Patient Activity Reporting Service

A new reason to develop data gathering has arisen in the last few months – the requirement to introduce referral management, usually in the form of Clinical Assessment Services or Clinical Assessment and Treatment Services (CAS and CATS), whereby all referrals are logged and vetted. This would be another tier, away from practices, which would collate referral letters.

The vision is to unite the need for accurate and timely data for Practice Based Commissioning and the desire for PCTs and some PBC groups to have some form of referral management within one data collection system.

Referral activity is recorded by a new Patient Activity Reporting Service, either instead of a CAS or CATS relying on later changes in pathways, or as part of current CAS and CATS. The PARS would produce monthly reports of referral activity, costs, and also show the patterns of care which could be changed either by training needs or by new pathways or by practice based providing.

Currently in Hertfordshire we only have crude and out of date data (Himas) which does not give the reasons for referrals or details of the hospital response. It is not clear what could be efficiently, safely and practically provided in primary care without live data.

The data produced by the Patient Activity Reporting Service would show actual expenditure for each month and committed expenditure. It would give waiting list details and also information about DNAs. For medico-legal reasons GPs should be aware of delays in treatment, and getting such reports again would be a clinically useful service alone (akin to PACT data for referrals).

- Information for Practice Based Commissioning needs to be timely. HIDAS and the data from NWCS/SUS are 6 months out of date by the time we see them.
- The PCTs are keen, if not determined, to develop CAS and CATS services.
- We need to run PBC with accurate data. The commissioning side needs to know planned activity and actual activity within a day of month end.
- PBC data will allow Commissioning groups discover patterns and redirect services. It adds meat to the PBC process, and has been missing to date.
- The data collected would not only provide referral information and financial information based on actual practice data, which is based on incoming and outgoing referral letters. We could then reinstate the stipulation that no payment is made by the PCT if no clinical letter was received.
- It would also allow for educational needs to be developed. It can be an automatic PUNs/DENs generator. It could allow us to re-establish local educational meetings.
- The Data Service could then develop arrangements with PBC to develop protocols, or reciprocal contracts, which would enable practices to be paid for extra work they do. The Service administers these arrangements. Provision is provided by practices or NHS Trusts.

Progress up to 20th April & Practicalities and Costs of running PARS

Server software has been modified to use HRG codes, and to produce monthly reports with the rigor of Fundholding Software. It gives referral reports but also a financial report based on our indicative PBC budgets. It would be PBC group wide, but can be extended. The server is now up and running and being beta tested. The software is held on a server **within NHS net**: http://172.22.203.242 and could be accessed by practices for reading reports or data input. Instructions and the SSH login programme required can be downloaded from that address, which can only be accessed from within the NHS net.

Staff in larger practices could be trained to put the data on, or data clerks could visit practices to input the data. Certainly practices would have access to their data on line, even if they did not input the data in-house.

An easier approach is to centralise data input. Copies of outgoing referral letters and incoming patient letters would be emailed using nhs.net email. It must be nhs.net email as it is encrypted (there are other systems that can encrypt email to send and receive but they require extra clicks…easily forgotten).

Clearly there are Caldicott issues in this approach. Copies are to go to a clinical (doctor-led) service within the NHS net, and the service part of PBC. It is directly related to patient care.

The HIDAS (Midas) reporting system that is currently available to all GP practices in West Herts on NHS net site: http://10.150.193.31/home/ allows you to drill down to individual patients. The trouble with that site is that consists of out of date data based on hospital data input. There is no data validation. Primary care data is likely to be accurate, as we know our patients and have all the letters. The proposed service would fall well within the latest guidelines at DH on http://tinyurl.com/26rkba

To save data input we would require a download of patient lists from clinical systems or from the PCT/PSU Exeter system. Other data has already been collected and is ready to be imported onto the system – such as consultant codes, GP and practice codes, and Provider details and codes.

Patient Data: this requires the correct protocols in place regarding patient confidentiality as apply to General Practice. We have the Miquest HQL editor that would allow us to create a Miquest search, in order to collect the data in the correct format to input onto the Patient Activity Server. Pat Potts of Herts PCTs has kindly generated a search which has been tested and could allow lists of patients to be extracted and imported.

All practices would need to do is to securely email copies of outgoing and incoming letters. With respect to incoming letters, most practices scan in these letters: in doing so, scanned-in letters go into a temporary folder before allocating. It would be a matter of using Adobe binder to copy or zipping all those documents into a single document for emailing to pars@nhs.net (an email address that has been set up for this task alone). The capture process would only take moments at any practice, and not impact on their normal scanning and allocation process. Indeed it uses that process.

The practice procedure will just require that staff remember to zip up the letters for emailing before allocating the documents to patients. It also needs knowledge as to where the temporary directory is held. I have seen that some practices scan and allocate one letter at a time….perhaps they would like to try a quicker approach with batch scanning, but they could email each letter one at a time if they wished. The emails to pars@nhs.net would have the practice code as subject line. The emails MUST come from an nhs.net email address and be sent ONLY to that nhs.net email address: as nhs.net email is encrypted and patient data must only be sent via nhs.net.

At the server end we have software that strips off the attachment and puts the documents in folders according to the subject line. Further software would break up pdf files for allocating and coding re: HRG and referral hospital.

At first data input will be centralised, but current practices could do it within their surgeries by logging into our server (and be paid accordingly).

We have collected together the codes and HRG prices for importation. Different prices to different providers, including primary care provision, can be added later. Prices can vary as HRGs can be "unbundled" and some services are outside tariff.

Calculation of Work involved in Referral Activity Reporting

This data would be based on GPs' outgoing referral letters and scanned in referral replies to GPs from hospitals and other providers. We believe that this will be more accurate.

Dacorum GPs had 164,367 total HRG and OPD NHS episodes last year on HIDAS, including 12,367 DNAs. Each episode generates at least one letter. Most episodes should have a referral letter. A document (bit of paper) in this context is either a single sheet or scrap of paper or a many-page document; one day these could be emails from providers. Some patients attend casualty without a referral letter, and some patients attend clinics multiple times. We can assume each episode takes 2 documents. This does not count community activity or diagnostics.

164,367 x 2 = 328,734 documents for Dacorum
Population of Dacorum, say 150,000
328,734 ÷ 150,000 is 2.19 documents per person per annum

We have looked at the actual saved (stored) hard copies of incoming documents scanned in over 2 month periods at Archway. This gave 1.56 documents per patient per annum of incoming letters alone. We need to add the outgoing referrals. This brought it up to 1.85 documents per patient per annum.

However, at Archway, the total number of scanned in documents held as files on the computer and therefore actually scanned in during 2006-2007 was 2.50 documents per patient per annum. We assume that participating practices would not be able to sort from their scanning folders prior to input or sending to PARS. The scanned in files (see example list below) includes other things scanned in apart from secondary care letters, such as some internal documents, and also Harmoni OOH notes and X-ray results. We do need to count diagnostics, starting with radiology.

The total number of scanned in material worked out at 2.50 documents per patient per annum.

For Dacorum 2.5 x 150,000 = 375,000 documents to be processed per annum

The estimates from HIDAS, and the work done on the sampling procedures from scanned in documents and paper originals, suggests that 2.5 documents per patient is the working figure we can use.

The first 1,000 referrals will be slow to input as hospital details and expected costs at each hospital will need to be added to the PARS software; these would be computerised PBC shadow contracts, with built-in contract monitoring.

A single worker can input up to 120 referrals an hour on the system. However, it is more realistic to make it 60 referrals an hour, especially if filtering non-referrals materials is required. All documents would need to be sorted and some 277,000 entered onto the system.

A full time worker is unlikely to be able to manage more than five hours a day solid data entry: 5 x 60 referrals = 300 a day = 1500 a week.   There will also be other duties to perform, such as running reports, dealing with practice questions, collating other data and developing the tables of Patients' Unmet Needs & Doctors' Educational Needs from this raw data, and the development of new clinical pathways for patient care.

375,000 documents ÷ 250 working days per annum = 1500 documents processed per day. This requires 5 full time data entry clerks.

Costs of Patient Activity Recording Service

Total costs:	£
5 x 20,000 (inc. on-costs) data clerks	100,000
General management and practice liaison and support	55,000
Clinical Director and IT management and development	55,000
Software agreements for support and licences at 20p per patient on the systems	33,000
Rent, rates, utilities and insurance	30,000
Equipment and consumables	20,000
N3 connection is assumed to go via upgraded surgery connection	0
Total	293,000

£1.95 per patient

Rounding to £2.00 per patient

Future Developments

The processes can be speeded up by more automation, but we need to achieve accuracy of data.   We will be looking to work with the Choose and Book team and with CfH in developing these systems. We will be co-operating with developments at CfH; Dr Bulger is a member of the National GPSoC (GP Systems of Choice) Committee. This proposal is a pragmatic approach that would add substance to PBC activity immediately.

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Example of the file names of the table of scanned in documents

Anticoagulant Clinic{C-West Herts Trust Letter
Cardiology urgent referral{C-West Herts Trust Letter
Chest pain clinic urgent referral{C-West Herts Trust Letter
Chest pain clinic{C-West Herts Trust Letter
Chest X%2dray{C-West Herts Trust Letter
Chest X%2dray{C-West Herts Trust Letter
cardio referral{I-SK
DVT Clinic{C-West Herts Trust Letter
DVT Clinic{C-West Herts Trust Letter
Early intervention team{C-West Herts Trust Letter
Ecg{C-Archway Surgery Data
Ophthalmology{C-Other NHS Hospitals
Diabetic annual review{C-West Herts Trust Letter
diabetic{C-West Herts Trust Letter
retinal screening{C-West Herts Trust Letter
Urgent 2 Wk Referral{C-Outgoing Letter
Histopathology{C-West Herts Trust Letter
A&E{C-West Herts Trust Letter
A&E{C-West Herts Trust Letter
Casualty Consultant{C-Outgoing Letter
Coloproctologist{C-West Herts Trust Letter
Coloproctologist{C-West Herts Trust Letter
Coloproctology{C-West Herts Trust Letter
deceased in%2dpt summary{C-West Herts Trust Letter
ss referral{I-SK
{C-Photo
Discharge Drugs{C-Other NHS Hospitals
Discharge summary{C-West Herts Trust Letter
drugs and info{C-West Herts Trust Letter
Harmoni{C-Non Hospital
letter to a&e{I-SK
Oncology{C-West Herts Trust Letter
Oncology{C-West Herts Trust Letter
Patient Summary{C-Other NHS Hospitals
Transfer Summary{C-West Herts Trust Letter
x%2dray result{C-West Herts Trust Letter
day hospital{C-West Herts Trust Letter
Discharge Summary{C-West Herts Trust Letter
Drug Treatment{C-West Herts Trust Letter
urology nurse referral{I-SK
Cardioloy{Private Hospitals{I-SK
Urology{C-West Herts Trust Letter
Urology{C-West Herts Trust Letter
2 wk urgent referral{C-Outgoing Letter
leg{C-Photo
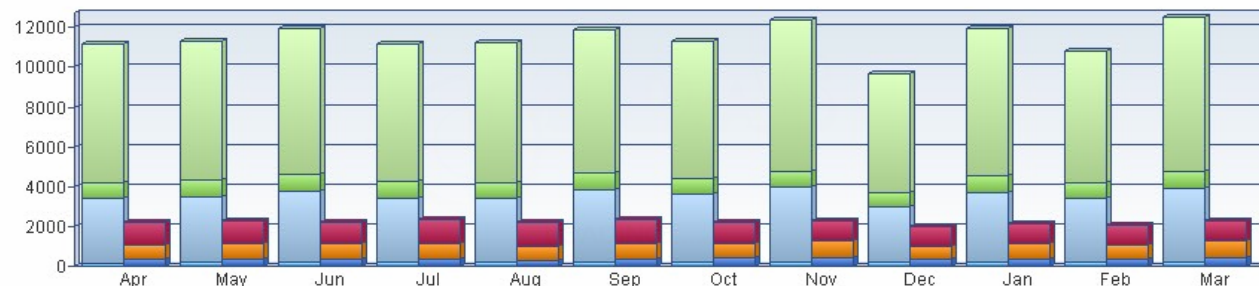Flexible Cystoscopy Report{C-West Herts Trust Letter

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HIDAS
Contact: adrian.lambourne@nhs.net

Hertfordshire **NHS**

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Activity Summary

Locality:	Dacorum PCT			Practice:	(All)				Year:	2005/2006		
Description	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Total**
☐ Inpatient Elective Spells	369	386	380	366	315	377	422	449	355	335	330	421	4505
☐ Inpatient Day Case Spells	746	793	792	796	709	785	747	880	636	761	704	873	9222
☐ Inpatient Non-Elective Spells	1115	1148	1076	1175	1183	1217	1049	993	998	983	966	999	12902
☐ Outpatient New Attendances (DNA)	172	194	186	215	205	218	182	245	217	228	188	208	2458
☐ Outpatient New Attendances (Seen)	3257	3285	3564	3225	3225	3618	3407	3789	2807	3479	3204	3735	40595
☐ Outpatient Review Attendances (DNA)	765	857	828	863	814	887	801	816	720	884	789	885	9909
☐ Outpatient Review Attendances (Seen)	6984	7004	7319	6924	7071	7194	6926	7580	5971	7405	6613	7785	84776

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