

Reducing the need to use individual medical records for invoice reconciliation around A&E and other ‘event-based’ commissioning

Nothing in this paper should require additional work by front-line clinicians. Some hospital systems will require changes to deliver the data needed for reporting – and there will need to be oversight arrangements, to which we will come later.

Fundamentally, there is a need for the care providers and commissioners of care who lead on this work to answer a simple question: **What information is specifically needed, for what purposes?**

It is imprecise and irresponsible simply to say “we need all the data for anything”. Such an approach would also be excessive.¹ Commissioning and measurement of services must not take place out of ‘policy-based evidence-making’.

Some data will ultimately be published as open data; some of it should be restricted to strictly-controlled internal use only. The published data should allow third parties to ensure that the commissioning process hasn’t created perverse incentives. Ill-considered or inadequate implementation may lead to a repeat of past perverse incentives, which it is claimed have cost lives. This being the case, the reasons for and incentives behind any changes should be made transparent.

The current model, one of building large pools of bulk personal datasets², is a model that was developed in the late 1990s – i.e. around the same time as Internet Explorer 6 was being designed – and neither is suitable for use in 2015, as the NHS is highly aware.

When developing new datasets, there is clear need for exploratory work to examine whether the data to be used are accurate and that any new dataset will be fit for purpose. Such work is clearly research – producing publishable knowledge of why a new metric is to be constituted in the way it is, and the tradeoffs involved, before the metric is produced on an ongoing basis.

The difference between research and a ‘fishing expedition’ is largely a matter of consent and governance, and CCG-level Information Governance is insufficient for unsupervised access to the sort of bulk personal datasets involved.

medConfidential does not dispute that bulk personal datasets in some form may be necessary for exploratory research; that is the nature of research. But any and all such bulk personal datasets – including potentially a fully-linked medical history, where consented – should only be made available to approved researchers in a safe setting. An expansion of the HES Data

¹ According to the Third Data Protection principle, “Personal data shall be adequate, relevant and *not excessive* in relation to the purpose or purposes for which they are processed”, Schedule 1, DPA 1998: <http://www.legislation.gov.uk/ukpga/1998/29/schedule/1>

² Discussion of ‘bulk personal datasets’: <https://medconfidential.org/2015/collect-it-all-comes-to-the-nhs/>

Interrogation System (HDIS) facility could provide relatively straightforward access for bodies to request their own statistics, produced automatically into the future according to their remit.³

Deconflating confused incentives

Producing CCG/GP-level aggregations of events will allow hospitals to be very clear about areas where A&E is providing care that should be provided by a GP, or similar. These are then issues which the CCG/GPs in the relevant area should be encouraged to take up. Some of the datasets may also focus on or identify where other steps could be taken, e.g. an area with a disproportionate number of citizens having serious car accidents may wish to have an NHS-associated safe driving campaign to reduce the number of accidents – prevention being better than treatment.⁴

An alternate proposal is the possible merger of invoicing into the definition of direct care, “as happens in the US”. However, not everything in the US health system is a model to replicate. The adoption of such an asinine proposal would be a dramatic shift for the NHS, representing the final prerequisite for the end of the UK’s ‘single-payer’ model of healthcare. Those proposing any such change (including parts of NHS England) must be extremely clear about the ramifications of their proposal.

The NHS’s Five Year Forward View, and NIB publications relating to its implementation, raise the pressing question of whether the NHS wants to be building more bulk personal datasets for commissioning in secret silos, or to provide an evidence base for well-informed, democratic debate on health care decisions in localities.

We note the legal title of NHS England is the “NHS Commissioning Board”. Knowing what services to commission is the most difficult thing it does, so any decisions must be fully transparent, with all of the various metrics informing those decisions being published.

Attempting to cram audit and verification into the same data product with every other purpose will result in problems. Where a particular aggregated statistic raises questions, those questions should be asked, and answered, by the relevant bodies – with those who hold the data requiring justification. Only when trust between bodies has demonstrably broken down should a third party audit/verification process be engaged, and any provider or body with an excessive number of such audits may be worthy of additional commissioning scrutiny.

³ Relatively quickly, we would expect a set of figures that almost everyone wants to be identified/defined, which (over time) should be standardised and published - but which, in the interim, can be created ‘on demand’ for each area within HDIS, while standardisation and approval is progressed. Such a mechanism would also allow for the ‘decommissioning’ of some s251 flows, as it provides a rapid-response production capability for any information that is currently created using individual-level data but which gets missed from the first tranche of structured published figures - and a rapid-response function for emerging priorities.

⁴ An existing example of just such a use case was ‘Getting the Right Treatment’ in Tower Hamlets: <http://www.thensmc.com/sites/default/files/Getting%20the%20Right%20Treatment%20FULL%20benchmar%20case%20study.pdf>

Why the *status quo* is broken

The regular publication of an adequate variety of standardised measures for commissioners should (also) provide for meaningful cross-checking. So if one particular measure is prioritised for a period, while the figures for that measure should hopefully improve, the publication of other measures alongside and related to it should be able to show whether or not that “improvement” was at the cost of regressions in other measures – and whether the ‘net overall effect’ has been positive. Such changes and trade-offs may be acceptable, and that is a valid matter for public debate, but the metrics should always ensure they can be debated in an informed way.

The various consultancy companies offering services to the NHS can also watch for the effects of interventions – either by themselves or their competitors – and the trade-offs inherent in those processes can also be known. These statistics must all be produced automatically and published on a regular, fixed cycle with the process assured by a trusted body (which, currently, is HSCIC).

One of the key underlying drivers for the mass sharing of bulk personal datasets is a lack of trust between bodies and divisions *within* the NHS. Simply put, accountants in one part of the organisation do not trust the accountants in another not to mislead or offer them misleading information. While regular, ongoing statistics can be produced by HSCIC using information provided to it, the Department of Health must be clear that penalties for providing false or misleading information⁵ apply here also.

For those familiar with the GP Extraction Service (GPES), which allows approved and agreed queries to be run on a GP practice’s dataset, and for the aggregated outputs to be returned to the requestor – all observed by HSCIC, with multi-party governance across the system – this may sound familiar. It should.

The GPES principles, processes and protocols ensure that all parties are respected and treated fairly. A ‘GPES-beyond-GPs’ could and would have to respect the interests of all parties involved, with the aim of producing aggregated data for better care. Any such approach must, however, be based on existing open standards that recognise the sensitivity of requests and the need for full transparency on all such flows.

A process to list the statistics required

The questions that commissioners and accountants may wish to ask will vary for a range of reasons. However, as (to be lawful) purposes must be defined, the complete list of these questions is finite and can be enumerated – meaning that, over time, the aggregated, properly-treated answers can be generated automatically.

⁵ Sections 92-94, Care Act 2014, c. 23, PART 2: False or misleading information:
<http://www.legislation.gov.uk/ukpga/2014/23/part/2/crossheading/false-or-misleading-information/enacted>

These non-disclosive output datasets, produced and published in a timely fashion, could also be used for other purposes, e.g. to tell if “A&E is busy today”. The full list of datasets available, and their frequency of publication, should be in a Register that is published as open data. This would facilitate and enable informed discussion and debate on new measures, and between measures – even, and especially, measures proposing new models of care or treatment.

The alternate world, which ignores the compelling argument for more appropriate, aggregated counts, would be one of the continued mass ‘sharing’ of bulk personal datasets to non-medical staff and others, for non-direct care purposes. Continuing down this path puts the reputation of – and public confidence in – *all* types of secondary uses at risk.

Were the opt-out offered by the Secretary of State in 2013 and (albeit imperfectly) manifested in the NHS Constitution to be revoked in one of the fits of bureaucratic intransigence for which NHS England is renowned, we believe this would lead to a proliferation of patient actions beyond the NHS’s control, such as DPA Section 10 notices⁶ prohibiting processing, and challenges under broader Human Rights law.

The NHS should seek an end state where no individual-level clinical data is required for invoice reconciliation. There is no reason for this not to be the case before the end of the next spending round.

The NHS must run on evidence-based policies that relate to what is best for citizens’ health and care, within known constraints. The widespread use of bulk personal datasets as opposed to properly researched, well-designed and targeted metrics and specific measures for specific commissioning purposes, will not only perpetuate some of the worst data handling practices; it will in all likelihood fail to improve understanding, efficiency or care.

NHS Protect

Where an NHS body believes figures are being fiddled, that constitutes fraud – or an offence under Sections 92-94 of the Care Act⁷, if it relates to care – which is within the remit of NHS Protect to prosecute. If there are insufficient aggregated statistics to meet or measure a particular standard, then additional ones should be designed and produced, at minimal burden to the providers themselves. NHS care providers shouldn’t be playing forensic accountant; that’s NHS Protect’s job.

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⁶ Section 10, Data Protection Act 1998: <http://www.legislation.gov.uk/ukpga/1998/29/section/10>

⁷ <http://www.legislation.gov.uk/ukpga/2014/23/section/92/enacted>

Questions towards implementation

Some initial thoughts on data, that will fall roughly into two categories:

Data for A&E:

- Admissions (and source, and time since last admission)
 - will likely need numbers of incidents, repeat incidents, severity, time period, by CCG/GP of patient (based on PDS)
- The nature of those counts – and the various criteria for them – should be agreed by hospitals, commissioners and medics.

Data for Commissioning around Hospitals:

- What metrics do Commissioners need, from the data held by hospitals or elsewhere?
- Where there is a clearly identified need, design an aggregated tabular dataset.
- Publish aggregated figures at CCG level, with small numbers suppressed
 - unsuppressed or lower geographies may be released to CCG for authorised internal use via a secure electronic environment, allowing simple relevant comparisons between appropriate other geographies