HEALTH SERVICE JOURNAL hsj.co.uk

HSJ INTELLIGENCE

AN HSJ SUPPLEMENT/27 NOVEMBER 2008

GOLD STANDARD

HOW TO STREAMLINE PATIENT RECORDS

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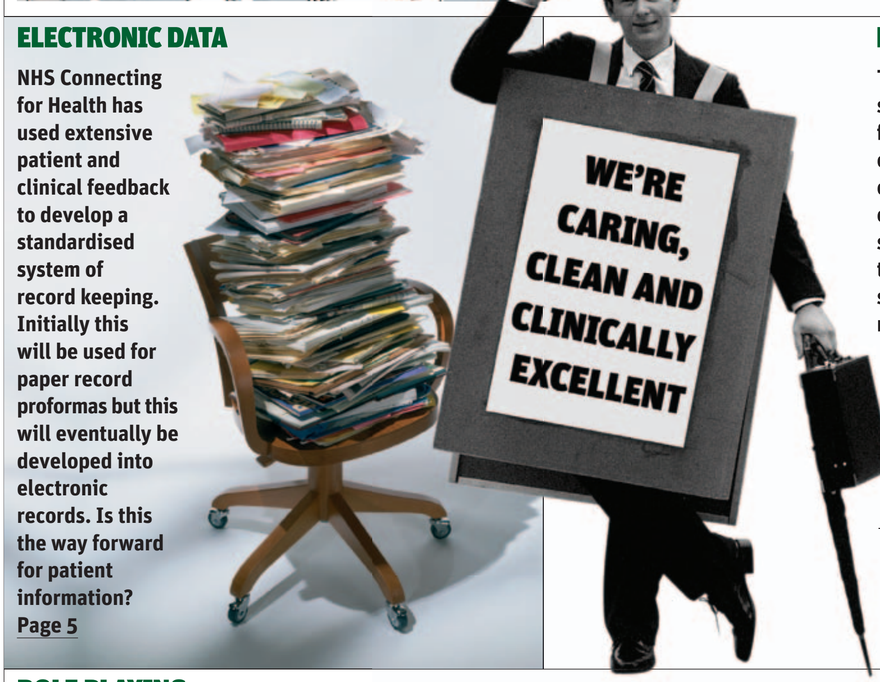

NHS Connecting for Health has used extensive patient and clinical feedback to develop a standardised system of record keeping. Initially this will be used for paper record proformas but this will eventually be developed into electronic records. Is this the way forward for patient information?
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An online game, Virtual PCT, allows players to take over as chief executive of a primary care trust with debts and relatively poor community health. Players are ranked against each other to create a board of best results. But the aim of Virtual PCT is serious: to encourage professionals to think about the needs of their local populations and how to deliver services to meet those needs.
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A NOTE FROM THE EDITOR

Ear to the ground

Welcome to the latest issue of *Intelligence*, the quarterly *HSJ* supplement dedicated to innovation, information and technology.

In this issue we look at the impact of patient response websites (page 2). For the trusts that have yet to take this means of communication seriously, the message is that they do so at their peril. Online comments are increasing in their importance and influence and early fears that such facilities would be abused have proved unfounded.

There are numerous examples of how trusts have made real changes to patient care and sites such as NHS Choices and patientopinion.co.uk are already proving their worth. However, censorship remains a sticking point and is an area that needs to be dealt with before this system can release its full potential.

Meanwhile, how will IT fare in the financial crisis? Spending is obviously a concern but as Lyn Whitfield asks (page 4), with politicians preoccupied will time out of the limelight mean setbacks for the national IT programme? ●

If you have comments or ideas for future issues email rebecca.allmark@emap.com

CRITICAL MASS

Several websites now provide the public with the chance to air their grievances or praise their treatment, and even the NHS has got in on the act – but who is listening? Daloni Carlisle investigates

Not so very long ago it took pen and paper for patients to send comments about their treatment to their local hospital. Then along came emails to the chief executive and finally the internet.

There are now two main websites where patients can relate their experiences: the NHS site NHS Choices and the independent site www.patientopinion.co.uk. Both claim high levels of use and they are now starting to work together.

They say that something extra happens when patients are able to leave comments on a website. For a start it is not just the hospital that sees it, other patients and the public can too. Likewise, the hospital's response can be posted online for everyone to see.

But do hospitals view it any differently? Or is this just another version of the ward noticeboard, pinned with thank you cards extolling the staff's friendliness, kindness and general caring attitudes – but minus the chocolates and flowers?

NHS Choices has been running its "comment on a hospital" facility for over a year, although during last summer it started to gain more prominence by having the most recent comment on its front page.

These are automatically fed back to the hospital concerned, with each trust nominating a named person to receive them. There are some 800 communications a month.

It is very much of the moment. Darzi's review of the NHS has emphasised the need to obtain more patient feedback and here is one way.

But that was not always the case. When the facility started, there were fears it would be abused and become a sounding board for whingers and be stuffed with inaccurate and possibly even libellous comments.

So far these fears have not been realised. Although there has been no formal study on the comments, a quick read through paints a picture many would recognise.

There is plenty of praise for hardworking staff, a few comments about treatment and some gripes about the environment, car parking and administration (see box, right).

This is possibly down to the way NHS Choices invites comments and the moderation model the site uses.

"We ask about the positive and the negative," says Gary Ashby, programme director for NHS Choices at the Department of Health. "Typically we get a bit of both."

Patients who do comment are asked when they were treated and then for their comments on what they liked, what could be improved, and to give ratings on cleanliness, teamwork, respect and dignity and whether they were involved in decisions about their care. Finally, there is an email confirmation that they actually made the comment. When the comment appears, a green tick or red cross denotes whether or not the patient would recommend the hospital.

But no comment gets this far until it has been moderated, or assessed against a series of rules: is it offensive; does it identify any clinician or staff member; should it be handled as a complaint rather than a comment?

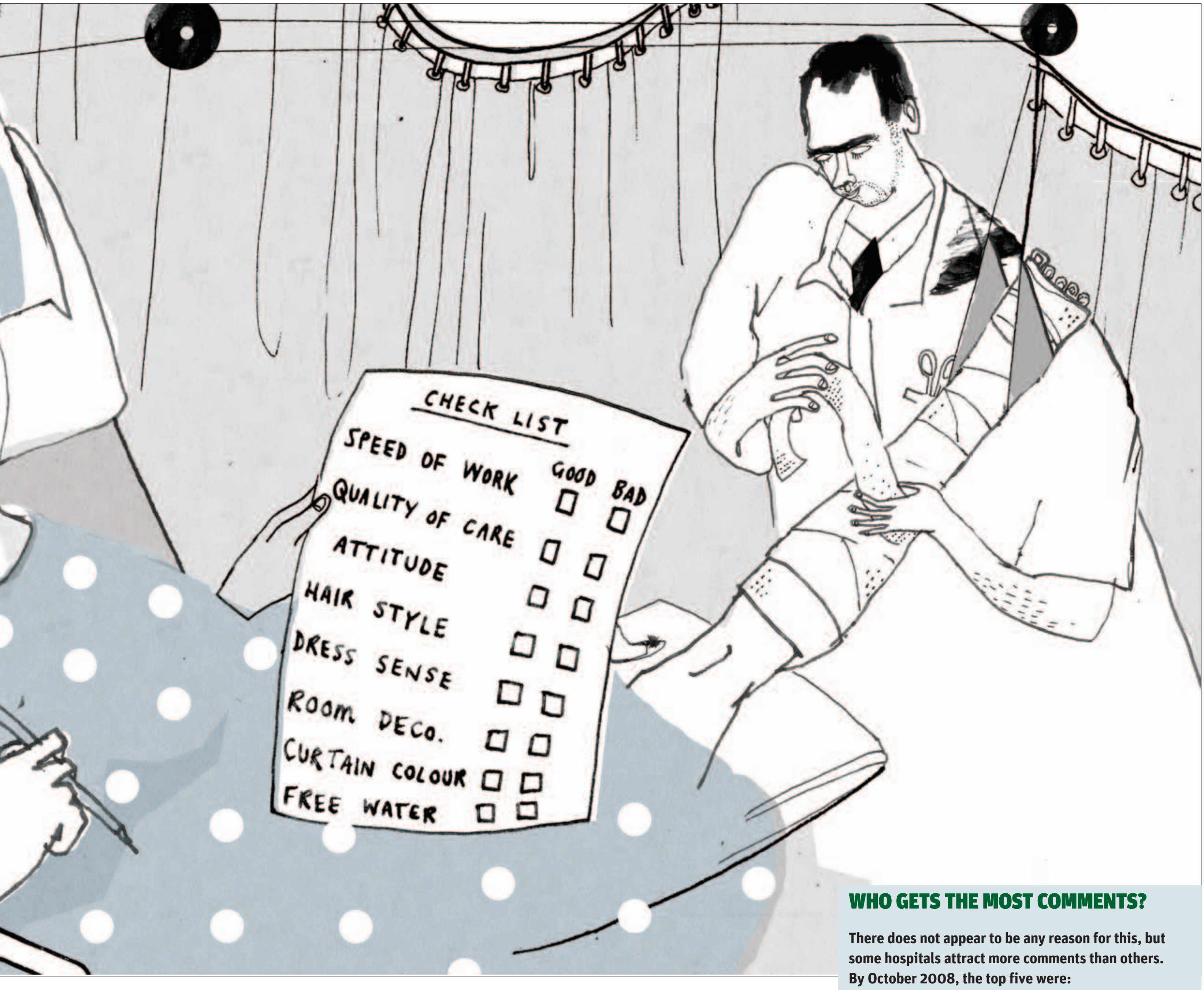
"We do have to advise people whether it is something that should be handled as a complaint," says Mr Ashby. "While we can publish on our website, we are not in a position to guarantee a response."

This has led to at least one accusation of censorship. Over on YouTube are two videos from a woman calling herself "Jawbreak", detailing the operation to break and reset her jaw and her subsequent nursing care at the Royal Surrey County Hospital. The surgeon was excellent, she said, but the nursing care was appalling.

Jawbreak wanted to use the NHS Choices site instead of making a formal complaint to the hospital. But when she did so, the website refused to put it up, sending her a message to say the moderators had decided her comment was not fit to publish.

"This is obviously censorship," she comments. "In practice, if they don't like what you have to say, they won't put it up."

Needless to say, NHS Choices denies this. "We



CATH ELLIOT

‘We ask about the positive and negative. Typically, we get a bit of both’

set out our moderation rules clearly and follow them strictly,” says Mr Ashby. “Application of the rules has to be down to interpretation, so what we have done and will continue to do is go over them.”

The Royal Surrey County Hospital added that Jawbreak’s complaint had been dealt with but said: “We think the site is excellent. As a trust we carry out exit surveys because we need to know what patients think. This is one more way of getting a response from patients.”

A very similar response comes from other hospitals. Craig Noonan, communications manager at Royal Preston Hospital, which receives more comments than any other, says: “We welcome the feedback we are receiving from the website, although it is only one small part of the way we get information.”

His only regret is that because patients’ contact details are not displayed, the hospital cannot get in touch directly.

In London, West Middlesex University Hospital chief executive Tara Donnelly is an

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WHO GETS THE MOST COMMENTS?

There does not appear to be any reason for this, but some hospitals attract more comments than others. By October 2008, the top five were:

- **Royal Preston Hospital: 50**
- **Russells Hall Hospital (Dudley): 49**
- **Wythenshawe Hospital (Manchester): 47**
- **North Manchester General Hospital: 46**
- **Queen’s Hospital (Barking, Havering and Redbridge): 43**

Royal Preston Hospital attracted mostly highly complimentary comments, such as this one from Patricia Hall, treated in May 2008: “They took good care of me and went out of their way to allay my fears and worries. Were very considerate because I am disabled and overall made my stay a lot easier. Many thanks.”

Queen’s Hospital, by contrast, had many negative comments, especially about its switchboard. One anonymous patient wrote: “I have been trying to contact Appointments for days: the line is either permanently engaged or just rings endlessly. You ask people to notify the hospital if they need to cancel or change an appointment – how are we supposed to do this if no one answers the phone?!”

He/she did not get an answer on the website either.

3← enthusiast of the website. "We actually encourage people to comment by including the web address in our welcome pack for all patients and we always respond," she says.

One recent comment included the following: "It did take me a while to work out where I should park my car; when driving oneself to A&E and therefore unable to use the drop-off zone, in the stress of the situation it is easy to get confused. The threat of wheelclamping doesn't help with the stress levels either."

Ms Donnelly says: "We have changed the signs as a result of that helpful comment. There are some very practical points made in some of the feedback."

Patient Opinion director of research and informatics James Munro would heartily support such a practical response. Like NHS Choices, the site uses pre-moderation. It is paid for by subscription, mostly from hospitals interested in seeing comments about their services.

"There are lots of people in a trust who can respond," he says. "We want to push this down from conversations at the managerial level to a level that is much closer to the front line. There is a real opportunity here to see if the web can change practice."

For example, a patient comments that the noise of nurses' shoes kept her awake at night. Dr Munro asks: "Does this really need a committee and a policy? Or could it go to the nursing staff themselves, who could decide to wear soft-soled shoes?"

NHS Choices and Patient Opinion are now working together. A few months ago Patient Opinion merged NHS Choices' comments with its own, so both can be seen on its site. It is now keen for NHS Choices to do the same.

'It took me a while to work out where to park; when driving oneself to A&E, in the stress of the situation it is easy to get confused'

"We are happy to do so," says Mr Ashby. "This is about helping the public, not about organisations."

Other developments are in the pipeline. Patient Opinion has just completed a pilot project asking mental health service users to comment on their care; it has taken the lead here, as mental health patients may trust an independent site rather more than an official health service one.

Meanwhile, NHS Choices is looking at how to get patients' comments on GP surgeries –a tricky area, especially in the light of the controversial comment website set up by medic and site developer Neil Burns, www.iwantgreatcare.org.

"We may have early adopters," says Mr Ashby cautiously. "We are not going out there to ruffle GPs but there are already some who are willing to do it and certainly it is important. We want to work out how we might do it."

The other area ripe for development is using comments to feed into patient related outcome measures.

There are some trusts that are not taking the development seriously and simply give stock responses – or no response at all. To them, Mr Ashby has a simple message: dismiss this development at your peril. ●

LYN WHITFIELD ON PIVOTAL TIMES

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As the world's financial system crashes and burns, politicians and journalists are understandably preoccupied with matters other than the NHS, never mind its IT. Many people in the health service will welcome a period in which both are out of the limelight. But is that a good thing?

This could be a pivotal time. The centralised approach of the national programme, with its "ruthless standardisation" driven by contracts for just a few big systems, has been mutating for a year or more.

It is strategic health authorities, not local service providers, that are now in charge of producing "visions" for the future of local service provision and sorting out the IT to support them.

Yet primary care trusts and hospital trusts are being told to draw up their own IT plans, and it is all beginning to echo the electronic patient records set out a decade ago in the *Information for Health* strategy.

Meanwhile, the *Health Informatics Review*, published this summer, stresses that while "strategic" systems remain the vision, "interim solutions" will be needed as their development – and deployment – gets ever later.

On the face of it, this is all good stuff. Any number of critics of the national programme have been calling for national standards to be set, but for local organisations to be allowed to choose systems that comply with them.

Indeed, there is a whole new line of thinking that says the development of new, web-based solutions is making increasingly obsolete the national programme to rip and replace with new end-to-end systems.

However, for the new approach to work, health service organisations will have to support it – and spend on it. One of the problems with *Information for Health* was that many organisations signally failed to do just this. So what are the odds this time?

On the plus side, every Department of Health speaker and every consultant who takes to a conference platform at the moment opens their presentation by referring to Lord Darzi's 10-year vision and explaining how it will not be achieved without information and, therefore, IT. Organisations have been told to identify IT requirements in their budgets. We are already seeing some nice infrastructure and business intelligence projects coming to fruition.

On the downside, there is a palpable sense at NHS IT events that, while it is clear that responsibility is shifting, the detail of who will be responsible for what in the future remains far from clear. This makes it hard for organisations to decide what they should be spending on right now.

And then there is that financial crisis. The government has insisted that health and education remain its priorities for what must be very tight spending rounds in the near future – and the NHS has a three-year settlement in place.

However, rocketing fuel and food prices will not be doing much for health budgets. And trusts that were relying on selling off buildings, land and other assets to fund projects are unlikely to get the price they need any time soon. There is a danger that, with choices to be made, IT spending will not be a priority – particularly as a recession will depress wage demands and make it easier to recruit staff, taking away some of the pressure to substitute labour for capital in the form of IT systems that can do the same jobs.

'With financial choices to be made, IT spending will not be a priority'

This is why a period of political and press neglect may not be a good thing. For, like it or not, the health service does respond to targets on which pressure is maintained. Just look at the Healthcare Commission's recent health check. Which of the "core standards" that all trusts are supposed to meet remains one of the least complied with? Boring old records management.

In this context, it is worrying that there are signs of a leadership vacuum at the top of NHS IT.

Sure, the DH is sending out letters telling trusts to stop all those USB sticks turning up in high streets and on trains. But from the two new heads of NHS IT appointed in September, we have heard hardly a word.

Say what you like about former lead Richard Granger, but he did not arrive and vanish into the DH's executive offices. And while quiet can be nice, this is really not the moment for drift.

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ELECTRONIC DATA

STANDARD BEARERS

For the first time, we have a system for standardised patient records. By Iain Carpenter and Michael Thick

An essential way of improving patient safety is to standardise medical record keeping. This summer's Health Informatics Review highlighted the importance of improving information standards across the NHS and the need for clinicians to have the right patient information at the right time.

Patient records serve two purposes. The first is to support direct patient care by acting as an aide mémoire for clinicians and aiding clinical decision making. The second is to provide a legal record of care to support clinical audit, research, resource allocation and performance planning.

Currently there is too much variation in acute clinical practice, with headings within patient records differing hugely both within individual hospital teams and across different hospitals. This has major implications for patient safety: clinicians often have to ask patients repeatedly for the same information during their hospital stay, and mistakes can occur. Inconsistent data can also make clinical audit and information gathering for research less effective.

Now, for the first time, profession-wide standards for patient records have been developed in a project co-ordinated by the Royal College of Physicians in partnership with NHS Connecting for Health and agreed by the Academy of Medical Royal Colleges, which represents the whole medical profession.

The standards have been drawn up by the RCP health informatics unit in consultation with the medical Royal Colleges and specialist societies and funded by NHS Connecting for Health.

These standards provide a clear structure for the clinical content of admission, handover and discharge records of patients admitted to hospital. They propose 36 headings, including information such as observations and findings, investigation results and patients' past medical history.

The RCP and Connecting for Health were committed to developing the standards that represented the consensus view of a whole range of medical professionals, as well as patients and their carers, and initially sent out both the records and a questionnaire to all groups.

More than 3,000 clinicians responded, with over 90 per cent agreeing that medical records did need to be structured and more than 80 per cent agreeing that most of the proposed headings were useful.

Interestingly, some of the headings that clinicians felt were least useful were seen as the most important by patients, such as "patient's ideas, concerns and expectations" and "information given to patients, carers and relatives".

The clinical and patient input should now ensure that the standards will not restrict the range and depth of information that clinicians or researchers wish to include in their medical notes. We also hope that the clinical expertise in particular will ensure the electronic patient record does not reduce medical notes to tick boxes and "dumbed down" clinical practice.

While this initial feedback on the new standards was largely positive, it had to be tested in real, clinical settings.

A prototype admission proforma was originally piloted in 10 hospitals between June and August 2007 and most consultants said the new headings gave them a good picture of the patient's presenting condition.

Some junior doctors and consultants felt that additional sub-headings were needed, as well as more space for free text.

The comments were taken on board and the RCP has developed an example admission proforma that complies with the new standards, which can be downloaded by hospitals and tailored to their specific requirements if necessary.

Similarly, the headings for the handover and discharge reports were also piloted, this time in 13 hospitals and with their associated GPs between December 2007 and February 2008.

GETTY

Now that the standards have backing from the Academy of Royal Medical Colleges, they need to be developed in further detail to achieve common patterns of clinical documentation below the headings. Initially they will be used for paper record proformas and will eventually be built into technical standards.

Once the new electronic records come into use, the benefits will truly start to show. Clinical information in electronic records will be recorded and then re-presented in the appropriate place, improving efficiency and saving time.

In terms of using the clinical information for internal and external reporting purposes, national audits will also be easier to conduct using comparable data across the country. It is likely that revalidation will include an evaluation of clinical performance with some evidence from medical notes.

> **'Once the new electronic records come into use, the benefits will truly start to show, with improvements in efficiency and time saving'**

It will also be possible to incorporate routine clinical data into the design, conduct and governance of large-scale clinical and epidemiological research, making it far easier and more cost-effective to carry out.

The task now is to build on the work already achieved, and this has already begun.

In October, NHS Connecting for Health supported a clinicians' workshop at the RCP for doctor, midwifery, nursing and Allied Health Professional representatives to discuss how detailed clinical record structure and content standards can best be developed to reflect the consensus views of professionals in their individual areas of expertise.

Feedback from this event will be used to inform joint working between NHS Connecting for Health and the Royal College's health informatics unit to develop technical support.

Of course, consultation never ends, just as patient records will never remain entirely static. As an ageing population continues to produce increasingly complex health needs, records will need to grow in sophistication in order to reflect this. ●

Professor Michael Thick is chief clinical officer at NHS Connecting for Health and Professor Iain Carpenter is associate director of records standards at the Health Informatics Unit at the Royal College of Physicians.

Find out more

A Clinician's Guide to Record Standards

➔www.rcplondon.ac.uk

ROLE PLAYING

WINNER TAKES ALL

An online game gives players a chance to explore how local information impacts on PCT decision-making

High Quality Care for All declares that quality must remain at the heart of all the NHS does and that "the next stage in achieving that high quality care requires us to unlock local innovation and improvement of quality through information".

The importance of information cannot be overstated. A great deal of improvement depends on understanding your local population's characteristics, needs and habits. As healthcare continues to shift more responsibility into the primary care sector, a dearth of timely, high quality information has become apparent.

To highlight the various types of information needed by primary care organisations and professionals, the technology experts at Dr Foster Intelligence created an online game: Virtual PCT.

The premise of the game is simple. Players take over as chief executive of a primary care trust after various scandals have created debt and relatively poor community health. In charge for 10 years, players must juggle the health needs of their community with the financial demands of the trust. It runs for about seven minutes while players are ranked against others to create a board of best results.

The game raises two important questions for primary care professionals:

- What do you know about your population?
- How can you use that knowledge to provide the right services for your population?

The next stage review recognises the all-encompassing demands of answering those questions: "Locally, primary care trusts, on behalf of the populations they serve, should challenge providers to achieve high quality care." This must go beyond practice based commissioning and involve all clinician groups in strategic planning and service development to drive improvements in health outcomes.

What do you know about your population?

For public health and commissioning teams trying to decide where to start on their quest to provide world class services, the task can seem daunting. The health service has incredible amounts of data, but not always in easily understood or usable formats. Challenges facing local healthcare organisations can appear intimidating, not least because of the amount of work it takes to put an exciting, innovative idea into practice.

So where should commissioners start? First, some basic questions must be answered in order to build up an image of the local community.

- How many people live in this PCT area?
- How do we expect that to change?

Then current services need to be evaluated.

- What services are community members using most frequently?
- Could some care be provided more efficiently or effectively somewhere else?

The Virtual PCT game shows instantly how important this knowledge is. As the game runs over its 10-year period, players have the opportunity to look into the make-up of the population. Simplified into ill and healthy members of the community, the glance into the local population makes it much easier to decide where to place hospitals, GPs and health visitors.

The PCT's population moves and ages as the game progresses, making regular updates on who is living where necessary to manage both the healthcare provided and the associated costs.

Being able to see at a glance exactly where the PCT's budget is being allocated, how much each service costs and whether the trust is in the black or the red is obviously helpful.

It particularly highlights the need for timely, accurate performance management data in a section of healthcare under more national scrutiny than ever.

After an initial understanding of the current situation, commissioners and public health teams need to delve deeper into the specifics of the population and create detailed profiles of the community.

Questions that need to be asked include:

- Which socio-economic groups live here?
- What information is available from our joint strategic needs assessment?
- Which inequalities can be identified?

Again, of utmost importance is the quality of data available. Primary care teams must be able to use information that comes from a variety of sources easily and regularly. Without such a cross-sector view of the population, accurate profiles become nearly impossible to create. The necessary information includes data on inpatients and outpatients, lifestyles, deprivation and cultural backgrounds.

Targeted communication

Once an accurate image of the local healthcare economy and population characteristics has been built, the next question is: how do you reach that population and provide the most appropriate, effective and efficient services possible?

Arguably the most difficult aspect of creating world class public services, reaching a community in the way that is most needed, can take many years. And that is the conundrum facing many primary care professionals: how to balance the current needs of a population with the economic advantages (and disadvantages) of planning for the future. Staying within budget and meeting national targets cannot be ignored, but neither can the benefits of planning ahead and making strategic decisions on provision.

Some of the most effective solutions to that problem can be found in social marketing. By using the knowledge created by the mix of lifestyle, health and deprivation data, commissioners and public health teams are able to meet health needs with social solutions.

For example, a trust wishing to address a

MILES COLE

‘Players take over as chief executives of a primary care trust and they have to juggle the health needs of their community with the financial demands of their trust’

variety of health related behavioural problems in young women set out to understand what would motivate them as a group to make healthier lifestyle choices. Using a variety of information sources and research methods, the project team found that the decision to breastfeed was made around the ages of 14 or 15 – years before the young women conceived. Therefore, future education and communication needed to reflect that behaviour.

Another interesting finding from the research was that the effects breastfeeding has on body weight were stronger motivators for the young women than the general health benefits of it.

By tailoring communications to the lifestyles of the community, healthcare professionals can use technological and creative solutions to traditional problems.

This supports the next stage review’s call for every primary care trust to “commission comprehensive well-being and prevention services, in partnership with local authorities, with the services offered personalised to meet the specific needs of their local populations”.

Efforts must be focused on six key goals, (which must include obesity, smoking and sexual and mental health). All of those goals need clear and targeted communication to be achieved.

Assessing outcomes

Virtual PCT spans a 10-year period so that players have enough time to make a real difference in the area. The most important aspect of the game’s ability to evaluate the population regularly is the use of that data and knowledge over time. If a new initiative has not produced the desired results, professionals know they must try a different approach.

Therefore, if in the world of Virtual PCT, a large hospital has not reduced the amounts of illness within a designated period of time, perhaps a smaller hospital is what is needed instead, along with several health visitors and GPs.

Evaluation is essential to continued improvement. As primary care professionals take on more responsibility, they are also going to have to evaluate their work more rigorously. Evaluation helps keep interventions and plans relevant, as well as providing flexibility for both patients and staff.

Patients need flexibility in care as their needs change, and staff need flexibility to be able to adapt services to provide for both the expected and the unexpected.

Winning the game

At the end of the 10 years in the Virtual PCT game, players can add their names to the results board and compare their performance with others. Being within budget and managing a healthy population is ideal, but with the many changes in population, policy and costs over time, that achievement can often appear nearly impossible to reach.

Far from giving up, however, the evidence shows that dedicated health professionals will simply look for a solution and begin testing the many creative approaches they, and their colleagues, design.

High Quality Care for All states: “We will continue the journey of setting frontline staff, both providers and commissioners, free to use their expertise, creativity and skill to find innovative ways to improve quality of care for patients,” and all of this requires, of course, quality information. ●

➔ To play Virtual PCT, visit www.drfosterintelligence.co.uk/virtualPCT/default.asp

DATA BRIEFING

PAUL ROBINSON

Identifying coding inconsistencies

Recent reports have highlighted inconsistent coding of patient episodes. Though it is difficult to identify the variations in coding without a detailed analysis of case notes, we have had some interesting results from recent advance work.

We divided each trust's data into comparable packets. The detailed methodology involved taking hospital episode statistics data by trust and then splitting it into the various health resource group "chapters". Chapters relate to physiological systems and sections of the anatomy.

Within each chapter there are around 40-50 health resource groups. In most instances these are sub-divided into cases without complications and those with complications. There is one other category used within each chapter, for "complex elderly" patients – they have a variety of issues but are identified as being predominantly within that chapter's physiological system.

Two of the graphs here (centre and bottom) cover the trusts within NHS London and show the findings for these elderly patients in two different chapters: Chapter D (the respiratory system) and Chapter L (the urinary tract and male reproductive system). Clearly there are significant differences between trusts with extremes of 6.2 per cent and 17.5 per cent for Chapter D and 0.1 per cent to 10.4 per cent for Chapter L. These variations do not reflect quality of care issues but rather the recorded information made available to coders.

Other data (not shown) indicates one trust having only 53 per cent of its Chapter D patients without complications while another shows 76 per cent. For Chapter L, the variation is even more extreme, ranging from one trust having as few as 31 per cent of its patients without complication to three trusts having as many as 93-97 per cent.

Looking at English trusts by average number of diagnoses recorded – a significant indicator of the quality of data recording – adds to the picture.

The top graph represents some trusts for which we have recently carried out case note audits and shows the relative scale of "recovered income". That is, the additional income identified due to the original coding missing complexity of interventions, because the more complex the intervention, the higher the tariff.

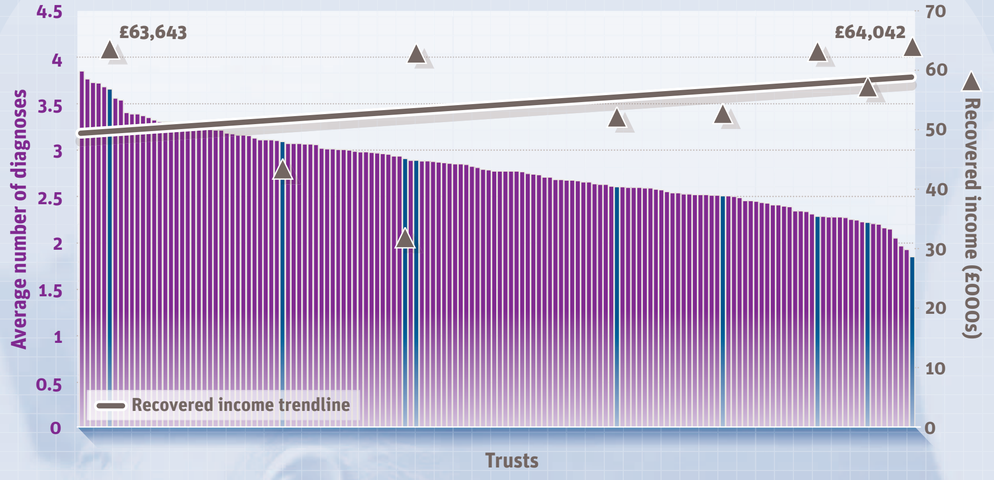
In general there is a correlation between the level of recovered income and the average number of diagnoses. The trendline shows that recording to a greater depth generally means less recovered income.

The separation by health resource chapter offers a way of identifying problems coding early on. ●

Paul Robinson is head of market intelligence for CHKS.

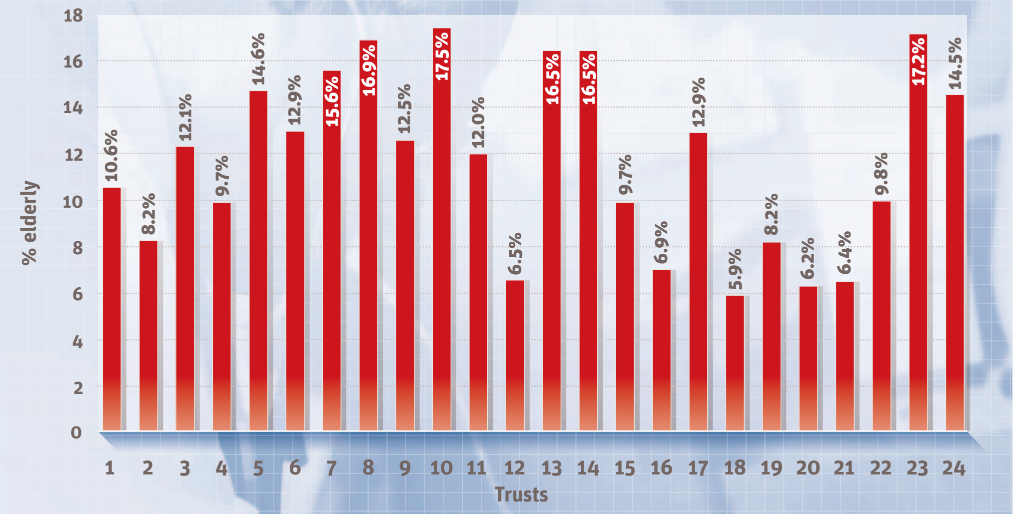
Fuller recording means less recovered income is identifed

Recovered income in relation to depth of coding



'Complex elderly' recording varied significantly between London trusts

Respiratory system



Urinary tract and male reproductive system

AL GRANT

Age of consent

The “permission to view” model allays the fears of the public and clinicians about summary care record privacy, says Gillian Braunold

Ever since we began introducing the summary care record in our early adopter primary care trusts, we have discussed how to ensure patients are fully aware and happy to have an electronic record of their key health details.

We have continued to take soundings from nurses and doctors who have raised concerns about carrying out their duty of confidentiality towards patients. The University College London report we commissioned confirmed our view that it was important to change the consent model – to simplify it and make it work better for patients and clinicians.

The revised consent model will mean that healthcare staff will have to ask the permission of patients before viewing information on their record. The creation of summary care records will continue to operate on an implied consent model so that patients opt out rather than opt in to having one created. The public information programme will continue to make patients aware of their choices. However, the revised consent model will provide additional security for patients.

Introducing “permission to view” as an extra protection for patients offers them control over its use while at the same time making it possible to provide them with safer, better quality care.

‘The revised consent model will mean that healthcare staff will have to ask the permission of patients before viewing the information held on their record’

We believe we have now laid to rest the controversies that have rumbled throughout the early stages of implementing the summary care record programme. Key stakeholders such as the British Medical Association and the Royal College of Nursing have indicated their support for the revised model. Discussions among healthcare teams have also suggested that clinicians’ concerns about securing patient consent have been dissipated.

It is also important that managers working in GP surgeries, acute hospitals and community-based clinics feel confident that this new consent model satisfies the concerns that have been raised. Gaining their support is equally vital as they will play a crucial role when the full national roll-out happens during 2009-10. They need to feel they are doing something that not only benefits patients but meets the highest standards of information governance and respect for patient confidentiality.

On a personal level I feel pleased – and relieved – that we have been able to respond positively and quickly to criticism, whether from independent research or close colleagues. Our insistence that we need to have early adopters so we can learn the lessons from their real-life healthcare experiences has proven to be the right approach.

I feel we have taken a significant step further along the road of improving the safety and quality of care that patients can expect in emergency or unscheduled situations. For a confused or elderly patient, struggling to remember their medication, this is a very important change indeed. ●

Dr Gillian Braunold is clinical director, Summary Care Record and HealthSpace, NHS Connecting for Health.

FRANK BURNS ON A CONSPIRACY OF SILENCE

In 1989 I arrived at the Wirral as a fresh-faced chief executive at a “first wave” trust.

Within days of my arrival I was presented with a contract for the installation of a then “state of the art” clinical information system being purchased from the United States. Even allowing for my exaggerated sense of self-importance, I baulked at committing to what, at the time, was an eye-watering sum of money for in effect a local project to implement a hospital information system – one even more ambitious in functionality than had been attempted in the disastrous 1980s national HISS [hospital information support system] project.

Fortunately the Wirral project was too advanced for my nerves to get the better of me and we proceeded. I determined that, good or bad, we had bought the damn system at the request of the medics and I was going to make sure it yielded every penny of potential value to staff and ultimately to patients and taxpayers.

It was not all plain sailing – there were moments of panic as we made the transition from paper to electronic processes, with occasional full-blown confrontations with the clinical community when they tried to insist that some element or other should not be implemented. I would swallow hard, remember the financial commitment and insist we press ahead.

Within three years, in 1991, the system was fully implemented (including enterprise-wide electronic prescribing and medicines administration!). Almost 20 years later it continues, as far as I am aware, to give good service – albeit probably hanging on to life by its fingernails pending delivery of a shiny new national IT programme model.

The point is, I cannot see how we could possibly have achieved what we did if the system had been chosen nationally and was being implemented by external project teams.

Looking at what is currently happening with the national IT programme, I ask myself why, seven long years after it was launched, the notion of nationally (well, regionally) standardised systems survives as a concept despite the fact that not a single hospital has taken delivery of a functionally rich clinical system and what has been delivered has reportedly caused mayhem.

It is hard to imagine private sector companies the size of NHS trusts tolerating a 10-year delivery period.

Inevitably there has been a great deal of public frustration expressed by both clinical and IT staff up and down the NHS, and politicians of all parties have been highly critical of the delays.

By contrast, apart from a few brave souls, there seems to be little pressure being applied to the Department of Health by NHS boards and their senior managers to change direction.

It is possible that in the finest tradition of public sector bureaucracies, the heavy hitters of the health service are getting stuck into the DH behind the scenes, but have been unsuccessful due to the contractual, financial or political problems of dismantling the programme.

And yet is it not also possible that there is no serious “behind the scenes” attempt by boards and their senior managers to close it down? Why? First, because boards still do not understand the importance of effective patient management systems to underpin the safety and quality of the service and do not appreciate the urgency of getting these systems in place.

‘Chief executives support the project as it relieves them of accountability’

Second, chief executives may continue to support the IT programme because it transfers responsibility for managing these organisationally demanding projects to a third party and relieves them of their own accountability for problems and delays.

Most chief executives have always subscribed to the naive belief that they could have clinical IT delivered in the back of a van and plugged in “ready to go”. Perhaps even after waiting for seven years (and still counting), they are hanging on to the forlorn hope that this is still possible.

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MARKETING

MAKE IT SNAPPY

Some of the best foundation trust websites market their activities strongly to the public using snapshot videos and photos, says Michael Guida

Foundation trust status brings with it the challenge of responding to the demands of the market. Having a set of services that meets the needs of the local community is one thing, but communicating that online is quite another and something many foundations have not yet taken seriously enough.

Some might feel the internet is a side issue to the business of delivering good quality healthcare. While the internet does exclude some groups, the big consumers of healthcare services – families and over 60s – are online in large numbers.

NHS Choices underlines the government's commitment to the internet as a major channel to reach the public. It also makes comparison possible between hospital trusts and, in doing that, encourages the idea of competition.

While foundation communications teams are well versed in reputation management, press, PR and organising events, marketing their trust services to customers is new terrain. If foundations really are independent businesses, then winning customers and keeping them happy is a main skill.

Gradually, marketing is becoming a job that gets senior team attention – from directors of communications, yes, but also from those responsible for business performance and service or corporate development. Marketing is a new way of thinking for many trusts, but as more and more of the public behave as canny consumers shopping for health, all foundations need to distinguish themselves from the crowd.

Selling performance

A simple but persuasive example of how to promote a trust successfully online is a good video.

At the Newcastle upon Tyne Hospitals foundation trust the management and clinical teams, along with patients, have presented a convincing and reassuring picture on camera of what happens at the trust in a series of short videos. Just a click from the homepage, these videos do a lot of work: they convey the attitude and ethos of the trust, showcase personalities and specialist facilities, highlight positive patient experiences and underline that the hospitals in this trust are led by friendly and professional staff.

In many ways, what the Newcastle videos do for the trust is sell the place and its people. True, selling is not part of the conventional vocabulary for the NHS but when it is NHS staff and patients doing the selling, the pitch feels honest. This is less about competing with other trusts and more to do with telling the story – explaining the service offer in straight, simple terms.

Interestingly, while senior teams in foundation trusts have carefully developed their positioning and service offer for the public and for GPs and made investment decisions about which areas to focus on, this rarely comes across on the trust website. In fact, the performance of trusts, in terms of Healthcare Commission ratings for example, is almost never promoted.

TOP TIPS FOR MARKETING FOUNDATION TRUSTS ONLINE

- **Do not be afraid to sell your achievements and performance**
- **Be clear about your service offer to the public and showcase your clinical staff**
- **Use the medium: video can give a powerful sense of place and people**
- **Be useful, with up to date, quality content that supports patients and visitors**
- **Use your site to build relations with GPs**

Salford Royal, with the strong strapline "Safe, Clean, Personal" is in addition a top-performing foundation trust, but you would be hard-pressed to find that from the homepage. In fact, it is virtually impossible to locate an example of a foundation that is being bold and clear about how well it is doing, which is curious when league table thinking is everywhere.

Beyond the stark and sometimes abstract world of performance information is the need to give a feel for the trust and its environments. Softer, more emotional information, often communicated using imagery, is guaranteed to engage busy browsers.

The tone of the site and the personality of the organisation are very much linked to visual impact. So in the same way that a grotty main entrance can cause problems with the perception of the whole hospital, a poor homepage can turn visitors away. Birmingham Children's Hospital foundation trust and Aintree University Hospitals foundation trust both distinguish themselves online with strong use of photography. One adopts a style that is gentle and focused on the patient, the other is slick, corporate and reflective of the organisation.

Both approaches are effective in their own ways, but are they giving the impression the trust wants to convey?

What is missing?

Having convinced the public that its foundation trust is the right choice, there is still more work for the site to do. The basics, like directions and up to date phone numbers, are crucial. But many trusts are still not making things easy enough – for example linking through to Google Maps without information about buses and parking.

Perhaps the heart of a hospital trust is its departments and wards. This is where real patient experiences happen and where quality of service is delivered face to face. And online, quick access to departments and wards is fundamental to delivering on what patients and visitors expect. This means more basics such as visiting times, but most important of all is being able to see the clinical team who look after patients.

Gloucestershire Hospitals and Southend University Hospital foundation trusts' websites have photos of their teams, with biographies, and some departments show nursing staff as well as the doctors. The importance of showing off clinical staff is something that independent providers such as BMI Healthcare are well aware of. Their clinicians speak to you from the homepage, talking of their experience and skill.

Finally, some of the best FT websites are aimed at GPs as well as patients. Despite Free Choice, GPs are still central to facilitating the selection of a hospital for their patients and trusts should address that aspect in their video marketing. ●

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ALAN MAYNARD
ON INCENTIVISING QUALITY

> **The purpose is to reward the good performers financially and penalise the poor ones**

For 60 years it has been traditional to use two policies when the NHS was in "crisis": spend more and/or "redisorganise" structures. Successive governments' love of reconfiguring purchasers and providers, and increasing spending in the absence of evidence of population health gain, is now being corrupted by a desire to incentivise quality.

"Quality" is one of the most abused words in the NHS. Any discussion of it should distinguish between process quality and outcome quality. This distinction is epitomised by the old joke that "the operation was a success but the patient died" – that is, the surgical process was good but the patient outcome was not.

Following *High Quality Care for All* and the announcement of a desire for "world class commissioning", there is a focus on methods to reinforce the power of primary care trusts. An example of this is the development of CQUIN – commissioning for quality and innovation. This concept builds on the US incentive scheme for hospitals marketed by Premier.

After some piloting in the North West, this is being rolled out by the local strategic health authority and is likely to go national in time.

Its purpose is to reward good process performers and to penalise poorly performing hospitals. As with the national service frameworks, standards are set for the delivery of some high-profile patient services in order to reduce clinical practice variations and deliver high quality care processes.

Premier focuses on five clinical areas: acute myocardial infarction, heart failure, pneumonia, coronary artery bypass graft, and hip and knee replacements. For each area, patient pathways and standards of care are set and performance related to these targets.

In the US Premier scheme, those hospitals in the top 10 per cent of performers annually get an uplift of 2 per cent in their payment by results tariff. Those in the second best 10 per cent get 1 per cent uplift.

The hospitals in the worst 10 per cent of performers lose 2 per cent of the tariff and the second worst 10 per cent lose 1 per cent of their tariff. These incentives are small but significant enough to affect behaviour.

In the US it is argued that average adherence to process standards has improved. Some even dare to hope that these incentives reduce variation in practice and save money.

Naturally the notion that improving process quality saves money is very attractive to policy makers in Whitehall. Commissioning for quality and innovation is all about encouraging SHAs to roll out these incentives in their local areas to benefit, hopefully, both patients and taxpayers. The use of these process standards is attractive but the cost of their implementation is not clear. They require greater sophistication in IT and systems management and this will challenge some trusts that are still failing to cope with payment by results coding, as demonstrated by the August report from the Audit Commission.

Another issue is whether Premier incentives focus attention on a narrow range of services and performance elsewhere declines. To guard against this, it is necessary to monitor performance in non-incentivised areas of care and this is inevitably going to add considerably to the costs.

Commissioning for quality and innovation will be supplemented by fixing payment by results tariffs in relation to best practice. This would delineate process conditions for some types of care and identify the cost of providing this care.

For instance a best practice guideline for stroke might include CT-scanning within 24 hours, starting rehabilitation within 24 hours and using thrombolytics promptly where appropriate. Those good practice units following these standards would then be costed, with the average cost being the basis of the payment by results tariff.

The standard set and the associated tariff will, it is hoped, incentivise hospitals to provide what is seen as best practice care. In stroke, these standards are already well articulated in the Royal College of Physicians' stroke surveys. Other areas might include fractured neck or femur, cataract removal and cholecystectomy. Again, such incentives will have significant implications for data collection and its analysis to inform local and national performance management.

These measures begin to replicate the incentives introduced into primary care by the GP quality outcomes framework, which proved to be poorly planned and very costly to the taxpayer. However, cost is not the only issue to be confronted when incentivising quality. Premier, CQUIN and process quality tariff setting all ignore the issue of patient outcome. There are departmental initiatives to extend the publication of mortality rates for hospitals and consultants. There is also an ambitious programme on patient reported outcome measures.

From April 2009 hospitals will have to measure patients' physical and psychological well-being before and after hernia repairs, hip and knee replacements and varicose vein repairs using the standardised EQ-5D (www.euroqol.org) and specific quality of life measures. Over the next three years patient reported outcome measures will be extended to other procedures.

Incentivising the patient reported outcome measure by including it in the GP quality and outcomes framework might be a nice way of reinforcing Choose and Book as an alternative to allowing primary care trusts to pay below tariff if patient reported performance is poor.

Incentives such as these are powerful. They have the potential to improve care if well managed, but the upfront costs of the necessary investment may be considerable in a world where zero growth in NHS funding may be optimistic.

Getting away from unfocused and optimistic funding of the health service with occasional "redisorganisations" of structures is welcome, but incentivising both process and outcome quality will be testing for all in the NHS. But it will certainly provide an exciting journey for managers, clinicians and patients alike. ●

Professor Alan Maynard is director of the health policy group at York University.

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