

The data challenge faced by PBC

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Dr Mike Ramsden, NAPC chief executive and chair of the NHS Information Centre, spells out what the difficulties are and what help is on the way

What are the biggest PBC data problems?

I can't stress enough that the quality of data available to PBC groups is extremely variable around the country.

Practices need data that lets them know what happens to their patients when they receive care from another provider, so they can try to change things if they want to.

You need to be able to see:

- what's been spent on your patients
- what care they've received
- how their care has been coded in the system
- if the figures or codes used are the correct ones.

In terms of quality, at one end of the spectrum there are some GPs who still don't have an indicative budget and then at the other there are areas where the data is flowing very well and good commissioning is happening as a result.

In the middle area there are complaints from GPs that although they have an indicative budget, it's pretty meaningless because they don't know what's actually been attributed to it.

Many of our [NAPC](#) members tell us that they just don't have sufficiently detailed information to gauge what's happening to spend-against-budget.

Data that is out of date is also a common complaint. Not only does poor data hinder commissioning decisions but it also makes integrated care more difficult to deliver. A scenario I often hear is where a patient is admitted, then discharged, becomes ill again and is readmitted. The first the GP hears about their patient being ill is after the second admission has happened.

Those responsible for spending have to know the implications of their decisions and keep control of what they're doing. When you have data, you can adapt.

Information is key to decision-making. If people are deprived of it then their decision-making will suffer. And PBC is all about better decisions being made.

Why is it so bad in some areas?

In some cases PCTs haven't given it sufficient priority or it's been defensiveness on the PCT's part – they don't want to let go of the responsibility.

But it would be wrong to point the finger exclusively at PCTs. There are a variety of reasons why information is not available. Some of it is down to the provider organisations (including acute trusts) not giving the data to the PCTs.

Sometimes the information the PCT receives from providers is rubbish and there is a case to validate very carefully what comes from providers.

You get poor coding that leads to wrong allocations and there are also allegations of 'gaming' where trusts have been accused of trying to gain maximum income from a single referral by allocating the highest tariff rate.

We have Payment by Results now but we are still dependent on how much effort provider organisations put into coding.

Under fundholding, practices were keen to do deals on the prices of procedures and this did aid information flow but Payment by Results and the national tariff have done away with that. However, the flip side of fundholding was the bureaucracy involved with practices having to generate an invoice for every patient. We have to get to

a situation where we move away from the fundholding bureaucracy extreme but where information about individual patients still gets through to commissioning groups so they can make decisions about the way forward.

What will change things?

We are starting to see procurement arrangements where data requirements are built into contracts to guarantee quality standards. But there is still a feeling that providers don't always treat data collection with the degree of priority that it needs.

There is an increasing recognition among top PBC policymakers that information is key to successful commissioning and more PCTs are working with practice-based commissioners now to ensure that a proper approach to information is taken.

There is scope for optimism. Organisations such as the Information Centre are producing tools and products that will also help commissioners. The Information Centre is responsible for the development of secondary uses services (SUS), which is obviously central to all PBC data.

ALL ROADS LEAD FROM SUS

Secondary Uses Services (SUS): an NHS-funded body that draws its data from hospital activity in England

Commissioning data sets (CDS) – the most unrefined data

Hospital episode statistics (HES) – more refined version of CDS

Commercial organisations (Dr Foster and the like) adapt SUS data to suit user's needs

Can practice-based commissioners reach the data parts that others can't?

Practice-based commissioners bring two very important things to the table. PBC groups are much closer than PCTs as commissioners to patients. They know first hand what's happening to their patients or what needs to happen to them.

The clinical knowledge GPs have can't be overstated either. Their confidence to challenge episodes of care, coding and tariffs for certain conditions can – and should – really shake things up.

A lot of the blame for data problems seems to be laid at PCTs' doors. Is that fair?

I don't think it is fair. The solution to these problems requires PBC groups and PCTs to realise they need to work together to change what providers are doing – a sense of 'we're in this together' and trying to work alongside your PCT rather than against it.

I appreciate some commissioners don't feel they're at that point with their PCT yet and don't feel they're getting what they need. But tenacity is everything and the DH has put so much emphasis now on the 11 world-class commissioning competencies.

The main guidance relating to PBC dictates that information should be provided to PBC groups.

If all else fails then you can also turn to your SHA for help and I would couch it along the lines of: 'What's your stance on this? We want to make a real difference and we've got to crack the information problem and need the SHA's support.'

What advice do you have for practice-based commissioners frustrated with their data?

Work as hard as you can at the local level with the PCT and the providers that you use. That's where you can make progress.

A top-down approach dictates and SHA instructions can only ever go so far. Try to pursue your PCT and get designated people who analyse the data so you have a name to contact and build a rapport with. Areas that have made progress with data have reported this has been a big driver for change.

PCTs would acknowledge there are flaws but they are not in my view wilfully obstructing information. By working together we can often find a way through problems that otherwise become a source of conflict and friction.

Interview by Susan McNulty, editor