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18 October 2000

Dear Colleague,

**Information Management Strategy for PCG/Ts**

Please find enclosed two copies of the final draft of the above strategy. This final draft has only been circulated to Chief Executives of the PCGs at this stage.

Chris Tite will be organising a workshop to present the recommendations of the strategy to a wider audience. We hope that this workshop will be held in three to four week's time.

I would like to draw your attention to two aspects of this document in particular:

- Section F, pages 76 to 80– Establishing PCTs for 1st April 2001

  This section identifies an action plan to support the establishment of PCTs

- Section E, pages 38 to 42 – common, shared district wide primary care system

  This section recommends the specification, procurement and implementation of a district wide primary care system with links to a central reporting database

Please do not hesitate to contact me if you wish to discuss either these or any other aspect of this document.

Yours sincerely

Code A

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Encl. 2 Copies x Final Draft of PCT Strategy

Distribution: John Kirtley
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cc Chris Tite (letter only)

NHS

## Portsmouth & South East Hampshire Health Authority

# PRIMARY CARE GROUPS/TRUSTS

# INFORMATION MANAGEMENT AND TECHNOLOGY

## STRATEGY

## 2000 - 2005

## FINAL CONSULTATION DRAFT

**PLEASE RETURN TO:-**

Chris Tite
Head of Information Management & Technology
Portsmouth HealthCare NHS Trust

October 2000

# E. THE WAY FORWARD

## 1. Introduction

The gap between the vision for IM&T in the care groups for which PCTs will be responsible for providing services and the current situation has been shown to be great. This section explains how that gap will be bridged over the next five years. It focuses in turn on each individual care group and service, defining key information sharing needs and service IT requirements and setting strategies for how these will be met.

## 2. Primary Care

GPs and practice staff will be involved in setting the strategic direction of PCTs and in their day-to-day management. They will also be responsible for providing critical NHS services to the local population. However, they will remain contractually outside the PCTs, which could potentially make difficult achieving a collaborative approach to IM&T in primary care. Nevertheless, GPs will be critical to whether or not PCTs are successful in improving the health of the populations they serve. If information and IT are to contribute to this, GPs must be persuaded of the benefits to them, their staff and their patients of collaborating in joint IM&T ventures.

GPs and Primary Care Trusts will be increasingly held to account for the quality of services they provide and it will therefore be in their own interests to have information that shows what that level of quality is. This means not only putting qualitative data into computers, but extracting and analysing it and comparing the resultant information across the Primary Care Trust and with District, Regional and national data. Achieving this will require the agreement and implementation of data standards, common formats and common data interchange standards. It will also require a relationship based on trust to be built up between GPs, PCT staff responsible for performance management of GPs and IM&T staff who provide the information to support this. Without this trust GPs will fear a 'big brother' approach to performance management and will not cooperate on developing clinical effectiveness information.

GPs are hard-working, independent professionals committed to improving the health of their patients. In order for them to commit time and energy to information and IT developments they must be convinced that to do so will ultimately improve patient care, that in the meantime their patients will not suffer because their attention is diverted elsewhere, and that they will not suffer financially as a consequence. This means that funding to support such developments must be directed not just at the technology, nor even at training, but also at awareness raising, communications, and providing cover for GPs and other clinical staff when they are involved in IM&T projects work.

In order to develop the culture and attitude within GP practices necessary for collaborative development of general practice IM&T, it is proposed the following is implemented:

- the NHSnet connection project for GPs should be completed with full training provided to both practice staff and other primary care team members to enable them to gain the benefits this offers;

problems. About six practices will test the new service over the next few months before it is rolled out to all practices, hopefully by the end of March 2001.

**d) Direct Booking**

Portsmouth Hospitals NHS Trust is collaborating with 17 local GP practices to pilot direct booking of patients into cancer clinics. This appears to have been successful, but volumes are currently too low to gauge this adequately. Portsmouth Hospitals NHS Trust therefore plans to roll-out the pilot to all NHSnet connected practices and eventually to include other specialties when they are ready. The pilot has already highlighted a number of issues that will need resolving if widespread direct booking is to be successful, but this strategy proposes that the current approach continues.

**e) Referral Rates**

A key task for PCG/Ts, and one in which GPs will play a key role, is that of demand management. The NHS Plan stipulates that "by April 2001 every GP practice and primary care group/trust must have in place systems to monitor referral rates from every GP practice, to match the information currently available on GP prescribing." Even without this, monitoring and managing referrals to secondary care will be a key method of influencing PCT expenditure on secondary care services and must be supported by technology. Ultimately, the shared primary cares system must make collecting and collating referral information a simple by-product of clinical referral processes. In the meantime, a pilot scheme, led by practices in Petersfield, is underway to develop interim methods for collecting referral data. Once proven, this must be rolled out to all practices, with appropriate routines put in place to enable central collation of data at a PCG/T level.

**f) MIQUEST**

MIQUEST is a data extraction tool that should work with all RFA99 compliant GP systems. Queries can be written centrally and then sent to GP practices on disk to be run on individual practice systems. The results can then be transferred on disk back to a central point for collation and analysis. This is a time-consuming and not very efficient process, but is the only effective option available currently for collating data from disparate GP systems. Currently only 16 practices in the District have agreed to implement MIQUEST. PCG/Ts must persuade all practices to implement MIQUEST and provide the necessary support for them to do so if they are to collate and analyse GP data effectively.

Currently use of MIQUEST is led by the Clinical Effectiveness Team, but they do not have sufficient staff to carry out all data extractions themselves. Therefore practice staff need to be trained in the use of MIQUEST and supported in this by Information Facilitators. The Clinical Effectiveness Manager recently proposed employment of three such Information Facilitators, but this was only accepted by one PCG, Portsea Island. This strategy proposes that:

- East Hampshire and Fareham & Gosports PCGs review the Information Facilitators proposal again and, if they still do not want to approve it, identify how else they will manage the collation and analysis of GP data; and
- for those PCGs that do approve the proposal, Information Facilitators are employed for them under the management of the Clinical Effectiveness Manager and a programme of MIQUEST roll-out planned and implemented for all GP practices in those PCGs.

### g) PRODIGY

PRODIGY is a computerised prescribing decision-support system available free of charge to GPs. During a consultation a clinician can enter a patient's diagnosis into PRODIGY and it will suggest appropriate treatment regimens. Advice on refinement of diagnosis, investigations, referral and treatment choice, together with shared doctor/patient screens and the printing of patient advice leaflets are also available.

GPs locally are generally unenthusiastic about PRODIGY, feeling it is too unsophisticated to be of much use. Trying to implement it in the face of such hostility would be difficult. This strategy therefore proposes to:

- identify a GP who is enthusiastic about the potential of PRODIGY;
- supporting him/her in piloting its implementation in his/her practice; and
- reporting back to the wider GP community on the outcome of the pilot; and
- if the pilot is successful, rolling out PRODIGY to other interested GPs.

### h) Prescribing Information

Considerable sums of money will be spent on drugs by the PCG/Ts, so managing this as effectively as possible will be vital to them in meeting spending targets. However, experiences within the service suggest this will be most effective if PCTs do not simply attempt to impose cost controls on GPs, but rather work with them to develop best practice in prescribing (e.g. not over-prescribing, prescribing most effective drugs, etc.).

Historically the HA managed primary care drug budgets and used a part-time information analyst in its Public Health Information function to analyse prescribing data from the Prescription Pricing Association (PPA) via the EPACT system. The PCTs will need to increase the prescribing information analysis resource if they are to properly address this issue, but this could actually be self-funding if effective. For instance, with a drug budget of £20M, a saving of just 0.1% would fund a full-time information analyst to support a PCG/T's prescribing adviser.

### i) Out-Of-Hours Services

There are two main GP out-of-hours services covering the District: H-Doc and Healthcall. H-Doc is a non-profit-making private company run by and involving 115 local GPs. Healthcall is a private profit-making business. Some GPs do not use either service, but provide their own cover.

The larger out-of-hours services maintain their own computer systems for logging calls, recording details of medical history and of treatment or advice given. H-Docs have about 100,000 patients on their system currently. They have recently introduced a method of automatically e-mailing GP practices every morning with details of their patients who contacted the out-of-hours service during the night.

NHS Direct will soon be running GP out-of-hours co-operatives on the Isle of Wight and in the New Forest and appear to have ambitions to expand these services.

There are a number of ways in which access by the GP out-of-hours service to GP electronic patient records would be of benefit:

- The out-of-hours service currently has to ask each patient calling details of their medical history and record these on their system for use by the on-call GPs, but this

In view of the potential value of the CHS, this strategy proposes that a review of the existing system is carried out. This would need to take into account a number of factors:

- the potential for integration with other systems to facilitate the development of the EHR;
- the potential for inclusion of CHS functionality in a shared primary care system;
- the lack of integration of the current special needs database with the existing CHS;
- the need to be able to interface with agencies external to the NHS (social services, education, Office of National Statistics); and
- the need for a more flexible and robust tool for database interrogation and reporting.

## f) Integrated Services For Older People

Portsmouth HealthCare NHS Trust's Elderly Mental Health (EMH) services are currently managed by different Divisions across the various localities, which should facilitate ease of transfer to the PCTs. They are delivered from St. James', Petersfield and Gosport War Memorial Hospitals, community based units, and by community EMH teams covering the whole District.

The Trust manages the Department of Medicine for the Elderly, which is based on the St. Mary's and Queen Alexandra's Hospitals, but also operates at community hospital sites throughout the District. Elderly Medicine provides outpatient, inpatient and day care services for elderly people with medical problems.

District Nursing services also primarily focus on elderly people, but they are managed in the community and are organised around Primary Care Teams based in GP practices. They have been dealt with earlier.

### (i) Elderly Mental Health Services

The current focus of EMH care is on developing partnerships with social services to deliver a client led, community-based service and there is a strong need for efficient and effective communication links to enable a smooth transition between episodes of care delivered by the various agencies.

Recently the EMH service defined their core IM&T development need as being access for the entire service to the Trust WAN, the CIS, Hantsnet, NHSnet and the Hospital Information System (HIS), pathology and radiology systems of Portsmouth Hospitals NHS Trust. Links are currently limited to administrative and management functions on the St. James' Hospital site and do not cover ward areas or community EMH team offices. The service identifies the following benefits of such linkage:

- fast and effective communication between all agencies caring for the client group;
- rapid response to diagnostic requests (e.g. blood results), speeding diagnosis, enhancing care regimes, shortening episodes of care and thus increasing the capacity of the service;
- improved administrative effectiveness (e.g. booking meetings, distributing minutes, reducing paper mail, sharing information); and

- greater individual professional development and evidence-based service improvement through access to best-practice guidance, research results, clinical trials results, etc.

The EMH service does not require individual network terminals for all members of staff, but shared access in all wards, consultant psychiatrists' offices, community EMH team bases and some clinics. The cost of the networking to these sites could be prohibitive if serving EMH services alone, but many of the sites are shared with other services, which would reduce the relative cost of implementation.

In order to provide more integrated services for elderly people, it is likely that there will be a closer relationship in the future between the EMH service and other services for elderly people, such as Elderly Medicine, District Nursing and Primary Care. For hospital-based EMH services it would therefore be sensible to pursue the same strategic direction for information and IT as for Elderly Medicine.

It is proposed that the information needs of the EMH service are met by:

- agreeing a client information sharing protocol with social services and other care partners;
- providing access to NHSnet/Internet for EMH clinical and clinical governance leads;
- developing additional data sets to meet clinical governance needs (e.g. condition, dependency, clinical outcomes, etc.) and building these into data pen / CIS/ OSS data flows where feasible;
- a rolling programme of Trust (or District) network expansion to all EMH sites, individually prioritised on the basis of benefits across all services, with networked PCs installed in all wards, consultant psychiatrists' offices, community EMH team bases and clinics;
- providing access to Pathology results reporting in all inpatient wards;
- implementing the CIS inpatients module in wards;
- implementing the CIS outpatients module for consultant-led outpatients clinics;
- merger of CIS and the Portsmouth Hospitals NHS Trust HIS so that EMH and Elderly Medicine data will be available on the same system;
- continued recording of EMH community activity on the CIS via datapens; and
- reviewing the functionality of the eventual AMH system and the acute HIS system to see which would best meet the needs of the EMH service and, if appropriate, replacing use of the CIS by one of those two systems.

### (ii) Medicine for the Elderly

Staff working within Elderly Medicine inpatient facilities have very similar clinical information sharing needs to other specialties based in the acute setting. They need to communicate routinely with support functions within their hospital as well as order diagnostic tests and access results. For this reason the decision was taken during 1999 to treat Elderly Medicine facilities based at Portsmouth Hospitals sites, in IT terms only, as part of that Trust. A project was initiated to put these services onto the Portsmouth Hospitals IT infrastructure. However, as these services will still