

INITIAL AGREEMENT

1. Title of Project:

1.1 eHealth: Primary Care Computing Strategy: GP Computing

2. Introduction / Background

2.1 General

2.1.1 The eHealth Strategy covers all aspects of health care delivery across NHS Scotland. This Initial Agreement addresses primary care systems – particularly systems supporting primary care and encompassing GPs and the wider primary care team. Historically the supply of computer systems to provide support to GPs has been two pronged.

- A system gifted to the health Service by a GP in the 1980s has been developed since as an in house system, developed and maintained by National Services Scotland (formerly CSA) – the software, but not hardware, provided free of charge to General Practices.
- Commercial systems selected by individual General Practices – reimbursement by Health Boards generally running at 50%. There are, at present , some 4 commercial systems in use by GPs.

2.1.2 In previous years each GP Practice system had to pass a test of accreditation which met a set of minimum standards and functionality. This was set at a UK level but allowed for Scottish variation. This system of accreditation at UK level has now been replaced - in England by the National Programme for IT (NPfIT) which aims to place GP functionality with the scope of a patient focussed clinical system covering all aspects of that patients care – from primary through secondary and tertiary care.

2.1.3 There is a need to bring stability and a clear rationale to the supply of GP systems across Scotland. We need to ensure that systems which continue to be used meet current and future requirements and, given that these systems will now be paid for by the NHS as a whole rather than the practices we need to establish cost effectiveness whilst recognising that clinical effectiveness is critical. It is proposed that this is best achieved by a business case process which will set out options including the “do nothing” option and others which are likely to involve use of procurement process under EU regulations.

2.1.4 Under the terms of the new GMS contract GPs have the ability to exercise choice of system. The procurement would aim to produce the most cost effective and clinically effective choice of appropriate systems.

2.2 Strategic Objectives

2.2.1 The White Paper "*Partnership for Care*" anticipates a much greater degree of standardisation in the provision of Clinical Information systems across NHSScotland viz.

- ♦ that funding will be targeted at integrated services – ‘a major focus for new capital development should be on community infrastructure, including modernised, integrated community resource centres and joint information systems’
- ♦ the need for ‘integrated Healthcare – patients expecting each part of the service to work with a shared understanding of their needs’
- ♦ the need for ‘NHS Boards to develop Change and Innovation plans that ... ensure information systems support changing patterns of care’

2.2.4 The current NHSScotland National Strategic Programme for eHealth / IM&T recognises the need for a more structured and standard approach to IM&T and associated infrastructure deployment. The IM&T strategy re-enforces the guidelines laid down in the Scottish White paper and sets targets under a number of programmes to deliver. There are a number of key strategic statements and objectives which include:

- ♦ The need to ensure equity - that ‘healthcare professionals in all care settings across NHSScotland have access to a consistent level of information and communications support systems’
- ♦ The view that ‘consistent electronic communication is also key as geographical and administrative boundaries of care become less relevant’
- ♦ The goal of an Integrated Care Record to which local and specialty systems will contribute - emphasising the need for a degree of consistency and standardisation in the systems used across primary and secondary care.
- ♦ The need for ‘national procurement of integrated set of products to establish consistent level of support systems appropriate to each care setting’
- ♦ The need for a ‘standard NHSScotland approach to telecoms, email, directory service and SCI Gateway as electronic linkage mechanism between Integrated Care Records’
- ♦ The need for a ‘national core technical architecture and mechanisms for local linkage’
- ♦ The need to ‘establish appropriate national strategic systems across NHSScotland’
- ♦ The assertion that ‘Managed Clinical Networks that transcend traditional geographical boundaries will fail unless modern IT and telecommunications are in place to support clinical and administrative information sharing and exchange’.

2.2.5 The Department of Health is now however involved through their National Programme for IT, in the development of a single 'spine' record for each patient which will be accessible by all authorised clinicians to inform the care provided for patients, provided and managed by regional Local System Suppliers within a national framework. This has significant but still to be fully detailed implications for GP IT systems and suppliers. In the meantime no further updates to the RFA accreditation system in England have been issued.

2.3 Clinical Needs

2.3.1 General:

- System maintenance
- Ease and security of entry
- Speed of response
- Effective use of modern programming techniques
- Integrated suite of programs
- Option of local or central server solutions with 'thin-client' technology
- Option of system administration managed by the central team.
- Managed service by supplier or nominated third party
- Data security
- Audit trail
- Clinical Audit
- Training
- Support

2.3.2 Scope

- GPs
- Practice staff
- Practice Nurses
- Community Nurses
- AHPs
- LHCC and Community Partnership working

2.3.3 Compatibility with Scotland's eHealth / IM&T Strategy

- Open interfaces to third party software products
- Linkages to SCI products

2.3.4 Patient registration:

- Registration of new patient or family
- Fields linked to registration

2.3.5 Use by clinician in consultation:

- Consultation screen: general screening
 - encounter
 - allergies
 - Past History
 - Medication
 - care management

2.3.6 *Use by receptionists:*
 Appointments system
 Report generation

2.3.7 *For dispensing practices:*
 Dispensing module with stock control
 Medico-legal compliance

2.4 Proposed outcomes – benefits to patients, carers and healthcare professionals

2.4.1 Systems in support of Primary Care will bring these important benefits:

- Clinical decision support information in support of the clinical process
- Improved patient safety in clinical care.
- Greater patient involvement in their own care
- Flexibility to support service redesign and the shift in the balance of care provided in different settings
- Quicker exchange of information between professionals
- Quicker access to patient records with built in patient confidentiality
- When patients move within or between care settings the right information is transferred quickly and securely
- Continuous improvement by providing routine monitoring of quality standards
- Patients, carers and staff will find consistent information systems across NHS Scotland.

2.4.2 Systems must be able to change and adapt and change to meet changing health care needs and care delivery models. This must be reflected in very responsive updates in reference data and functionality.

3 Description of the service concerned

3.1 Current

3.1.1 GPASS was originally developed by a GP in the 1980s and gifted to the Health Department for use by GPs. Since then it has been developed by an in-house team and the software has been made available free of charge to GP practices. Around 85% of Scottish general practices use GPASS, which is a publicly funded GP IT system.

3.1.2 GPs have, however, had the ability to choose a commercial alternative to GPASS and 4 commercial suppliers are used in Scotland as well as GPASS.

3.1.3 As part of the new UK GP contract settlement, GPs are allowed a choice of nationally accredited IT system subject to certain conditions. The switch to the new contract involves a more intensive use of IT than many practices have been used to and has drawn increasing focus on to how different GP IT systems support practices in this work.

3.1.4 SEHD, with the agreement of SGPC, advised the service in November 2003 and reiterated the advice in May 2004 that business cases would be unlikely at that time to be able to identify clear benefits which would support decisions to switch supplier. SEHD indicated the intention to revisit this advice when the situation on suppliers meeting the development agenda and in particular the requirements of the new contract was clearer with at that time a commitment to conduct a fundamental review of GP IM &T in Scotland. This Initial Agreement marks an important early stage in the fundamental review process.

3.1.5 The GP contract provision on system 'choice' has cost implications for the service as developing functionality requires multiple software upgrades (currently 5) which have eventually to be met by NHS Scotland, with limited potential to achieve economies of scale. This approach is not consistent with experience elsewhere in the NHS where best value is usually sought through the provision of a single supplier.

3.2 Proposed service

3.2.1 The proposed service would:

- o deliver the clinical functionality listed above as extended or modified by consultation on this document.
- o Facilitate a number of different models including where:
 - o the patient data base might relate to a single practice or multiple practices
 - o operation is centralised on an area or national basis
 - o software releases / fixes to be made on very responsive basis

4. List of Options

The range of options will range from the "do nothing" to a full procurement exercise under EU regs. If procurement action results an important factor will be how GPASS relates to that procurement action and options will be explored in the Outline Business Case.

5. Capital Costs

5.1 Broad Indication of Capital Costs

Very difficult to say in advance of procurement action what capital costs might be put forward by suppliers who might be minded to minimise up front capital capital to establish a revenue stream.. Additionally the delivery model – by practice, by area - will have a material effect on the capital requirement but it

is unlikely to result in requirements in excess of £15,000 per practice or £15m in total. It is likely to be less than that.

5.2 Sources of Capital Funding

As an SEHD initiative central funds would be required.

5.4 Timescales:

To reduce uncertainty the process must be taken through thoroughly and with care but as quickly as possible. We should be starting implementation of any new service within 12 months. If significant change of system across practices results then a migration period of two or three years is likely to be required; in that event existing systems would not just have to be maintained but developed,

6 Impact on Revenue Costs

There is potential for reductions in overall revenue costs – particularly if a change in service delivery model – away from individual practice delivery – results. However if significant migration results we may have to sustain multiple systems to a high degree of user satisfaction over the migration period.

7. Policy

Ministerial agreement to the underlying policy has been obtained in principle.

Ministers have been assured that before any EU advert is placed their agreement will be sought.

Computing & IT Strategy Division

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