



# HISG – scope & activities



# Purpose & Scope

- The RCGP Health Informatics Standing Group (HISG) provides informed and authoritative advice and support to the College, the College Council and Council Executive Committee (CEC) within its domain of expertise.
- Our main purposes are;
  - To help the RCGP to develop a clear strategic vision in the field of information management in health care and its application to support clinical practice, decision-making and research.
  - To help the RCGP to implement appropriate changes to its policies



# Terms of Reference

- We will achieve our aims in the following ways;
  - Members of the HISG represent the RCGP in various NHS informatics projects and committees including the Joint GP Information Technology Committee (JGPITC) of the RCGP and GPC and the National Advisory Group (NAG).
  - Undertaking informatics research, projects and reports
  - Informal discussions with other groups including the Department of Health, relevant national and regional initiatives, suppliers of systems to primary care and other relevant groups
  - Formal discussions with other groups including the Department of Health, relevant national and regional initiatives, suppliers of systems to primary care and other relevant groups as agreed with CEC.



# Members

- Nick Booth
- Colin Brown
- Leo Fogarty
- Alan Hassey
- Alasdair Honeyman
- Peter Kiehlmann
- Philip Koczan
- Bob Milne
- Libby Morris\*
- John Nicholas
- Stephen Pill
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- Paul Robinson\*\*
- Laurie Slater
- Karen Lefevre



# Activities

- GP2GP messaging
- GP content of SCR
- Snomed-CT
- Scottish ECS
- PRIMIS
- CAP-GP
- ETP
- Document naming & exchange
- Documents/references
  - GPGv3.1
  - PDS – GP Guide
  - IG strand of IT DES



# GP component of the SCR

RCGP Health Informatics Group

Alan Hassey & Paul Robinson



# Introduction - 1

- **This report for the RCGP:** sets out the recommended interim content and standards for the GP summary component of the Summary Care Record (SCR) in accordance with Recommendation 4 made in the Ministerial Taskforce on the NHS Summary Care Record (December 2006)
- **Definition of GP summary:** An extract of information from the GP clinical record for a specific purpose.



## Introduction - 2

- **Purpose of GP summary:** To provide a GP summary dataset for use by other clinicians in unscheduled care settings.
- **Content of GP summary:** Drugs (prescribed items), allergies & adverse drug reactions, plus additional information agreed by the patient and GP.



# Principles

- The customer is the SCR EA community
- The customers should specify their data requirements
- We should deliver the required data ensuring that it has the following attributes:
  - Accuracy
  - Completeness
  - Timeliness
  - Relevance
  - Consistency
  - Appropriateness



# Constraints - 1

- The content of the GP summary should represent a minimum dataset that fits the defined purpose
- The processes for producing and updating the GP summary should be simple
- That as far as is practicable and safe, these processes should be automated
- The content of the GP summary will require active management and ongoing maintenance



## Constraints - 2

- Any summary is dependent on the record structure,
- In the current GP clinical systems, summaries are completely different from each other
- The content of the clinical summary depends on the context of the patient, the author and the reader
- Therefore patients have a crucial role to play in deciding what constitutes a meaningful medical summary for them



# Proposed content

- Drugs, allergies and adverse drug reactions: *automated process*
- GP summary from local system: *semi-automated process*
  - Should include significant current and past medical problems, procedures and treatments (see below)
  - Should be agreed with the patient
- Patient preferences (limited set): *manual process*
  - Ensures preferences are available in an emergency



## Codes & free text

- We believe it is essential that coded entries to the GP summary can have free text associated with them. Defining what information should be extracted is complex, and it is imperative to include free text, to enable the appropriate level of communication for these patients.



# Exclusions

- The GP2GP and ECS projects have also demonstrated the difficulties of trying to make various types of information available across IT platforms.
- For this reason and *to maximise the chances of success in a short time-frame*, we recommend excluding the items of information listed below from the GP summary:
  - GP Alert notes
  - \*\*\*Immunisation records\*\*\*
  - Laboratory test results
  - Lifestyle information
  - Screening information (including call/recall/alert messages)
  - Documents (file attachments)



# Types of content

- Major diagnoses
- Conditions that may have a chronic or relapsing course
- Conditions for which the patient receives repeat medications
- Conditions that are persistent and serious contraindications for classes of medication
- Major operations
- Significant therapies & treatment plans
- Significant investigations
- Fractures
- Other



# Patient preferences

- **Patient preferences:** should be recorded where they can be safely and reliably coded and may have a bearing on the consultation. We have produced an interim list of preferred terms under this heading below, together with their associated Read codes:



# Draft Standards

- The content of the GP summary should represent a minimum dataset that fits a defined purpose
- The content of the GP summary will include.....
- The data contained in the GP summary must have the following attributes....
- The GP summary from the local system should have the following types of content, including significant current and past medical problems, procedures and treatments.....
- As circumstances change over time these attributes and content will require that the summary is revised and maintained.....