

IMPLEMENTING THE IM&T DES: DATA ACCREDITATION

Introduction

As part of the agreed changes to the GMS contract for April 2006, a directed enhanced service (DES) was developed to facilitate the use of information management and technology (IM&T) to support the delivery of the National Programme for IT. The specification for this DES can be found in *Revisions to the GMS contract 2006/07: delivering investment in general practice* which is on the BMA and NHS Employers websites. Practices and PCTs will need to familiarise themselves with the specification before reading this guidance note.

A key objective of this DES is to support practices to achieve accredited data quality standards that are fit for sharing in the NHS Care Records Service. This guidance provides PCTs and practices with further information about the data accreditation process. Additional technical guidance will be published by the end of summer 2006.

Background

Clinicians have traditionally recorded notes on paper or on the computer without any requirement for ensuring that the terminology that is used bears a universal meaning. Medical notes are often used as internal working documents and have been annotated with internally created codes, which only have meaning in the local environment. Whilst it is recognised that any information that facilitates local knowledge can be helpful practices need to be working towards records which can equally well be shared by healthcare workers who may not have prior knowledge of the patient or of local protocol.

As notes start to flow electronically around the health economy it is critical that patient records are not misleading and are as complete as possible.

The vision

GP2GP record transfer is eagerly awaited by many GPs frustrated by the inability to safely transfer their carefully recorded coded records (which contain the relevant context) to the patient's next practice. For the receiving practice, access to accurate and complete records soon after a patient registers will improve patient safety and care, and avoid unnecessary work in generating duplicate records.

The NHS Care Records Service will connect the electronic health records of patients across the health service. Details of how the Care Record is being developed and the access controls that will be put in place to protect the confidentiality of patients are described elsewhere.¹

The first incremental step towards the vision of a complete electronic health care record that is shared across the health community is the provision of an electronic summary. This summary would be available to each part of the health economy that the patient attends and will support their safe care.

¹ <http://www.connectingforhealth.nhs.uk/delivery/programmes/nhscrs>

The challenges

There are a number of challenges that currently impede the accurate transfer of electronic patient records.

- The common practice of a clinician putting some information on paper and some on to the computer leads to the fragmentation of records. If these were to be sent on to another colleague, they would not have the total record.
- GPs have historically written free text in paper records and understandably like to record as much of the consultation as possible in the free text fields of their medical software. However, the considerable clinical benefits of structured coded records have become clear, in particular with regard to the Quality and Outcomes Framework (QOF). The “gold standard” clinical record will continue to rely on the use of free text, but as a qualifier to carefully selected codes which impart meaning to all in a consistent and reproducible way.
- The accuracy and completeness of some electronic records is not as good as many clinicians would expect. This is not just related to the methods for recording notes contemporaneously, but is often related to the systems used to store and move records. The protocols used for summarising and the resultant quality of records are not consistent. Likewise, there is considerable variability in the effectiveness of passing on correspondence when patients move practice.

The IM&T DES is intended to help GPs rise to these challenges.

Data standards

The standards described in the IM&T DES are those of the *Good Practice Guidelines* published by the Joint GP IT Committee of the BMA General Practitioners Committee and the Royal College of General Practitioners.² The requirements that are expected of practices which intend to solely use electronic notes for consulting are covered extensively in chapter 8 of *Good Practice Guidelines* and appendices 4 and 5. Primary Care Trusts (PCTs) should have appropriate processes in place to ensure adherence to the regulations described there.

The Guidelines also extensively describe the importance of systematic standardised data coding as well as information governance standards and the requirement for ongoing education and training. It is expected that PCTs and practices will want to make use of the guidelines as a reference tool during their preparation for the DES.

Preparing for accreditation

A key feature of component one of the DES is that practices should plan how they are going to address the specific requirements of the DES. The planning documentation must include a training needs analysis of the practice team and a development plan for the team to raise their data standards. Audit areas should be identified (some suggested areas that are sensible to start with are listed below).

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http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4008657&chk=rr8fQT

The detailed requirements of the submitted plan are contained within the text of the DES.

Support for practices and PCTs

PRIMIS+ will offer PCTs free education and training for their facilitator network with regards to the data accreditation process. Practices will be able to access education and training from their PRIMIS+ facilitators (or equivalent provided by their PCT) to help them prepare and run their audits.

Applying for accreditation

Only practices who are paper light can apply for accreditation. Practices should not normally be recording a patient's clinical information both on paper and in the electronic record. To apply for accreditation, practices must be using the computer system contemporaneously in the consultation.

The actual accreditation process is a three part process which includes a practice submission, a quantitative analysis of data taken from the practice computer and a visit that will provide the necessary qualitative analysis.

When a practice and its facilitator feel they are ready to apply for the accreditation standard, the practice will be expected to submit the following:

- Evidence of adherence to the Good Practice Guidelines for paper-light consulting, as agreed with the PCT
- Summarising protocols for promptly updating their records with information that is extracted from patient-related correspondence and messages that are received by the practice
- Disaster recovery protocols with respect of their information systems
- Evidence of the use of the computer record for telephone and home visit consultations
- A protocol for the assistance of locum clinicians to support their consultations and data entry
- A log of in-house training events undertaken including induction of new staff, locums and relief staff and a signing-off process in addition to a log of training undertaken by each member of the practice team linked to his or her training needs assessment as set out in their personal development plan
- Evidence of the completion of the self assessment as required by the Information Governance toolkit.³

Once the PCT has received the accreditation application from the practice it will organise the accreditation process

³ <http://www.nhs.uk/infogov/igt/>

The PCT will work with PRIMIS+ to perform quantitative analyses of the practice data and compare its quality to that of other paper-light practices. The analyses will assess some of the following (the precise searches chosen, following piloting for validity will be available in the technical guidance, which will be published in the summer):

- Prevalence of specified significant, common diagnoses, relevant to the practice demographics
- Prescriptions indicative of a major chronic diagnosis (for example insulin) linked to an appropriate diagnostic code in the summary record
- Problems/diagnoses classified as “significant” or “important” so that an accurate and complete summary can be created
- The rate of recording of drug and other important allergies and adverse reactions
- The utilisation of Family History codes
- The analyses of obviously inaccurate gender-specific diagnoses
- The presence of locally-derived codes in order to ensure their minimisation.

The PCT will then plan a visit to the practice which might be combined with the annual QOF visit. Medical assessors who have been trained by the PCT⁴ on the system being used by the practice to analyse consultation data will qualitatively assess the quality of the recording of the notes against the standards.

It is expected that the assessor will look at a cross section of records for every clinician in order that a practice standard can be properly assessed. The practice will be expected to seek consent from a block of patients beforehand.⁵

Accreditation would normally be expected to last for three years unless there were local reasons for the assessors to limit the accreditation to a shorter time period – for example, if several new clinicians recently commenced work.

Once the practice has passed the accreditation standard⁶ it will be eligible to join the NHS care record service and to share its patient’s summaries. The list of accredited practices in a PCT will be published and available to patients.

⁴ PCTs may choose to use PRIMIS+ core training to train their assessors. It is inappropriate for the PRIMIS+ facilitators to do the assessments themselves since they are assisting practices in their education and training.

⁵ A standard template letter will be available.

⁶ There will be an appeals process put in place for practices who fail to pass the standard, details of which will be in the fuller guidance to be published in the summer.