

ROUNDTABLE: COMMISSIONING INFORMATION

FULL MEASURES

Getting commissioning right will depend on getting the right data. But what does that mean? And what can we do to deliver all the data CCGs will so desperately need in just 12 months' time? Daloni Carlisle reports on a lively expert debate

There is a new currency in the NHS: information. That much is clear from the NHS information strategy released in May, with its vision of "putting us all in control of the health and care information we need".

Which sounds fabulous – but the stark reality right now for commissioners in the emerging clinical commissioning groups is they lack the information they need to do their job effectively.

This was the problem explored at a roundtable convened by *HSJ* and sponsored by Civica just days after the strategy's release. The starting point for the debate was this: the quality of commissioning will depend on the information and the extent to which commissioners can turn information into intelligence.

So chairman Alastair McLellan asked participants to get the ball rolling by identifying the three most important types of information commissioners need.

There was widespread agreement that commissioners need clinical information about what has happened to a patient and, in future, about outcomes, information that links along a patient pathway, and financial information.

Chris Calkin, chair of the Healthcare Financial Management Association's policy forum, and Dr Mark Davies, executive medical director of the Health and Social Care Information Centre, were as one – and noted how far the debate had come already that a finance director and a GP would be in such agreement.

Dr Davies fleshed out the underlying principles as he saw them. "Information needs to be open and transparent," he said. "It needs to be good quality and fit for purpose and it needs to be actionable. In a practical sense, we need to be able to do something with the information in the delivery of care."

Commissioners needed quality metrics, measures of outcomes, measures of patient experience and measures that would track patient journeys in integrated care systems, he said.

Finance was core to the current agenda, he added. "We need financial information in as real time as possible that will allow us to track the level of financial risk across the system."

David Stout, deputy chief executive of the NHS Confederation and a former PCT chief executive, added population data into the mix and made a bid for comparable information. "If you cannot compare one place to another, it means nothing to a commissioner," he said.

In real time?

Kishamer Sidhu, director of finance and contracting at North West London Hospitals Trust, said information must be relevant to the decision you are trying to make. "Often we find the information is not relevant and has been collected only because it's always been collected," he said.

Dr Charles Alessi, chairman of the National Association of Primary Care, called for real time information. "We have got so used to having information

which is six months out of date," he said. "It is interesting but not particularly helpful if one is trying to manage a resource over the course of a year or if it misses the immediate previous episodes for an individual."

The point about "real time" data prompted a debate. Dr Shahid Ali, GP and clinical lead for the NHS Commissioning Board's patients and intelligence directorate, said there was a balance between the cost of providing real time information and its usefulness.

"Definitely we need timely information but I would not argue for real time information," he said. "Real time information is a considerable challenge and I am not sure it is cost effective."

Dr Davies agreed. Every £1 spent on data collection was £1 not spent on direct care, he pointed out.

Dr Ali went on to talk about the difference between information and intelligence. "What I hear around the country is that we have masses of information but we need to turn that into something that is intelligible and can be used for strategic decision making," he said. "We need to look at how information links together to get a holistic picture of the situation."

Mike Singer, managing director of Civica's healthcare commissioning and costing business, said there were technological solutions to this last challenge. "There is talk of too much information. There are ways to pull the information together and use your technology to focus down on the

ROUNDTABLE PARTICIPANTS

Dr Charles Alessi chairman, National Association of Primary Care

Dr Shahid Ali GP and clinical lead, patients and intelligence directorate, National Commissioning Board

Chris Calkin chair, HFMA policy committee

Dr Mark Davies executive medical director, Health and Social Care Information Centre

Mike Singer managing director, Civica

Kishamer Sidhu director of finance and contracting, North West London Hospitals Trust

David Stout deputy chief executive, NHS Confederation

Alastair McLellan editor, *HSJ*, and roundtable chairman

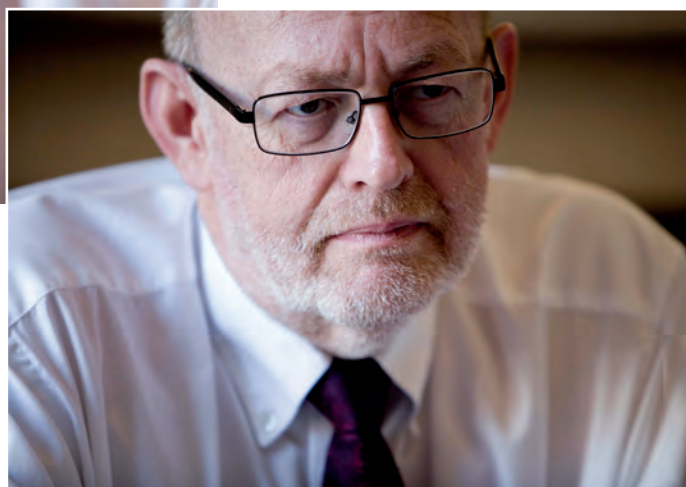
information you need at that time."

The discussion so far had hinted at some of the barriers and now Mr McLellan asked participants to be more specific about them. "What stands in the way of getting clinical information, pathway information and the finance information that is open, accountable, comparable and as real time as possible?" he asked. "I would hazard a





The panel (clockwise from top left): Charles Alessi; Shahid Ali; Mike Singer; Mark Davies; David Stout (right) and Alastair McLellan; Kishamer Sidhu; and Chris Calkin



suggestion that commissioners are not replete with information with all these characteristics?"

Dr Davies was first to answer. There were different challenges in different parts of the system, he said, with some common themes threaded through.

"Some of the really important things we need to address are the building blocks for really good quality data," he suggested. This included professionally led record keeping standards and improvements in coding. This second point implied a need to get clinicians closer to the data.

"We have a situation currently where, in secondary care, the workforce is almost entirely divorced from the data that describes their activity," he said.

The Information Centre had recently conducted a survey of more than 100 consultants

asking them how involved they were with their hospital's coding department. Nearly half, 45 per cent, said they never had any contact at all. "And then we are surprised by the quality of the data," noted Dr Davies. "Clinical engagement with data is a critical step in improving its quality."

This struck a chord with Mr Calkin, who has managed IT, clinical coding and medical records. He said: "Some of the lowest paid people in the organisation are information people, clinical coders and medical records [staff] and that is an important message. There has been under investment in frontline information services for years."

In the US, he said, clinical coders were all graduates while in the UK many people in

medical record departments did not even have a GCSE. One of his proudest achievements was getting all clinical coders in a hospital to complete a national qualification.

Dr Davies also called for a culture change – a point that was widely echoed in the subsequent discussion. "We have a culture at the moment where there is no tradition of sharing data with the public and the professions. We do not have a culture of being transparent and accountable for the service we provide and that culture needs to shift."

Dr Ali added: "We need to move from the position that information is desirable to the understanding that it is crucial and needs to be given that significance by CCG boards."

Mr Stout raised the thorny issue of data sets and asked whether we were currently measuring the right things. "We have not got a very well defined set of metrics about what quality is or commonly used standards," he said. "If we cannot agree what good looks like, how can we measure how good we are?"

The National Institute for Health and Clinical Excellence produced lots of good standards, he said, but no set of associated metrics against which to measure a service. "There is no orthodoxy about quality standards and, as a result, PCTs have no idea about whether they are commissioning a good quality service."

'In the US, clinical coders are all graduates while in the UK many in medical record departments do not even have a GCSE'

Era of 'big data' (clockwise from left): Kishamer Sidhu; Mark Davies; Chris Calkin (top) and Shahid Ali; David Stout; Mike Singer; Charles Alessi, who spoke of a new era where data can be used to revolutionise care; and Alastair McLellan



Poor data sets – or, in some parts of the service, an almost complete absence of data sets – led to information that was not operationally useful and therefore not relevant.

This led him into a second point: interoperability. “There is an ongoing debate about information systems and how they can talk to each other,” he said. “GP and acute systems, for example, or social care systems with any other system. Many of them are not connected.”

The centrally supported Secondary Uses Services, run by the IC, attempted to connect information but was “clunky”, he said. Locally, some health economies had tried to put in a “black box” to connect systems. “Some are making progress but it is not easy because there is a fundamental non communication in the system and at a patient level that cannot be a good thing.”

His final point was a call for health organisations to stop hiding behind the Caldicott information sharing principles. “People have rightly or wrongly – and I would say wrongly – interpreted Caldicott to mean that they cannot tell another organisation what they know about a patient. Caldicott does not say that you cannot share information but that you have to be transparent about your intention to use your data. It is used as an excuse and it is getting in the way sometimes of



‘All patients should have access to their records. The result would be massive and free data cleansing’

good clinical communication – and that also cannot be a good thing.”

Mr Sidhu called for a debate about who owned the data. “There are quite a lot of vested interests in data collection to prove different points,” he said. “We do not have common standards we expect from the information and it then gets very difficult to ... see what has gone wrong and ... right.”

Being clear about who owned

the data would help clarify issues around data sets and when to stop collecting information that has historically been collected, he suggested.

Dr Alessi said all the points raised so far were very significant and returned once more to Dr Davies’ broad theme of culture change.

“I think volition is the most basic message,” he said. “We know that there are system integrators that work so you cannot argue that we do not have an IT solution. Rather, there is a significant resistance to moving to a new environment.”

Fundamentally, providers worked in a fairly stable world with predictable income streams from agreed activity based on block contracts. “What you are asking is for these organisations to change to a system where things can change quite dramatically in a short period,” he said. “We are asking a lot.”

He also warned that the era of “big data” was on its way. “I do not mean more data but using data in a more significant way around patients and populations. If people can get this right, there is enormous potential for revolutionising healthcare.”

Dr Ali returned to the theme of standards and called for a national, independent organisation to collect and assure NHS data.

Mr Calkin called for a better understanding between primary and secondary care. On one hand, secondary care did not understand primary care’s need for information; on the other primary care did not understand the cost of providing information. “We need a culture change so we move to a position where there is an understanding of what information people need and what they are really asking for,” he said.

Mr McLellan then threw down the gauntlet and asked for the solutions. He asked what could practically be done in the next 12 months before CCGs take over commissioning.

Solving the data problem

Mr Stout outlined some local and some national solutions.

Patient power would be increasingly important, he said. “What can the government and commissioning board do to help explain to patients what they should expect from services?”

He wanted to see the IC take a leading role in data quality and standards and the NICE lead in developing quality standards with associated metrics.

He said: “The Audit Commission has been auditing PbR data for several years and showing how poor the data quality is, yet absolutely nothing happens. The IC has a strong role to play here.”

This is at the heart of so much tension within the existing



unnecessary enquiries that take up so much of people's time."

Dr Alessi returned to Mr Sidhu's earlier point, asking who owned the data. All clinical correspondence should be addressed to patients, not doctors, he said, and all patients should have access to their records. The result would be a massive and free data cleansing exercise as patients queried their own records.

Dr Ali agreed transparency – the ability to share data not just with patients but between organisations – would be important. "There are some information governance issues but information governance is all about making that process occur, not doing the opposite."

He also wanted to see more information expertise and use of business intelligence at CCG board level. Did that mean a board member specifically appointed for the information expertise, Mr McLellan asked. What could the NHS Commissioning Board do to enforce this?

Dr Ali said he had been pushing for CCG authorisation to include some reference to informatics capacity and use of business intelligence.

Information Centre's role

Dr Alessi agreed that this would be vital. "How can you be the custodian of the health of a population if you do not have the information?" he asked.

But Mr Stout was not so sure, not least as in practical terms much of the informatics service will be provided by commercial support services rather than directly by CCGs.

Many of the solutions suggested ultimately landed at

the door of the IC. Dr Davies tried to address them in the short time available. Reforms under way included the GP Extraction Service, going live in September, and new community data sets now in place. Work to reconnect secondary care physicians with their data was now taking shape.

Present on admission flags, for example for pressure sores, and individual named clinician data could transform the landscape, he said. It was time for other medical specialties to follow the cardiothoracic surgeons' lead in this respect.

Dr Davies said: "The role for the IC as set out in the Health and Social Care Act is very important and I am very pleased that that has been established. We are there to take the independent view of the information landscape and we will have very important powers regarding the data quality of central returns."

Mr McLellan's final question was about the business case. Who will pay for information – and on what basis? Providers might be responsible for providing data and ensuring its quality but it is CCGs who would need it for commissioning.

Mr Stout said that, ultimately, it was the taxpayer who footed the bill. "It will be built into the cost of running the system," he suggested. "Part of running healthcare will be collecting data that is practically useful to clinicians and needed by CCGs to do their job. If CCGs want more, then they can negotiate."

Dr Davies said the current reforms were designed to provoke a radical change in the system. "In that context I do not see this as a question of who pays for information," he said. "I see information as being part of the care package. It flushes out that whole issue of money spent on this means no money spent on that."

There are a lot of questions around information but fewer answers. If the reforms are going to succeed and deliver a sustainable NHS, then everyone – managers, clinicians, CCG leaders, the IC and the NHS Commissioning Board – need to start thinking about them fast. ●

system. As the Audit Office's recent review of payment by results data, *By definition*, highlighted: "During the last contracting round, problems with data definitions caused the late signing of numerous contracts, with many going to arbitration. The values of these disagreements were significant. For one trust, emergency admissions and day surgery with a value of £7.4m was questioned. At another trust the commissioner negotiated a discount of £5.95m because of the apparently high number of emergency admissions."

Working in a provider unit, Mr Sidhu wanted to see an independent mechanism for validating data strength and quality. While this should be an independent function, he also argued for more professional coding and information within provider organisations. "There is a responsibility for leaders to move [the coding] function from being a bureaucracy to something that adds value," he said.

Mr Alessi was provocative. "I think forcing a move to SUS from SLAM [service level agreement management] is the first and most important thing," he said. "If SUS was a method for payment then clinical coding would become very sexy."

Mr Singer felt that SLAM, currently provided by Civica to 185 trusts, could work well with SUS. "Why is £40bn of NHS

money going through SLAM?" he asked. "The IC has said that they understand that there is a need for local and national data so let's start bringing SLAM and SUS together. There is a need for local ownership and a concern about having one big system that does everything for everyone."

Mr Sidhu brought the provider perspective to this point. "Normally, we would go with SLAM," he said. "But commissioners have pushed for SUS at a dramatic level. They have forced up the quality of data going into SUS as a consequence and it is a benefit to us. The real debate is how we understand the reasons for differences in data."

Mr Singer pointed out that some providers were now taking the SLAM commissioning model and doing their own data quality assurance, sometimes with dramatic results. "North Middlesex is seeing a massive reduction in conversations between commissioners and providers about data reconciliation. They are taking out the 80 per cent of