Overall approach to assurance and evaluation of GP at Hand (GPAH)

Introduction

This paper provides a draft summary of the overall approach to assurance and evaluation of the GPAH practice. It outlines:

- The principles underpinning the evaluation;
- The questions answered by the 'assurance', 'independent evaluation', and 'ongoing analysis' parts of the GPAH practice;
- Some of the key data sources for the assurance and evaluation.

Principles

A. A need for prioritisation. We cannot answer everything, and the evaluation doesn't need to be (and in our time scales cannot be) totally comprehensive. Prioritisation should balance importance (e.g. where policy makers, or the CCG needs an answer quickly), against the feasibility of [rapid] evaluation.

B. Share widely, and ensure all stakeholders are able to influence the direction of the evaluation. Produce bespoke recommendations for the CCG and NHSE. These recommendations will need to deal with both immediate policy concerns (e.g. around the financial impact on the CCG of GP at hand), and horizon scan for future issues (e.g. what does this mean for digital-first primary care?)

C. Identify opportunities for quick, fact-based analysis that will provide rapid insight into key aspects of the practice and its impact. Use this to support and enhance the CCG's assurance role.

D. Recognise that GP at Hand will change and develop, therefore what we evaluate now might not be what we evaluate in 6 months' time – and prioritise accordingly. Recognise that as well as looking backwards at the effects of GP at Hand, NHSE and the CCG also need to think ahead to what might happen in the future (e.g. entry of other players into the market) and design policy accordingly. Evaluators will therefore need to be flexible in their approach to budgeting, developing their work plan, and in how they work with the CCG and NHSE.

E. Use appropriate comparators and counterfactuals:
    - We will want to compare the GPAH practice to the practice that would otherwise be received, but there will also be insight from comparing it to a benchmark for "excellent" primary care (e.g. one that is embedded within the local community, offers continuity of care and digital first).
    - Bear in mind that the current GP At Hand practice may not be the same as the long term sustainable model if, for example, the financial model changes.

DRAFT Overall approach to evaluation

Below we summarise a draft of the overall approach to the evaluation. This draws out the key questions that will be answered by the three different phases of analysis – CCG assurance; NHSE internal questions; and the independent evaluation.

Assurance (August 2017 – onwards)
Led by: H&F CCG clinical review team
Supported by: Analysts from NHSE's ORE
Aim: the majority of this work will focus on supporting the CCG to conduct an ongoing, thorough clinical assurance process to ensure that the practice is safe and effective. It will be led by the CCG, with additional analytical capacity offered by ORE.
Key questions:

1. **Clinical review**. Is the practice safe, meeting its contractual requirements, and have they addressed the questions raised in the previous clinical review?
2. What is the **financial impact of GP at Hand on CCG finances**?
3. What is the **financial impact of GP at Hand on primary care**

Independent evaluation (March 2018 - onwards)
Led by: Independent evaluator
Managed/ overseen by: H&F PCCC, with technical/advisory support from ORE
Aim: Provide robust, independent, and rapid analysis of the outcomes and impacts of GP at Hand. Build on any existing analysis already undertaken by NHSE and the CCG.
Key questions:

1. **What is the GP at Hand practice?** How is it staffed, what practices are offered, what is the business model, and how is this likely to change?
2. What is the impact of GP at Hand on **users of the practice/ their registered patients?** How does it affect experience, clinical effectiveness, continuity of care, equity and utilisation? Who does it work well for, and why?
3. What is the impact of GP at Hand on **the wider system?** This includes: the quality of care offered in other GP practices (building on other work looking at finances); referral pathways and quality of referrals; overall demand for primary, secondary, and community care.
4. What is the impact of GP at Hand on **the workforce** – both those employed by GP at Hand and the wider primary care workforce?
5. What does the **future for a digital-first model look like**? What policy changes should NHSE be thinking about?

Rapid analysis of emerging policy questions (January 2018 – onwards)
Led by: ORE
Reporting to: NHSE policy makers/H&F CCG
Aim: There are likely to be a series of questions that emerge on GPAH as the practice develops. NHSE may want some rapid, focussed, policy analysis on these. However, there is a need to keep the scope and focus of the independent evaluation relatively well defined. ORE can therefore provide this rapid analytical support to NHSE, with appropriate inputs and sharing with the independent evaluator.

Data sources and metrics

The ITT below, and annex, outlines a comprehensive list of research questions. The table below summarises the data sources available to answer these questions. N.B. that the evaluation will also make extensive use of qualitative data.

Source	Metrics/ questions answered
GP at Hand data	• Patient demographics and utilisation (N.B. some also likely to be held by CCG). • Business model. • Usage and effectiveness of AI triage; • Workforce makeup and utilisation.
CCG data	• Patient demographics and utilisation for GPAH and other practices within Hammersmith and Fulham (N.B. significant overlap with data held by GP at Hand). • Spend data on secondary care in H&F.
SUS/ HES	• Secondary care utilisation (pre and post) • Patient demographics
CPRD/ other primary care databases	• Comparative data on primary care utilisation/ registered patient health at non-GPAH practices
GP patient survey	• Satisfaction with GPAH and other practices; • N.B. significant data quality and comparison issues
Prescribing data	• Antibiotic and opioid prescription rates