

Information needs for GP Consortia

What factors do GP Consortia need to consider when determining data sources, and resources, to support their information requirements?

The NHS White Paper, Equity and Excellence: Liberating the NHS¹ proposes a major change to NHS commissioning through the creation of GP consortia. GP consortia will be responsible for commissioning the majority of NHS services for their patients. Consortia responsibilities will also include budget management and resource allocation, and commissioning services prioritised to reflect local need.

All GP practices will be required to belong to a consortium. The General Practitioners Committee (GPC) of the British Medical Association (BMA)² guidance on the White Paper¹ suggests that key factors consortia will have to consider include governance and decision-making structures. The GPC also concludes that the role of GP consortia will probably include:

...determining local health care needs and what services are required to meet those needs ... the entering into and management of contracts with providers and the monitoring and improvement of the care provided under those contracts

In order for consortia to fulfil these functions, they will require accurate data and information to provide clear evidence to support the decision-making process. They will need to know and understand how effectively current services deliver good patient outcomes, and the cost implications of present service commissioning. They will need systems to support analysis of data in order to influence and improve service delivery and patient experience and outcomes. Consortia will require accurate and timely information and data analysis for accurate budgeting.

The GPC² suggests that this will include ‘...information on expenditure, referrals, prescribing and clinical performance across secondary and community care’. The GPC acknowledge that historically, information provided to practice-based commissioners by Primary Care Trusts (PCTs) has been poor, and that for new consortia to function effectively they will depend on access to relevant information. They conclude that the process will need to be supported by the provision of detailed activity data from GP practices.

Consortia will be accountable to the NHS Commissioning Board for the outcomes they achieve³. The way this process will work in practice has been outlined in more recent documentation⁴. A GPC round-table discussion⁵ acknowledged that some accountability for the success of consortia ‘must sit at practice level and that a mixture of incentives would need to be put in place to encourage practices to comply with consortia decisions’. Delegates at the meeting also suggested that ensuring good information systems are in place in practices will be an important factor in supporting cooperation between practices and consortia. Northall⁶ (2010) also considers the issue of consortia engaging with clinical colleagues in GP practices and suggests that practices should be given the opportunity to investigate apparent issues with their own data.

The GPC discussions⁵ also highlighted other areas where good practice data and information will be required including referrals for further care, case-mix data, and population demographics. Northall⁶ (2010) suggests that practices will have accurate information relating to local patient needs. She advocates that where commissioning strategies are developed using good practice data, they are more likely to reflect local needs and consequently be more effective.

In considering the information needs of GP commissioners, in the context of Practice Based Commissioning (PBC), Wells et al (2007)⁷ concluded that effective commissioning depends on ‘...effective, timely information and the capacity and the capability to interpret that information’. They also emphasise the importance of using ‘real-time’ data. The Royal College of General Practitioners⁸ (RCGP) has suggested that timely and easy to use information systems will be essential for all GPs under the new arrangements. In addition, the RCGP suggests that reporting and accounting should be kept to a minimum and that a system of trust and transparency should be promoted between commissioners and providers. They question whether accurate information is available, the capability of consortia for data analysis, and if information systems are ‘robust enough to allow for effective commissioning’.

GP consortia will need IT systems that can extract data from secondary care and other providers, and translate it into appropriate useful information. Jenner⁹ (2010) suggests that current NHS IT systems do not provide accurate information that could be used by GP consortia. The importance of a systematic approach to using information in a collaborative manner to support appropriate needs-based commissioning is an important factor emphasised by other clinicians and NHS managers¹⁰. They also suggest that data and information become the core of the business in a commissioning environment, and using and understanding it are the keys to productivity success. However, it is also highlighted that consortia will require help in understanding how to use the large amounts of data available to commission better services for patients.

Therefore, GP led consortia will require access to appropriate data and information from GP practices, commissioned service providers and patients. They will require effective systems for data analysis and interpretation. In order for any data to be used effectively, it will be essential to ensure the quality of the data and to have robust data quality validation processes in place.

The present systems of PBC and Payment by Results (PbR) have both raised serious questions relating to the quality of data used for health-needs based service commissioning and payment for services provided^{11,12}. Providing practices with the opportunity to identify errors in their data by validating information from in- or out-patient data, or A&E attendances, against their own patient records has been shown to be an effective tool in ensuring accuracy of commissioning data¹¹. However, this depends equally on the quality of data on the practice system.

The Audit Commission¹² (2010) annual report on PbR emphasises the importance of accurate data not just for payments but also to plan and monitor healthcare to ensure effective commissioning. GP consortia should be aware of the findings of the report that despite overall improvements in the quality of clinical coding, there remain a high proportion of trusts whose coding is poor and inaccurate.

Furthermore, in response to the findings, the Audit Commission is planning to review commissioner's contract management arrangements and draws attention to the importance of accurate coding to support the increased focus on improving efficiency and outcomes.

The recent consultation document *An Information Revolution*¹³ suggests that GP consortia are in a good position to use summary information 'to analyse the relationship between patient needs, services provided, resources used and the outcomes achieved'. Sources of data include GP practice records. This further supports the proposal that GP data will be critical at all stages of the commissioning process, including as suggested above, the validation of data from other sources.

Data quality is therefore a recurrent issue for both secondary and primary care data. In Primary Care, the IM&T DES¹⁴ was expected to lead to significant improvements in data quality. However Greenhalgh et al¹⁵ (2010) in their evaluation of the Summary Care Record concluded that there remains an issue as to whether practices continue to maintain and improve the quality of their data. The evaluation suggests that key factors contributing to ongoing efforts to improve data quality are: 'the culture of the organisation; clear data quality targets and dedicated resources for working towards these; and a positive relationship with local data quality facilitators'.

In addition, National and Local incentives to improve data quality are not necessarily committed to providing ongoing resources to ensure data standards are maintained. Byrne et al (2008)¹⁶ note the importance of specific skills and behaviours within the practice to support data quality audit and improvements, and suggest that in order to develop these skills, practices will need the support of a skilled data quality facilitator. They also recommend continuing recognition of data quality as 'primarily organisational and educational processes that are ongoing and require regular stimulus'. The view that data quality is an ongoing process requiring audit and interventions, validated tools, expert resources and ongoing education and training is supported by the RCGP¹⁷.

Conclusion

The Department of Health (DH) has directed the creation of GP commissioning consortia in response to the understanding that the actions of GPs incur the majority of NHS expenditure⁴. The DH suggests that this occurs directly through prescribing and referring, and indirectly through the prevention and management of unscheduled care episodes. In order to ensure that the most effective and efficient services are commissioned to meet appropriate needs, consortia will rely on accurate and timely data and information from a variety of sources.

While PCTs rely heavily on secondary care data, consortia should consider the potential added value in using primary care data. The majority of GPs capture data at the point of care and have good systems for capturing data from other sources. It could be argued that GP systems can provide more timely data, particularly with respect to prescribing and referrals. Service planning and commissioning can be better informed by accurate information regarding patients' health needs and the resource implications. GP information systems can provide data to support this process and in particular have detailed information relating to patients with long-term conditions.

Commissioners could use GP data to support the process of assessing the cost-effectiveness of current services and considering alternatives to improve service delivery and patient experience and outcomes. GP data could help to monitor how effective current interventions are in preventing unscheduled care episodes, support validation of data from service providers, and provide outcome data to support performance monitoring of providers.

However, the usefulness of any data and information will depend on the accuracy and quality of that data and information. Consortia should consider how they will measure the quality of data from any source. They will also need to consider how they can improve it and then maintain that improvement, and what resources will be needed to ensure appropriate and accurate data extraction, analysis and validation.

In the current climate of PCT restructuring and budget restrictions, the value of health informatics services, and in particular data quality facilitators, should not be underestimated.

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