
A number of companies, including Docobo, Tunstall and BT, are already working with other PCTs and community services to roll out telehealth products across the country. Adrian Flowerday, managing director of Docobo, which is working with 40 PCTs and trusts to develop telehealth services, says many of the organisations are encouraged by using telehealth, because it means clinicians are able to use data more effectively and it fits in with the quality, innovation, productivity and prevention (QIPP) agenda.

However, he warns the NHS seems to be a lot less clear on how it can manage large-scale telehealth introductions and questions whether PCTs can get the clinical buy-in they need to make it a success. "It's the service redesign that's tricky," he says. "It's the staff training and helping community matrons to understand where it fits as a tool."

Mr Flowerday calls on PCTs to get a managerial grip. "It needs PCTs to manage staff and say 'this is what we are going to do', then identify the patients and give the technology to community matrons as a

ALAMY

‘The problem is that when we as GPs leave the surgery door we do not have decent remote access and PCTs won’t fund the kit we need’



tool,” he says. Docobo recently worked with nurses at University Hospitals of Leicester trust on a 12-month pilot, ending in April 2009, to assess whether it could help patients with COPD self-manage their condition. Known as doc@HOME, 40 patients had handheld monitoring “hubs” installed in their homes to record basic nursing observations and individual data. The patients answered a series of questions about their physical, social and emotional wellbeing twice a day, transmitting the data to a triage nurse via a secure server. Patients also recorded their observations, such as pulse oximetry and blood pressure.

Using a “traffic light” system, the triage nurse categorised patients according to their needs, with green meaning no intervention required, amber that the patient required a phone call, and red indicating urgent problems. The patient’s record was then accessed by a community matron who used the information to send a message directly to the patient asking them to visit their GP, for example, or to change the frequency and/or volume of their medication.

During the pilot, 58 hospital admissions in 43 patients were recorded. However, the nurses also recorded 202 patient interventions, such as a visit from a community matron, instigation by the triage nurse to start steroids or antibiotics, or advising the patient to see their GP. These interventions saved around 144 unnecessary hospital admissions, potentially saving the trust around £259,000 over the course of a year. The pilot study also showed that six months prior to the start of the system, 38 hospital admissions among 16 COPD patients were recorded. After the 16 patients started using the home hubs, the number of hospital admissions fell to only five hospital admissions over the following six months saving the trust more than £46,000.

Dr Grant Ingrams, chairman of the British Medical Association’s GP IT committee, agrees the NHS needs to become more savvy in its use of mobile technology in the community by both clinicians and patients. “The problem is that when we as GPs leave the surgery door we do not have decent remote access and PCTs won’t fund the kit we need,” he says.

He says that if clinicians working in community settings had access to patient information when they are working in patients’ homes or in nursing homes prescribing errors could be greatly reduced.

Getting the right piece of equipment is essential

ALAMY

“When we are in the practice we have the machinery that can constantly check up on our patients, checking allergies, prompts to check the correct dosage is being prescribed and if drugs could be contraindicated – this is not something we can do when we are on call, but it could and should be,” he says.

However in some parts of the country things are changing for the better. In Torbay, the care trust wanted the benefits of mobile working for its community health delivery but faced a major obstacle. Much of its local area does not have 3G mobile coverage.

After a number of unsuccessful mobile device trials the organisation, which commissions health and adult social care services for around 140,000 people across the area, has now piloted a system that has made mobile technology a reality. The trust has designed its own system with staff on the ground using laptops. Community matrons take their laptops out to patients and can access information and previous notes offline. When they return to their bases, the laptop is docked and synchronised with data held centrally.

By designing the system in this way the trust has ensured that clinical staff on the front line only have to input patient information once and that they have access to easy to use, accurate and up to date information. The system has been designed so that any changes staff make are auditable and records are archived in chronological order. The system was piloted for six weeks beginning in January after eight months’ development.

Malcolm Dicken, head of new ways of working at Torbay Care trust, explains: “In terms of mobile technology we have been looking at how we ensure that frontline staff have access to data when and where they need it and that it is ubiquitous and stable enough to be used across the health and social care setting for clinicians... If we ask clinicians to use IT and it does not work consistently in the same way they are already working they naturally get very frustrated with it, because they see it encroaching into the time they could be spending with patients.”

He says the trust trialled customer relationship management (CRM) technology with community matrons in an attempt to capture all the information they collect in a patient’s home, including assessment, scheduling, and recording of a patient’s vital signs, along with their demographics, allergies and medication. “We are now looking at producing the business case for how this could be rolled out trust wide,” says Mr Dicken.

However, it remains to be seen in these tight financial times whether Torbay and other trusts will be able to find the funding to expand this type of technology. Indeed, such innovative technology is about organisations being brave while perhaps at the same time seeking some reassurance from strategic health authorities or the DH to acknowledge the risks, because the benefits that ultimately could be realised outweigh those risks and have the potential to become a very powerful tool in the way the NHS works in future. ●

CONNECT TO THE FUTURE

Whether it's creating electronic patient records or transmitting patient test results, how do you get the most out of wireless technology? Helen Mooney reports

The Connecting for Health programme may have stalled, with many acute trusts still none the wiser about what their overall IT systems will look like in future, but this does not mean that trusts cannot invest time and money in developing their own local solutions.

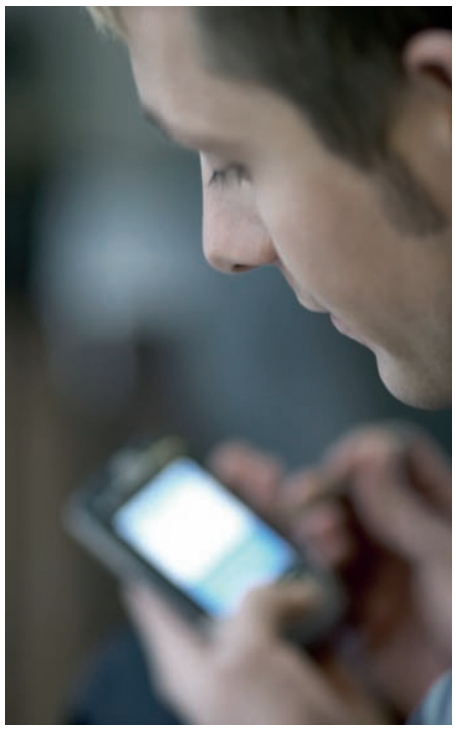
Indeed, there is nothing to stop acute trusts ploughing ahead and pioneering the use of wireless technology and handheld devices within their own organisations in order to make the job of frontline professionals more accessible by allowing better access to patient information and ultimately improving patient care.

So how do acute trusts ensure they are procuring the best value for money solutions for their organisations?

Although it may not yet be widespread, telemedicine – in which clinicians use mobile technology to talk to each other – is slowly developing in parts of the NHS. The digital picture archiving and communications system (PACS) has been a big success, but elsewhere earlier this year NHS North West reported on their major trial of cardiac telemedicine, carried out with Broomwell Healthwatch. It involved placing telemetric 12-lead ECG machines in 15 GP practices and two walk-in centres in Cumbria and Lancashire. Patients with suspected heart disease could have tests done on-site.

The results, instead of being analysed by a non-specialist GP, were wirelessly transmitted to a call centre where a team of clinically trained staff were available 24/7. Specialists communicated by telephone with the clinical staff attending the patient.

The results were dramatic, showing that 82 per cent of patients did not need a hospital appointment. The strategic health authority audited 55 patients treated using the system and found that it saved 16 accident and emergency attendances and four hospital admissions. Offset against the costs, the six-month pilot scheme saved £3,965. Nationally, that would amount to 90,000 accident and emergency visits, 45,000 admissions and £46m saved.



'The vast majority of projects are about changing the way people work. It's really about how IT can improve process change'

Another local mobile solution has been successfully implemented at King's College Hospital foundation trust in London. The organisation has rolled out VitalPAC into its iSoft iCM-based electronic patient record. VitalPAC is a way of vital signs being recorded electronically rather than written on a chart at the end of the patients' bed. It means clinicians can access observation charts, including early warning scores, at a click of an icon within the trust's EPR system. VitalPAC enables nurses to record a patient's vital signs at the bedside, using a personal digital assistant, as part of their routine care. The system analyses the data and automatically flags up any deterioration in the patient's condition. Senior clinicians are more frequently and quickly alerted to patients whose condition is deteriorating.

The new tools are available to clinicians at the patient bedside, from their office or even remotely from home.

Colin Sweeney, director of ICT at King's, says: "VitalPAC is another piece in the jigsaw of building an electronic patient record. We are using it in conjunction with iSoft's iCM, which we use for order communications and results."

Meanwhile, community midwives at Portsmouth Hospitals trust are now using Blackberry smartphones and digital pen software. Notoriously IT-phobic midwives can spend a large part of each day transcribing handwritten notes into the computer system. However, the trust is seeking to cut down on this transcribing time by rolling out digital pens to help them. The pens are linked to their Blackberry phones, which in turn are linked to the server, transferring handwritten notes directly to the patient administration system, explains trust IT director Bill Flatman.

"They can then spend more time visiting patients and less time transcribing their notes. This is about coming up with the technology appropriate for the requirement," he says.

Mr Flatman argues that extracting a return on investment from IT projects is "90 per cent about the people". He says: "There are technical projects that can be viewed as pure IT, but the vast majority of projects are about changing the way people work. It's really about how IT can improve process change."

Mr Flatman added that introducing local small scale IT solutions that make clinicians' jobs easier should be the way forward for trusts. "You have to be careful and not overplay the benefits of new technology in business cases and you have to make sure that the balance is there between saving time for clinicians and how much training is required. You need to be thinking about both the business and clinical objectives of new technology," he explains. ●

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