The Intelligent Practice

Understanding the information needs of GP commissioners

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This report has been produced by an independent steering group of experts from the NHS. They were not remunerated but were supported by research and production teams at Dr Foster Intelligence, who also funded the printing of the report.

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The Dr Foster Unit at Imperial College London is directed by Professor Sir Brian Jarman, a former member of the Bristol Royal Infirmary Inquiry, and Dr Paul Aylin, an expert witness at both the Bristol and Harold Shipman Inquiries.

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Foreword

The Intelligent Practice is the fourth report in the Intelligent Board series. Although GPs do not formally operate a board system, there is considerable similarity in their decision-making processes to those of NHS trusts, PCTs and SHAs. As a consequence this report should be read in conjunction with *The Intelligent Board* and *The Intelligent Commissioning Board*, as the principles they set out will be relevant.

GPs as commissioners are at the front end of the government's drive to introduce professional purchasing services to improve the quality and availability of healthcare for their patients. It is crucial that they are in receipt of timely and accurate information on which to base those important commissioning decisions.

I was joined on the steering group by an excellent, enquiring and innovative range of GPs representative of most parts of the country. During the steering group meetings and subsequent email discussions, the group returned to a number of points which will be key to successful Practice Based Commissioning (PBC). These are:

1. The challenge and the potential issues of conflict when GP practices are commissioning services which they themselves provide.
2. The need to achieve a consistent quality of commissioning between GP practices, given the differences in the capabilities and interest of practices in PBC.
3. The essential need for GPs and PCTs to work as a team within the overall support and guidance of SHAs.
4. The immediate need for all PCTs to understand and act on their obligation to provide timely and accurate information to GP commissioners on which they can base their commissioning decisions.
5. The similar obligation on GPs to provide accurate and timely information to PCTs on patient experience, outcomes, etc.
6. The need for direct incentives to GPs to change current referral patterns to provide more appropriate care for patients in the community.

The group was unanimous that the successful implementation of PBC is an essential pre-requisite to the modernisation of the NHS. But the accurate, real-time information which GPs need to make decisions is not currently available in many areas. We therefore strongly recommend that a number of information framework pilots are set up between PCTs and commissioners in a representative cross section of different population profiles, with a view to developing a model(s) which could be used as a baseline by commissioners.

The Intelligent Practice is intended as a starting guide for both commissioners and PCTs. It sets out two minimum information frameworks: the first outlines the indicators required by all GPs, regardless of the extent of their involvement in the commissioning process; the second is the further information required by leading edge commissioners. They are not intended to be prescriptive, but to be used as a guide to be adapted according to local circumstances. The group intends to revisit this framework in 2008 so it can benefit from the experience gained from the implementation of PBC.

Finally, I would like to thank everyone on the steering group for their positive, helpful and innovative contributions. This was undoubtedly the most difficult of the Intelligent Board series to put together and it is only due to their input and the excellent research and guidance provided by Dr Foster Intelligence that we were able to compile a framework of information which I hope all GPs and PCTs will find a helpful roadmap through this new territory.

Sir William Wells
Chairman, Appointments Commission

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Introduction

Background

The health service is in the midst of significant change: a shift from a system dominated by providers to one which is aiming to meet the needs of those who use it. GPs are at the forefront of this process. They are best placed to understand the needs of their local communities and to design services accordingly.

One of the key aims of the policy is to actively engage GPs and increase their role in aligning the allocation of resources to the full care pathway (not just what happens within the surgery). Using the information which will be made available to them, practices, or groups of practices, will be able to come up with ways of challenging current services and investing in and designing new services that might be more cost effective and more convenient for patients.

Under practice-based commissioning (PBC), GP practices[1] are being given their own 'notional' budgets with which to 'buy' health services for their patients. Commissioning practices are accountable to their PCTs, who negotiate and enter into the contracts with providers in line with past GP referral decisions and remain legally responsible for the funds. The notional budgets reflect any NHS services their patients receive, including attendances at Accident and Emergency departments, drugs, and all referrals to hospital for outpatient and inpatient treatments.

Most practices are now signed up in principle to PBC via their PCTs. However, it is widely acknowledged that it is a long way before the full benefits of PBC are realised. There are significant variations between PCTs and practices in their understanding and implementation of practice-based commissioning.

So what incentives exist for GPs to become commissioners of local services? According to Department of Health guidance, 70 per cent of any efficiency savings will be available to the practice for 'reinvestment in patient care', although that is not clearly defined. Will it, for example, include investment in the practice environment, such as redecoration, building work, etc? This could be rewarding to the GP as it will not eat into the practice's potential profit.

However, there needs to be a direct incentive for GP commissioners if there is to be any real impact on referral patterns. Department of Health guidance recognises this (in *Practice Based Commissioning: Practical Implementation*), and calls on PCTs to develop local incentive systems.

There is less clarity around what the penalties for GP commissioners might be if they fail to balance the budget or commission services in line with the agreed commissioning plan. But GP commissioners operate in an environment where their budgets are part of the unified budget across their local health economies; as a consequence, poor budget control by a few will penalise all of their colleagues in the health economy. Their financial performance will have an impact on the future role that general practice plays in the health service. From next year the unprecedented levels of additional investment in the health service will cease and will be limited to the rate of inflation. Therefore the efficient allocation of resources will become even more important.

This report

There is a consensus that PBC is the right way to commission local services. Therefore, engagement with the commissioning process is necessary, but it will be challenging for many practices. This report aims to be a practical resource for the GPs and practice managers commissioning services at practice level. It recognises some of the key issues and challenges they will face in doing so given the current policy context. The report does not focus on the information needs of providers of primary care or community services.

It sets out an information framework for practice-level commissioning including some principles around the presentation and interpretation of data. It makes a clear distinction between the information needs of every GP and those of a lead commissioner or commissioning practice. As a result we have developed two frameworks, including specific metrics and indicators which practices may wish to adopt and adapt.

The steering group agreed that this is not a 'one size fits all' framework. It is intended to be a starting point which commissioners will adapt and develop in line with their needs and local circumstances as they gain experience from the practical impact of their commissioning decisions.

What is an intelligent commissioning practice?

The key themes which have emerged in the previous Intelligent Board reports, in particular *The Intelligent Commissioning Board*, therefore remain relevant to GP commissioners, as they are to board members.

◆ Devolving decision making. The Department of Health must devolve power and responsibility to practices for the introduction and implementation of commissioning for their local populations within a clear framework of accountability, including that of financial accountability.

◆ Partnership. GP commissioners and PCTs must work as a team to agree and implement a commissioning plan to improve the quality of an access to healthcare for their populations.

◆ Common framework of information. Consistent information across all organisations in the local health economy is essential to support and inform commissioning and decision making.

◆ Information overload. Effective decision making requires appropriate, real-time information. All too often in the NHS, at boards and practice level, information is irrelevant and over-long. Leaders in organisations need to clearly set out the information they need.

◆ Accountability. There must be clear lines of accountability with transparent contracting arrangements, particularly where practices are both commissioning and providing services.

There are a number of key areas of information which are underdeveloped at present. In particular, commissioners and providers both need to improve their financial reporting and sharing of information about the needs and experiences of customers. There is a clear responsibility for PCTs to provide information to GPs in order to enable them to make their commissioning decisions. Similarly, there is an obligation for GPs to reciprocate with information in respect of their patients' experiences, preferences and outcomes.

The steering group

This report has been developed by a steering group of practising GPs, actively involved in practice-level commissioning. The group was chaired by Sir William Wells, Chairman of the Appointments Commission and responsible for the Intelligent Board series.

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The steering group took soundings more widely in the development of this report and the information frameworks. In total, the group met four times and was supported by research and production teams at Dr Foster Intelligence.

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Context and challenges

GP commissioners, whether practices, localities or consortia, are adopting practice-based commissioning with various levels of enthusiasm and support from their local PCTs. This section outlines the role of GP commissioners, the local partners with whom they must work and the key issues and challenges.

What does good commissioning look like?

The key outcomes of good commissioning can be summarised as:

- Improved health outcomes and reduced health inequalities.
- A mix of services, in and out of hospital, that are appropriate to the scale and nature of the needs of the local community and within available resources.
- Value for money for the taxpayer.
- Services that comply with the core standards and are improving with developmental standards as monitored by the Healthcare Commission.
- Engagement from patients, the public and other key parties, including the local authority, the voluntary sector and, where appropriate, the private sector.

What is practice-based commissioning?

Commissioning is the process of securing and managing appropriate healthcare services for relevant populations at value for money for taxpayers. It involves three main phases:

1. Understanding needs analysis. Understanding, segmenting and anticipating the needs of local communities and patients and planning and prioritising accordingly.
2. Planning services. Defining services to meet these and contracting them from the most appropriate providers.
3. Managing contracts. Monitoring provision and managing contracts, to continuously improve outcomes for patients and local communities, including managing demand for services.

PBC will devolve responsibility for determining which services are most appropriate for patients to GPs, whether by practice, locality or consortium. GP commissioners will be supported and enabled by PCTs, providing relevant and timely information and contracting support. GP commissioners remain ultimately accountable to the PCT for the delivery of the agreed local commissioning plan.

They will need access to information in order to:

- Understand current utilisation of resources and anticipate future trends
- Design and deliver effective local services
- Understand and manage their budget
- Manage demand for services
- Monitor quality of commissioned services

What other organisations do practice-based commissioners need to work with?

The steering group considered which organisations will be key to the flow of information in the local health economy and therefore the devolution of commissioning to GP practice level.

PCTs: PCTs are obliged to provide information to GP commissioners. In order to develop effective commissioning, GPs and PCTs (and indirectly, the SHA) must work in partnership. There should be a mutual flow of information between the PCT and practices. PCTs in particular should provide practices with information about population health. GP practices need to feed back information about the needs, preferences and experiences of patients.

Providers: commissioners need access to real-time information about the availability of local services according to the patient pathway from the NHS, independent and voluntary sectors. They also need comparative information on the cost and quality of those services.

Other local services: GP commissioners will need information about other local services from local authorities, in particular social services, education and housing, all of which have a significant impact on health needs. GPs will also need to provide local services with information about their populations.

Patients: feedback from patients registered at the practice, information from patient groups and information about the experience of patients treated by local providers will be important. There is a compelling business reason for GPs and PCTs to collect this information: it will enable practices to deliver and commission services which meet their patients' needs.

What information currently exists to support practice level commissioning?

The key to good commissioning is effective, timely information and the capacity and capability to interpret that information. The information GPs currently receive to support

commissioning at a practice level is variable, ranging from good to non-existent. Figure 1 sets out the minimum information PCTs should provide GP commissioners with, according to the Department of Health.

Figure 1 Minimum information requirements for GP commissioners. (Source: *Practice Based Commissioning: Practical Implementation*)

Activity and financial information on:

- Elective activity, inpatients and day cases
- Non-elective admissions, including information on length of stay
- First outpatient appointments and follow-up appointments
- Use of diagnostic tests and procedures
- Consultant to consultant referrals
- Prescribing
- Community and mental health services
- Primary care, including essential and enhanced PMS and GMS services
- Accident and Emergency attendances

Data on waiting times between outpatient referral and addition to a waiting list.

Commissioners (practices and PCTs) should note variations in these measures for their populations and should also be able to compare their data against the national average by benchmarking:

* Referral rates
* First outpatient attendances
* Admission rates
* Follow-up rates

In order to gain insight into the health needs of their populations, commissioners will also benefit from information on the demographics, needs and demands of their practice population. Moreover, they will need to be aware of new providers of primary care and other services entering the market.

There are a number of sources of information needed by GP commissioners. These include providers, public health teams, practices, the PCT and private enterprises.

In many cases, the challenge for GP commissioners is not the availability of information, but its presentation. They lack real-time information about the pathway of care of patients, relying on paper-based discharge summaries in many cases. Information is often paper-based and needs to be developed so that computerised online discharge summaries and information about patient outcomes are consistently available to all practices.

What are the information challenges for GP commissioners?

There are a number of challenges facing GP commissioners which they will need to overcome with the support of their PCT to ensure that PBC is effective. These include:

◆ Developing a clear understanding with the PCT around roles and responsibilities. GP commissioners need to work on managing demand and developing new pathways in collaboration with PCTs, while PCTs remain responsible for the overall budget and setting commissioning priorities. PCTs will also need to ensure that a comprehensive and equitable range of services is delivered with advice and input from clinicians.

◆ Developing the information flow to and from practices. Effective commissioning will depend on accurate and timely information to inform decision making. In particular, information needs to be developed along the patient pathway, in line with the 18-week access target and for community services. Commissioners need to demand the type of information they require in contracts, with minimum standards of timeliness and quality.

◆ Analysing and interrogating information and data. Traditionally GPs have worked in isolation, and have not had access to information allowing them to benchmark their performance against that of their peers. Commissioners need to be equipped with both the information and the skills to interpret and act on it.

◆ Developing local health and social care systems optimising the involvement of the third sector and private sector.

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Information frameworks

GP commissioners face new responsibilities and challenges. They need to build up a fuller picture of the current and future health needs of their local populations and the extent of local provision in order to plan and redesign services.

This section outlines some key principles which GP commissioners might adopt, together with a framework for the presentation of information. It is intended that commissioners should adapt this framework according to their local circumstances and it should not be seen as prescriptive or compulsory.

There are some areas where the current information available is insufficient for commissioners and needs development. SHAs and PCTs must play a key role in developing information across their local health economy.

Principles

All information should:

- Be clearly and simply presented, including graphic overviews supported by a brief commentary.
- Be updated in a timely manner, working towards a real-time information culture.
- Direct attention to significant risks, issues and exceptions.
- Provide an appropriate level of detail.

Ideally, commissioners should be able to access key information about contemporary and historical performance online and in real time. This is not currently possible, but we would expect considerable progress to have been made by health economies in 12 months' time when we will review this framework.

The key tests of the success of an information resource should be the extent to which it:

- Prompts relevant and constructive challenge
- Enables performance improvement
- Supports informed and devolved decision-making
- Is effective in providing early warning of potential financial or other problems
- Develops all commissioners' understanding of the organisation and its performance

Frameworks for identifying information requirements of practices

Some GPs will be actively involved in the designing of local pathways and the commissioning process. Others will inevitably be less engaged. Therefore their information needs will be variable.

The frameworks set out below distinguish between the baseline information which all practices will require and the more in-depth indicators which lead commissioners will want to review to inform their decision making. They should fulfil a number of important purposes:

◆ Support GPs to make more efficient and effective use of information in order to maximise their management capacity.

◆ Structure the process of understanding needs, planning services and managing contracts.

◆ Manage the distinction between provision and commissioning.

GP commissioners should bear in mind the following when reviewing these tables:

◆ In line with the principles set out above, information should be presented by trend and forecast along with relevant benchmarks in real time wherever possible.

◆ The emphasis should be on reporting by exception, with the ability to drill down wherever possible. GP commissioners and PCTs should look for fluctuations in performance and activity.

◆ As PBC is embedded, the information commissioners require will develop and should be revisited over time.

Availability of data

It is important to emphasise that in some of the key areas of activity there are gaps in the information that is routinely available. In particular:

◆ Routine and nationally comparable data is available on almost all hospital activity (although not in real time). Information is less developed for out-of-hospital services, where availability and quality of data vary regionally. Nor are there many widely accepted measures of quality or efficiency for these services. Some locally collected data will be available and will be a starting point, although it provides limited opportunity for benchmarking.

◆ Approaches to measuring patients' experiences vary widely and the only nationally comparable dataset is obtained from the annual (or less than annual) programme of national patient surveys. These will be insufficient for effective monitoring of customer satisfaction and commissioners should encourage more routine monitoring using

techniques from the private sector, such as focus groups and market research. Tools are emerging to monitor patient experience routinely.

Presenting information to GP commissioners

There are three key areas of commissioning activity against which boards might look at a number of indicators (outlined in table 1):
1. Strategy. Understanding the health needs of local communities and market intelligence.
2. Choice and quality. The experiences of patients and information on the quality of local services.
3. Activity and financial statement. The utilisation of services and performance against budget.
In addition, there are a number of more detailed indicators which commissioners will wish to review in order to monitor performance against contract and when designing services (outlined in table 2).

Table1: Intelligent information for all GPs

Indicator	Description	Comment	Frequency	Source
Strategy	**Health needs information** • Breakdown of population by age, gender, deprivation and ethnicity • Mortality rates (overall rates and cause, eg, CHD, suicide) • Morbidity rates (eg, heart disease, mental illness) • Risk factors prevalent in local population, preventable deaths • Birth rate • Hospital admissions - acute, by source of referral, eg, A&E • Hospital admissions (mental health)	This information is available now at PCT level, but not at practice level. Information wider than healthcare should be included to give a strategic overview of education, employment, housing stock, etc. All this information should be shown as a trend, and broken down by geographical area, if possible	Monthly, by exception	ONS, practice registers, PCT and providers
	Market intelligence • Existing service providers, new and potential market entrants (including the independent sector) • New models of care	Real-time information about local services should be provided, which should include information on their financial stability. This should give information about cost, quality and capacity and up-to-date information about decommissioning. Examples of services include specialist clinics, intermediate services and self care providers	Monthly, by exception	PCT
Choice and quality	**Patient experience** • Patient feedback on services/ providers (themes of staff attitude and responsiveness, whether patients are treated with dignity and respect, complaints, cleanliness, communication and patient involvement in decisions) • Number and percentage of direct referrals eg, to diagnostic tests • MRSA by site		Monthly	Local surveys, complaints, providers
Activity and financial statement	**Utilisation and budget** • Accident and Emergency attendances by ACS condition • Referral rates and conversion rate by practice to secondary care, including independent sector treatment centres • Out-of-hours services: cost of service vs number of admissions • Prescribing by disease group	Indicators should be available for all practices against these four key budget headings. It should be possible to analyse this data at individual patient level. This data should be benchmarked and shown by practice, specialty and disease group	Weekly	A&E data-set, NWCS data

Table 2: Intelligent information for GP commissioners

Description	Comment	Frequency	Source
Elective and non-elective activity • Number of inpatient FCEs by provider • Standardised admission ratios • Length of stay • Number of day case FCEs • Day case rate • Consultant-to-consultant referrals by specialty	All indicators listed here should show activity and spend information, broken down for each patient care pathway, such as diabetes, mental health and CHD. This breakdown should include data for independent sector treatment centres. These indicators should be reported by exception, and should only be reported if activity goes over budget or appears to be an outlier	Weekly	NWCS data
Outpatients • Number of first outpatient appointments • Number of follow-up outpatient appointments • DNA rate		Weekly	NWCS data
Diagnostic tests and procedures • Average wait for diagnostic tests and procedures, by test • Number of referrals for diagnostic tests and procedures, by specialty • Number of diagnostic tests and procedures carried out, by specialty		Weekly	NWCS data
Primary and community care • Number of referrals to community services (eg, sexual health services) • Primary care activity including essential and enhanced PMS and GMS services		Weekly	
Mental health • Number of referrals to mental health services • Length of stay • Number of hospital stays • Number of outpatient contacts		Weekly	Providers
Waiting times • Number of patients breaching waiting time standard by disease group and specialty • 18-week wait, including diagnostic waits by test and weeks waiting	Information in this section should be provided by exception in line with the local commissioning strategy agreed with the PCT	By exception	Providers
Outcomes • Readmissions by specialty • Mortality by specialty	Outcomes data should be presented by provider, to include independent sector treatment centres. Readmission rates are particularly important for mental health and respiratory conditions	Weekly	NWCS data
Quality of coding • Ethnicity • Diagnosis codes • Missing/invalid practice codes		Weekly	NWCS data

1 Practice-based commissioning may be delivered as a locality model (ie, groups of practices acting as a commissioning consortium) but for consistency we refer to commissioning practices throughout the report