Health, Social Security and Housing Scrutiny Panel

MONDAY, 14th APRIL 2014

Panel:

Deputy J.A. Hilton of St. Helier (Vice-Chairman)

Deputy J.G. Reed of St. Ouen

Senator S.C. Ferguson

Witnesses:

Information Technology Lead, General Hospital

Clinical Lead, Future Hospital Project

[10:32]

Deputy J.A. Hilton of St. Helier (Vice-Chairman):

Good morning and welcome to the Health, Social Security and Housing Panel. This is a public meeting being held today with Dr. Graham Prince, who is clinical lead for I.T. (information technology) at the General Hospital. We will start by introducing ourselves. I am Deputy Jackie Hilton, Vice-Chair of this panel.

Deputy J.A. Hilton:

Thank you very much indeed. I would like to start by just drawing the public's attention to the notice on the seats and also to offer the apologies of our chair, the Deputy of St. Peter, who cannot be here today because she is unwell. So, thank you for coming. I would like to start by asking you if you could briefly outline your personal involvement in the Health White Paper and in the future hospital programme.

I.T. Lead, General Hospital:

Okay. So, the Health White Paper; I was involved in a couple of meetings which were general meetings where a lot of people were invited, more to hear information before the White Paper was published. As far as the rest of the White Paper was concerned, I was not really consulted about the informatics elements of the White Paper prior to its publication specifically, and so that was something that I had to get involved with after publication of the White Paper.

Deputy J.A. Hilton:

For the panel, could you just explain what the informatics strategy - I think it is called - is?

I.T. Lead, General Hospital:

Okay. Well, the informatics strategy really arose from a number of concerns which I had, which came out of the publication of the White Paper. The White Paper had a significant stream of workload which was to do with informatics, but at the time I felt it started at the wrong kind of level. It made assumptions about the state of informatics and information technology within Health and Social Services which were more advanced than where we actually were. At the time the White Paper was published, I had been working part time - I am an anaesthetist but I had been working part time - to push forward informatics in Health and Social Services since 2006 when we started the integrated care record programme. I realised that we still had some way to go at that time, at the beginning of 2012. We still had some way to go to attain what we wanted to attain from the I.C.R. (integrated care record) programme. So we had had to descope the I.C.R. programme in 2009 before we contracted and a number of significant elements had been taken out of scope of the programme for a number of reasons but basically financial. I felt that there was an assumption within the White Paper that perhaps we had a perfectly functioning informatics set-up within the hospital. In fact, at that time, at the beginning of 2012, we had concerns over the manpower in our applications team. We also had a number of elements of the programme, particularly the community programme, which had not been brought in and there was still a great expectation among the people working in the hospital and in the community that those elements should be brought in. Then, further to that, the White Paper, if you like, updated the integrated care record programme to the kind of level that people were talking about in 2012 when the U.K. (United

Kingdom) had just produced their informatics strategy. A lot of the elements within the White Paper were similar to the elements within the U.K. informatics strategy.

The Deputy of St. Ouen:

Just for lay people like ourselves, what do you mean by informatics?

I.T. Lead, General Hospital:

Well, I think informatics is a combination of the computers and the things that you do with computers in health care, but also the information that we want to collect and to be able to use and how we use that information. So it is a combination of just computers but also the things that you are able to do with computers. There are many things within health care which computers can help in making health care more efficient and in allowing us to make changes in the way we do things in health care and to assess whether the changes we make are being effective. It is quite difficult without computers and without collecting good data and analysing your data to be able to tell whether a change that you have made has been effective or not effective.

The Deputy of St. Ouen:

Regardless of the equipment that you may or may not have, unless you are capturing data in the first place a system would be useless.

I.T. Lead, General Hospital:

Yes. So you could collect this kind of data on pieces of paper, but it is incredibly time consuming to do that and just to be able to analyse any piece of data is impossibly hard. So you think: "Oh, I just could not possibly do that." We could have been doing this since 30 years ago, but it is only since we had the availability of computers that it has been possible to count the data and to realise more which things we do are effective and which things we do are ineffective. I think that is why computers are so much tied up in health care now because we have been able to ask questions and get answers to questions that previously we just did not have any possibility of asking.

The Deputy of St. Ouen:

You say that assumptions were made in the White Paper or, sorry, the White Paper assumed that perhaps the hospital and Health Department were collecting information at a higher level to that which they were.

I.T. Lead, General Hospital:

Yes. I think there were numerous areas where we had not been able to push out with information technology, and I am thinking particularly of community health where there was a big desire to change and improve the way we were collecting data. Community health systems, what you have

is a lot of ... rather like in a hospital. You have a lot of people working co-operatively in mental health care and social care. There are lots of people working together on the same patients. They all want to know what each other is thinking, but you have the additional situation that you are working in a much more geographically varied site. You are not all together in one place where you can control everything. People have produced programmes which can assist with this and we have not been able to bring in one programme so, in fact, all of our ... we have all of those services, but those services are not necessarily able to see easily what each is doing and we are not able to measure what each of those services is doing to the quality that we would like to be able to as an organisation.

Senator S.C. Ferguson:
You said I think a minute ago that it was not until 2012 that the community programme started being worked on.

I.T. Lead, General Hospital:
Well, no, that is not quite true. We wanted to do or to introduce informatics into the community system, so a community system was part of the original I.C.R. programme, but in 2009 when it became clear that we were not going to have sufficient funds to complete everything within the I.C.R. programme that was one of the things that was descoped, which we removed from the programme because we did not have enough money to do it.

Senator S.C. Ferguson:
Yet part of the White Paper was pushing the fact that community care is where the growth must be, pushing the sort of primary patients back or retaining people in the primary care set-up, keeping them out of hospital longer, and yet you ...

I.T. Lead, General Hospital:
Yes, so we were not doing that as well as we could be. I felt that the funding that was highlighted within the White Paper looked like it was probably inadequate to provide for all of the aspirations of the White Paper. So when I read the White Paper I immediately got down and ... I was running at that time a small committee, a small group called an Information Strategy Committee, and that was attended by Jason Turner, who is the Health Chief Finance Officer and also in charge, overall takes responsibility for information within Health. So I produced, essentially, a presentation which was looking at the things that I felt that we needed to do in order to get ourselves to the point within the timescale of the White Paper which would provide for the requirements, the aspirations, of the people in all of the Health and Social Services Department. There were various headings that I looked at those under. So the first concern that I had was that our applications team, the people who support the introduction of new systems within the hospital, was understaffed,

undermanned. The second issue was that there were a number of programmes that there was an expectation that we should be able to have in order to run a safe health service. That included the community health but also included things like e-prescribing and extension of the electronic patient record throughout all areas of health care. Then there was a whole area around connection with the G.P.s (general practitioners). So if you are going to have a truly excellent communications system all areas of health care have to communicate with all areas of health care. If you like, that would be community, it would be mental health, it would be the hospital, it would be general practice, and all of those areas need to communicate efficiently with each other and to share information with each other. So there were a number of things that we wanted to be able to organise which I think have only become more important with the passage of time.

[10:45]

Things like e-referral, referral of patients electronically, discharge of patients, the production of patient discharge letters electronically so that we can see what drugs patients are having when they leave the hospital, and all the communications from general practice so that a general practitioner does not have to send a piece of paper to get an X-ray test done and so that they do not have to send a piece of paper in order to get a blood test done and equally much so that the results of those tests automatically come back into the G.P.'s computer. The whole of that was not really funded and so I raised these concerns at this meeting with Jason, and I remember having a sleepless night before that meeting because I was really concerned that the White Paper was not achievable unless we could do those things. I did not think that ... the amount of money that I could see within the White Paper that was put for the informatics cross-cutting work stream did not look like enough to do that. Jason listened and a couple of days later he called me up and he said: "I think we need to do something about this." As a result of that, he put aside some funding to get Capita, who are one of these companies who provide short reviews, to set up a short review over three months at the end of 2012 where they would look at our informatics needs. It was that informatics strategy document produced by Capita which has gone forward to, if you like, show the size of the gap between where we are and where we need to be if we are to do all of the things that are required within the White Paper.

Senator S.C. Ferguson:
So the £12 million has been spent on the strategy so far, is that correct?

I.T. Lead, General Hospital:
The £12 million was spent. The £12 million that we had in 2006 - I think it was voted in 2005 - has been spent and, in fact, more than that because we were able to ... we held some discussions with InterSystems which resulted in them agreeing to provide order comms, which was not originally a

part of the programme, in recognition of some difficulties that we had had in getting proper service from them. We now have a good relationship with InterSystems, who own TrakCare, and we have what we originally contracted to do in 2009 and we have order comms, which is an extra bit.

Senator S.C. Ferguson:
Which has cost us how much?

I.T. Lead, General Hospital:
What, order comms?

Senator S.C. Ferguson:
Sorry, order ...?

Deputy J.A. Hilton:
Order comms.

Senator S.C. Ferguson:
Order comms, what is order comms?

I.T. Lead, General Hospital:
Order comms is an electronic system for ordering and resulting. So now doctors are able to go into our system and see any blood results or histology results or any lab results or any X-ray results in electronic format and they are also able to order those tests without filling out a form, which can get lost. They can order those tests on a computer and that automatically goes to the department and is then processed.

Deputy J.A. Hilton:
That system is only available for doctors within the hospital system and not the G.P.s?

I.T. Lead, General Hospital:
That is correct.

Deputy J.A. Hilton:
Okay, thank you.

The Deputy of St. Ouen:

Can you just confirm that following your concerns around funding Jason Turner engaged Capita to undertake a review to look at the areas of concern that you had raised and that review was subsequently completed when?

I.T. Lead, General Hospital:

That review was completed January 2013.

The Deputy of St. Ouen:

The conclusion of that review was ...?

I.T. Lead, General Hospital:

The conclusion of that review was that there needed to be continued funding of health care and I.T. going forward if we were to achieve the aspirations of the Health White Paper.

The Deputy of St. Ouen:

As I understand it, following the decision in 2009 around funding, the community system, screening and prescribing - I think were the 3 areas that you identified - were excluded from the programme. Are they still excluded or has work now started?

I.T. Lead, General Hospital:

The reality is that the programme at the moment is closed. Programme implies a kind of separate work stream which has a particular set of outcomes, and we have achieved the outcomes which we eventually contracted to do, which was the introduction of R.I.S./P.A.C.S. (radiology information system/picture archiving communications system), which is a radiology information and picture archiving system, the changing of the hospital patient administration system, the introduction of a new theatre system and new emergency department system and new maternity system and a new pharmacy system. So all of those things have been done and we had to do those things because the current software which we were using for that functionality was at end of life and no longer supported. So what we eventually did was the minimum amount that we could do to ... the maximum amount that we felt we could do with the money, but there was also a minimum amount that we could do. We could not just leave those systems which we were currently using in place, so we had to replace all of that stuff. We did all of that stuff and we did the picture archiving system. We ended up with a much more resilient and future-proofed computer system, which we can now build on. But having spent that money the question was how we were going to do those other things which we felt needed to be done to have a resilient healthcare system.

Senator S.C. Ferguson:

So how much do you need, do you reckon?

I.T. Lead, General Hospital:

Well, my feeling would be ... and I think that you have to accept that I am the kind of person who does not really have to be involved in the nitty-gritty. So the first thing I would say is that any figure is going to need to be worked through more, but my feeling is that really health care in terms of project work needs to be spending somewhere in the region of £3 million per year in order to take us from where we are through to where we need to be.

Senator S.C. Ferguson:

How many years?

I.T. Lead, General Hospital:

Well, at least for the next 4 to 6 years but I think ...

Senator S.C. Ferguson:

Thank you. Sorry, it is unkind, I am sorry.

I.T. Lead, General Hospital:

It is a reasonable question to ask.

Senator S.C. Ferguson:

I am a taxpayer. **[Laughter]**

I.T. Lead, General Hospital:

Yes, absolutely, but the reason why we want to do these things is because we believe that we can spend our money more effectively if we have that information technology supporting us. Ultimately, what the paper, P.82/2012 ... it does not say: "If you do this, the amount of money that you spend will go down." What it says is it will go up but it will go up less over the period of time. Over the next 30 years or so it will go up less. What we are saying is that informatics is an absolutely key part of being able to reduce our healthcare spend.

The Deputy of St. Ouen:

I will just bring you back to the 3 areas that were excluded. Can you confirm whether funding is now available to deliver the community health system?

I.T. Lead, General Hospital:

I cannot confirm that. Essentially, when Capita produced their strategy we had further discussions and I took the strategy document to the Corporate Management Executive Team at the hospital. I explained why it was we needed to do these things. That strategy was approved by C.M.E.T. (Corporate Management Executive Team). Now, the funding was very high level funding within that document and it was, I think, pragmatic. There was an understanding that we had already completed the Medium-Term Financial Plan going through until 2015 and so there was a small amount of funding which I think Jason felt was realistic in order to basically improve our informatics resource within the hospital. It was about providing people who would make sure that we could efficiently implement informatics change in the future. But most of the spending happened after 2016, which would be phase 2 of the current plan for the Health White Paper. So we would get ourselves prepared during the period of time, 2014, 2015. We would appoint these people and we are starting to make those appointments at the moment. We produced business plans which would then go into the next Medium-Term Financial Plan, which hopefully would result in us receiving appropriate funding to do those things that we felt we needed to do. Those things have changed slightly with the idea that we may be having a dual-site hospital, but they are still pretty much the same things. There are some slight alterations in detail. Having a dual-site hospital just makes the case for having an electronic system much more robust because obviously you do not want to be moving excessive numbers of paper notes up and down the hill. If our pharmacy is going to be up the hill or down the hill, there is going to have to be movement of things from wherever it is to wherever the patients need to pick it up from. So those kinds of things just make the case for doing this stuff more robust.

Senator S.C. Ferguson:

When will you get to the point that when a patient is discharged their notes are sent by email down to the doctor?

I.T. Lead, General Hospital:

What, to the general practitioner?

Senator S.C. Ferguson:

Yes, because at the moment I believe that the notes have to go on paper, is that correct, and that the general practice has to input them into their own system?

I.T. Lead, General Hospital:

Yes. That is just one of the many depressing things that we do with paper in the hospital. These things do need to be improved. There have been numerous things which have prevented us becoming more electronic in our dealings with other groups of people, and I think G.P.s are one of

those groups; mental health and hospital health is another area where there is poor communication. But if we take specifically the issue of general practitioners, I think there has been one big change going on in the background which is just coming to fruition and we saw a little bit about it in the newspapers, which is the G.P. central server project. I have been sitting on the project board for that. Essentially, what the G.P. central server means is that all G.P. notes will be held in one place in one computer, if you like, and each patient will only have one entry on that computer system. That computer system will physically be elsewhere but essentially it means that we have a target to communicate with. In the past, if I wanted to send a discharge letter to a G.P. electronically, well, I have 16 different practices; there are 16 different systems going on out there. Now we have one system. Not only that, the patient may have been in 3 or 4 different practices having treatment and, therefore, I would have had to have known which one to send it to. Now we have got to a situation where we have one target where we can potentially send information to and any G.P. who has a requirement to speak to that patient potentially could see that discharge note.

[11:00]

So once you have a target then you can start looking at the process of setting up those connections, but it is not without cost. Equally, G.P.s will want to send us their referrals electronically, but it is not without cost to make those changes into the system. Both of the systems are potentially able to receive and send that kind of information but money will have to exchange hands to make that happen.

The Deputy of St. Ouen:

Currently, when is it planned to achieve the comprehensive integrated care system?

I.T. Lead, General Hospital:

I have been meeting with the management accountants, with Jason and Anne Homer, in order to try and make a list of all of the things that we feel that we would like to do and to find out from everybody working in health care as much as possible what they feel needs to be done and to try and put those into some kind of order so that we can seek funding in an appropriate way using the appropriate systems. But I cannot magically make these things happen without there being funding. We have a list which we believe is reasonably inclusive of projects that will require to be done, and depending on the availability of funding we will do them as quickly as we can. There are about 100 projects on that list, some of which are projects which cost millions of pounds.

Deputy J.A. Hilton:

The G.P. central server project, that has not been financed yet, has it?

I.T. Lead, General Hospital:

The G.P. central server project has received funding from the Social Security Department, I think somewhere between £1 million and £2 million.

Deputy J.A. Hilton:

But it is not live at the moment, though?

I.T. Lead, General Hospital:

It is not live. It is pretty close to going live. It will go live somewhere in the second or third quarter of this year. But you are right, until we have that target to aim at it is pretty difficult to do the connectivity part.

Deputy J.A. Hilton:

Yes, okay. Can you confirm for us today that in your opinion as I.T. lead all the new services or existing services that the Health White Paper is going to be delivering between now and 2020 have been costed and submitted in a business plan? Is that what you are saying?

I.T. Lead, General Hospital:

No, they have not been costed and submitted in a business plan. Those business plans are yet to be made but we have done our best to do a high-level costing of those plans. But it still remains to produce a detailed business plan.

Deputy J.A. Hilton:

Whose responsibility is it to do that, produce that business plan?

I.T. Lead, General Hospital:

One of the things that I said at the beginning was that we are short of resource and one of the first things that we needed to do was to appoint some high-level resources in order to do this kind of work. Essentially, there are 3 senior roles that we felt acutely needed to be filled, which were recommended in the strategy document. That was we needed a business support group manager. A business support group manager is somebody who is owned by the Information Services Department and does the high-level control of the Information Services Department resources who work in the hospital. We have just appointed that person. He started work last week. The second role is a director of information for the hospital. This would be not necessarily a particularly techie person but somebody who understands the information needs of health care and probably would be somebody who would come from the U.K. with experience of healthcare I.T. in the U.K.

Senator S.C. Ferguson:

That is not altogether ...

I.T. Lead, General Hospital:

Well, I think you have to ...

Senator S.C. Ferguson:

I think there have been problems, have there not?

I.T. Lead, General Hospital:

... draw the distinction between the U.K.'s collection of data, which is well ahead of where we are in Jersey at the moment, and the difficulties. They have tried to do some things which are incredibly difficult to do and some of those have failed, but there is a huge amount of healthcare data available from the U.K. They have great ambitions to move forward with more healthcare data. So hopefully we will get somebody to help us, and my feeling is that that kind of person would be the person who would be involved or those 2 people would be the people who were involved primarily with the production of business cases. Then there is a third role, which is a programme manager, who would be a more techie person, again owned by Health and Social Services, and would support that business planning process for the major parts of the I.T. strategy.

Senator S.C. Ferguson:

Where does the central I.S. (Information Services) Department come in this?

I.T. Lead, General Hospital:

Yes. The Information Services Department give us our technical support. The programme manager would be somebody to run extraordinary programmes. When we ran the I.C.R. programme, our programme manager was never a part of the Information Services Department. It was an external person who came and specifically ran that programme and then went away at the end of the programme. If we are continually going to be requiring a programme manager to continuously run our programme of I.T., then probably that is somebody that we should have and that person would work constructively with the business support group manager. That is my understanding of the plan. The chief of information is a role which is at present in most hospitals in the U.K. and that is somebody who really has an understanding of health care and can interpret the requirements for information in a healthcare area, which is quite a specific area. You do not need somebody who is necessarily ... that is why I say it is not somebody who necessarily is about computers. It is somebody who understands how you interpret information and also how hospitals work.

Senator S.C. Ferguson:

Well, yes, certainly the most successful projects I have seen have been run by people who come, like yourself, from the specific background but also who understand the techie side of it and are able to make the connection.

I.T. Lead, General Hospital:

Yes. Increasingly, it seems that the way things are moving in the U.K. is that a hospital would have a chief information officer and then they would have a chief clinical information officer. So somebody who is slightly more of a clinical bent and somebody who combines some level of clinical knowledge and some level of technical knowledge.

Deputy J.A. Hilton:

Can you just confirm that the 3 new posts that you have just spoken about form part of that applications team that you said were under-resourced and under-staffed earlier?

I.T. Lead, General Hospital:

Yes.

Deputy J.A. Hilton:

They do.

I.T. Lead, General Hospital:

There are within the I.T. strategy a number of other posts which are also important to get our applications team working fully efficiently.

Deputy J.A. Hilton:

So with these additional new staff, you have said that they will build up the business case for the new systems that you require to deliver what the White Paper is saying it is going to deliver. My understanding now is the Medium-Term Financial Plan is being progressed as we speak, so are you confident that you will be able to get your bids in for this work that needs to be carried out in time?

I.T. Lead, General Hospital:

I have had nervousness about this. Ultimately, I am not responsible for getting these roles appointed, but the feeling was that we ought to appoint them sequentially and that, therefore, until we got the business support group manager in there may be confusion between the requirements of these 3 roles and which ones people would want to apply for. So the feeling was that we should

appoint the business support group manager and then appoint the director of information and then appoint the programme manager.

Deputy J.A. Hilton:

The business support manager, he is in post now?

I.T. Lead, General Hospital:

He is. He started last Monday.

Deputy J.A. Hilton:

The director, when are you ...?

I.T. Lead, General Hospital:

Well, I saw a job description for it last week and I said that that looked like a pretty good job description, so I guess that will be going forward within the next couple of weeks.

Senator S.C. Ferguson:

These are all grades what, 14, 15?

I.T. Lead, General Hospital:

I could not answer you that. I just do not know.

Senator S.C. Ferguson:

It usually says on the job description.

I.T. Lead, General Hospital:

Perhaps the version I saw was a slightly earlier one because I do not think it did say.

The Deputy of St. Ouen:

I would like to just understand the potential implications of delaying or excluding the development of the community system, screening and prescribing. Can you just talk us through what those potential implications are?

I.T. Lead, General Hospital:

Well, the community system, I think if what we are trying to do is to move health care more efficiently and get as much health care as possible done outside the hospital, then a community system will help in the coordination and communication of information between all of those groups. These systems, their ability for everybody to see everybody else's notes, they are updated in real

time, and so that kind of resource is going to be much more effective than having pieces of paper which may not get into the notes terribly effectively. So my expectation would be that it would be more difficult to make savings through efficiency in community care without a decent community system. That is the concern about that. The e-prescribing gains us benefits because of the help it gives in a number of areas. Firstly, at the moment every inpatient has a prescription chart and the prescription chart sits at the end of the patient's bed. You prescribe a new drug. It often has to go down to the pharmacy. When it goes to the pharmacy the prescription chart is not available at the end of the patient's bed so if the doctor comes to see the patient there is nothing there. They would not be able to see which drugs have been given or whatever. The prescription chart has to be reviewed at discharge in order to see which drugs the patient is being discharged on and it has to be hand transcribed. Each time you write one of these forms there is a risk that information would be transcribed incorrectly. Most reviews of e-prescribing have shown that overall there is a slight reduction in the number of incidents due to incorrect prescribing but there is a large reduction in the number of serious incidents due to prescribing. That is because the e-prescribing system also gives you help. It tells you if you are giving penicillin to a patient who is allergic to penicillin because the computer knows the patient is allergic to penicillin. It tells you if you are giving one drug which is going to interact in a serious way with another drug. These kinds of risks are reduced by having an e-prescribing system. If you are planning to have, as is the current plan, the pharmacy moving up to Overdale, then there is going to be an awful lot of movement of prescription charts up and down the hill and it is going to take longer to do these things. My feeling is that we are going to need to have e-prescribing in place by the time the pharmacy moves up the hill. I think that goes up there for 2018 or 2019. Realistically, putting in these kinds of systems takes a year or 2, so we are going to have to be ready to start pretty quickly in 2016 if we are going to make e-prescribing be in and embedded by the time we move the pharmacy. The third thing was screening. I think screening is something which is a separate issue. You get an enormous amount of help in screening from all of these systems, both from the G.P. system and from the hospital system. I think there are great hopes for how the G.P. central server will be able to help with screening, but we are at an earlier phase with the G.P. central server system. Already I think deals have been done to allow extracts of information from the G.P. central server system, which will assist in screening. There is another area which we have not discussed, which is the area of extension of the electronic patient record, which I think is another key bit.

[11:15]

Currently, quite a lot of patients, even patients who do not have too much wrong with them, often have this kind of thickness of notes, written notes. If you look through that stuff, you will find that a lot of it is just very repetitive. Every time they come into hospital the same questions are asked and the answers are written down in the same way. Letters are written, copies are sent. All the

letters and the copies end up being filed in the patient's notes. A lot of this stuff potentially can be collected on to TrakCare, our patient administration system. Already any letters that are typed via our secretaries, they are there in that system and we can go and look at those. All of the results which are filed in the notes, they are in the patient record and somebody has to file those. The written notes which are the description of what is wrong with the patient when they are admitted to hospital and a description of the care that they get, potentially we can collect all of that electronically and that will produce a really good record and much reduce the amount of paper that we are having to store and filter through. There is also the possibility that we could scan some of the old notes and that I think is something that is made more important by the possibility that we might be working on 2 sites, to try and get as much of the patient record into an electronic format so that you can look at it up there when they turn up in outpatients and half an hour later when they turn up in the A. and E. (Accident and Emergency) Department the record will not still be up there and need to come down in a lorry but will be visible on screen.

Senator S.C. Ferguson:

Yes, but one of the things about converting stuff from paper to computer is that you have to review the system you use on paper in order to make the best use of putting it on computer. How far have you got with that?

I.T. Lead, General Hospital:

Well, I think we are talking about early stages.

Senator S.C. Ferguson:

It is sort of garbage in, garbage out sort of touch.

I.T. Lead, General Hospital:

We already have 2 areas of our hospital working with an entirely electronic patient record. The Emergency Department and the maternity unit have electronic patient records and we have been through that process. It was painful doing it and getting it right and there were many times when many of the people involved thought that we would never get it right. But we are now 2 years down the line and there is much more happiness with those trial areas. Potentially, the benefit of electronic patient record only increases as you use it in more parts of the hospital system.

Senator S.C. Ferguson:

Right, so that, in fact, you have been doing Lean without calling it Lean?

I.T. Lead, General Hospital:

We always try and do Lean. We try and do Lean.

Senator S.C. Ferguson:
Yes, I know. The minute you give it a name it is a box-ticking exercise.

I.T. Lead, General Hospital:
Lean is difficult to do if you do not have some kind of way of measuring what you are doing already. You start; you measure what you do already; you change it; you see whether it is any better. We would assume that it would be better if we had thought about it, but people like you want us to be able to explain, to show you that we have made some benefit.

Senator S.C. Ferguson:
Well, like the Stroke Unit at Plymouth Hospital where they have improved throughput, they have improved outcomes and, incidentally, the costs have reduced.

I.T. Lead, General Hospital:
Yes.

Senator S.C. Ferguson:
That is what we are looking for.

I.T. Lead, General Hospital:
Yes.

Senator S.C. Ferguson:
And better patient result. Because nobody wants ... anyone who goes into hospital just wants to go in as quickly as possible, get treated as quickly as possible and come out fit as quickly as possible, and stuff the ... sorry, no, bother the experience, they just want in and out.

I.T. Lead, General Hospital:
Well, they are keen on the experience as well but I do think ...

Senator S.C. Ferguson:
They will grumble if the food is ... **[Laughter]**

I.T. Lead, General Hospital:
They will and they will grumble if anything goes wrong. But it is crucial that we can measure what we do if we are going to make changes, and that is what ... these systems, they generate data in the background. I showed you at a previous meeting how we have been able to generate data about outcomes from our computer system in a couple of weeks by asking the right questions. We

did not know we were collecting that data but it turned out we were. So the advantage of having these computer systems is that you can produce these huge spreadsheets with very detailed information and analyse it any which way that you want. That is what helps you to make progress in health care.

Senator S.C. Ferguson:
Have you pulled the Statistics Department in on this?

I.T. Lead, General Hospital:
I have not specifically.

Senator S.C. Ferguson:
Because this is the sort of thing that is the breath of life to them and they might also be able to play with the numbers and come up with even more results.

I.T. Lead, General Hospital:
Potentially. That is what our applications team are skilled at and increasingly I think people working in health care are becoming skilled at analysing data and it is ...

Senator S.C. Ferguson:
Yes, but this is surely the one thing that everybody screams about: our departments are not communicating laterally as well as longitudinally.

I.T. Lead, General Hospital:
Well, I think we want to do that.

Senator S.C. Ferguson:
Why are you not connecting with the Statistics Department?

I.T. Lead, General Hospital:
Healthcare data is something where there are sensitivities and so the moment you start talking about transferring healthcare data or confidential healthcare data to an area where people are outside your organisation there is a nervousness from the general public that their data will not be safe. We want to be absolutely certain that our data is always used safely and appropriately. Perhaps that makes us move slightly more slowly than we could do otherwise, but I think that ultimately is the reason why we need to be very careful. Because the last thing we want is to lose the confidence of the general public that their data is being used safely and appropriately.

Senator S.C. Ferguson:

Providing the names are not included ...

I.T. Lead, General Hospital:

I am with you on this. I am very much for the idea that we will do more with our data. There is an infinite, vast amount of data being collected within our systems and to a degree somebody has to ask us a question and we will try and give them an answer. If the Statistics Department want to be a part of that I am delighted.

The Deputy of St. Ouen:

Why have electronic patient records not been extended to other areas within the hospital given that you say the trial has been completed in a 2-year period?

I.T. Lead, General Hospital:

There is a funding issue. Coming back to this funding thing, ultimately we have to pay TrakCare to allow us to develop those other areas of the electronic patient record. There is also the way it impacts on the work of the hospital. So when you are going to set up your computer system to do something differently, the first thing you have to do is to set it up in the way in which you think that it will work appropriately. Then you have to get people out from your departments to test the system to destruction, if you like, to make sure it does all of the things that they do with paper records at the moment. You usually find in a small hospital that that means that you have to backfill those people. You cannot just take senior people out of a department and expect it to work *ad infinitum*. One of the big mistakes or one of the things that we underestimated was the amount of backfilling that was going to be required in order to smoothly bring in these electronic areas of the system. So I think it is to make sure that we have sufficient funding. It is not just about buying the software. It is about getting the people who can safely develop the software to get it to work perfectly within that area and then making sure that we have people to backfill to free up the people within that area to test that the system is resilient and functional and to then train the other users in using the system.

The Deputy of St. Ouen:

You have highlighted a number of benefits that will flow from the G.P. central server. What part is missing to provide that fully comprehensive integrated care record system that we look for?

I.T. Lead, General Hospital:

There are large numbers of small areas, but I think the electronic patient record - that is everybody collecting their patient notes electronically - the e-prescribing, the order communications links. So when we are doing all of those things within the hospital, when the community system is in, then in

order to get a movement of information across the way computers work is that that little bit of information here has to go into just the right box in the G.P. system. So we have to ... that is a job of work to make sure that the information moves from the right boxes to the right boxes. That is made a lot easier by having the G.P. central server because there is only likely to be one box to deal with for each piece of information. Somebody is going to have to set it up so that the right information goes into the right place.

The Deputy of St. Ouen:
So we are quite a way off maybe achieving this?

I.T. Lead, General Hospital:
It requires work and the work will not be done for free. It requires expert people to do it, but it is money well spent because all of health care works on good quality information and everybody needs to have that.

The Deputy of St. Ouen:
Just moving on to ... I know we have probably touched on it with the answers you have given already, but we would just like to know what involvement you have had regarding looking at the provision of a hospital on a single site and a dual site option.

I.T. Lead, General Hospital:
Well, I was involved in a meeting that we had at the town hall relatively early on in the system where I think until that time I was in the same ... I had the same amount of knowledge as everybody else in the hospital, which was that we were looking at the prospect of building a new hospital. We did not know where a new hospital might be and then we had the town hall meeting. That would be when, Bernard?

Clinical Lead, Future Hospital Project:
August 2013.

I.T. Lead, General Hospital:
Yes, so about 8 or 10 months ago where we for the first time looked at the feasibility of doing a dual-site hospital. We talked about what the right model might be for a dual-site hospital. So from that point I knew that there was a likelihood that dual site was the way we were going because the financial arguments seemed to stack up for having a dual-site hospital. Then more recently as the process has moved on I started to have meetings with Bernard and we discussed how living on 2 sites might change the informatics needs.

The Deputy of St. Ouen:

If you rewind, was the dual site option ... sorry, start again. Given that there was not a financial restriction placed on the provision of a new hospital, would it have been the consultants' view that it would be better to provide it on a single site?

I.T. Lead, General Hospital:

I do not know that I ever really ... I mean, that certainly was not my view that there was ... that we were kind of involved in or I certainly did not feel I was involved at the level where we were making a decision as to whether it was going to be a single site or a dual site. In a perfect world, I guess you would build a new hospital in a new place and you would then transfer everything across on day one, but I can understand that that carries a number of costs and expenses which are not there in the current system. So I guess I would say in a perfect world, yes, single site hospital would be great, but if a dual-site hospital is the pragmatic reality then we can make a dual-site hospital work.

The Deputy of St. Ouen:

That is key; you are confident that we will be able to make a dual-site work?

I.T. Lead, General Hospital:

I have worked in hospitals where the actual hospital site is larger than the distance between here and Overdale.

[11:30]

Senator S.C. Ferguson:

Roller skates I think are the answer, are they not? **[Laughter]**

Deputy J.A. Hilton:

Okay. Was there anything else that you wanted to ask? I think we have covered more or less all areas, have we not?

The Deputy of St. Ouen:

Yes, I think we have.

Deputy J.A. Hilton:

I just wanted to ask you one thing. Do you ever regret agreeing to take clinical lead for I.T.? **[Laughter]**

I.T. Lead, General Hospital:

That is an interesting question.

Deputy J.A. Hilton:

Well, it seems to me that you have to do your day job alongside that and it is such a massive project.

I.T. Lead, General Hospital:

It is massive and as it has gone by I have become more passionate about it. Of all the things I do it is the thing where I really see the potential for improving health care. Jersey is a wonderful place for doing healthcare informatics. If you work in Southampton, there is a hospital and it looks after a group of people here and then you have an ambulance trust and it looks after maybe those people and there is another ambulance trust that does those people, another one that does those people. You have a mental health trust and that is not quite the same place as the hospital. All of these trusts have different information systems. In Jersey we just have one Island. We could have the best healthcare informatics system anywhere in the world in Jersey.

Deputy J.A. Hilton:

Yes, I agree with you there.

I.T. Lead, General Hospital:

That makes it pretty exciting to do this stuff and obviously I want it to be as good as possible. That means that I am passionate in trying to get us to make it good and to fund it to be as good as it can be. There is real benefit to be had for the general public in Jersey in doing that.

Senator S.C. Ferguson:

Are you a techie as well then?

I.T. Lead, General Hospital:

Well, you know, I have a computer. **[Laughter]**

Senator S.C. Ferguson:

Well, no, when I was growing up my G.P.'s hobby used to be rebuilding clocks and I just wondered if you had ...

I.T. Lead, General Hospital:

I have never built a computer but I use computers. I am an anaesthetist. Anaesthetists tend to be people who use monitors and computers and that kind of thing. I have had a computer since 1982 when they did not do as many things as they do now.

Deputy J.A. Hilton:

Okay, thank you very much indeed. I will close the meeting.

I.T. Lead, General Hospital:

Thank you very much.

Deputy J.A. Hilton:

Thank you. That was very, very interesting.

[11:32]