The development of a quality scorecard to support primary care commissioning and contracting

Background

As world class commissioners, PCTs have a responsibility for ensuring the highest quality of service to their local population across all areas of primary care contracting. This is specifically defined in Competency 8. The PCT will need to spend time developing both its strategic and operational priorities to ensure improved quality of service, access and cost effectiveness, and to allow for innovative commissioning according to local need.

The NHS Next Stage Review established a clear vision for quality. High quality care for all emphasises the need for professional development, and stronger clinical leadership, it calls for the development of information tools to compare clinical quality and productivity, and urges clinicians to record the experience of patients to demonstrate high quality of service. The definition of quality used in the document and now widely adopted is that there are three dimensions – clinical effectiveness, patient experience and safety of services. The Next Stage Review document Our vision for primary and community care outlined steps which PCTs can take to deliver improvements to service quality specifically in primary care.

Since the Next Stage Review was developed, the financial situation for the NHS has changed. In the current economic context, it is imperative that the NHS identifies efficiency savings with the focus firmly on improving quality and efficiency simultaneously – this is the core of the Quality and Productivity Challenge. Improving quality and value for money are two sides of the coin – prioritising effective treatments, reducing waste, ensuring that referrals and prescribing are managed correctly all contribute to quality of care and a more efficient health service.

From 2012, the Care Quality Commission will register all primary medical care providers. This will help commissioners ensure standard assurance and support them to manage poor performance issues. At the higher end of the scale, the RCGP is currently developing an accreditation scheme that looks specifically at organisational standards, which will help commissioners and practices to define quality. All providers of NHS care, including GPs and dentists, will also have to publish quality accounts that set out the quality of care they provide to their patients.

Quality scorecards (sometimes referred to as balanced scorecards or performance frameworks) can be used to identify exemplars in developing high quality services, resulting in the sharing of best practice locally to ensure equity of service provision for all patients.

PCTs will not be starting from scratch. As part of the World Class Commissioning series for Primary Care, the DH has recently published a guide: Improving quality in primary care. This sets out steps to measuring quality and provides a possible framework for quality scorecards.
Many PCTs are already adopting this approach. Northampton PCT has recently developed a scorecard to determine future commissioning decision. Tower Hamlets PCT has successfully developed an evolving scorecard methodology to support contracting and performance management. As part of its bold re-commissioning of PMS contracts, Suffolk PCT has developed a dynamic performance framework to support the ongoing contract implementation process.

This approach is not restricted to primary medical care services. In partnership with the Department of Health, NHS PCC has developed a performance framework for dentistry. NHS PCC has also developed a pharmaceutical needs assessment toolkit for community pharmacy commissioning. Both have been adapted by subscriber PCTs to inform commissioning and future investment in service provision.

The primary and community care strategy also encourages community services to develop a quality performance matrix to identify best and emergent practice and to inform PCT and local authority commissioning decisions.

Benefits for primary medical care

The scorecard approach for primary medical care can both measure and score general practice. To quote Tower Hamlets PCT, it can “transparently assess the quality of general practice on an annual basis and speed up the rate of improvement”. The scorecard itself can be used to manage contracts effectively, inform patients about the effectiveness and efficiency of their local services, determine future commissioning decisions and identify areas requiring support and development. In the development of any quality scorecard, a PCT should be clear about what the information is being collated for and how it will be used.

In summary a balance scorecard can:

- Promote quality and support improvement in efficiency and effectiveness
- Detect falling performance early enough to initiate preventative action
- Detect poor performance and provide evidence for improvement or decommissioning of services
- Demonstrate where there is capacity for further service development
- Showcase the need for remodelling and establishing new patient care pathways
- Provide data and information for effective commissioning (including consolidating public health data, patient satisfaction levels, access and responsiveness information, QOF data, etc)
- Demonstrate high quality of service to patients to inform access and choice

Advantages and challenges of the quality scorecard approach

The process of implementing the scorecard can improve quality standards – however, PCTs need to invest significant this time to develop them and make them work.

Contractual compliance can be rigorously checked, but generally PCTs rely on service providers demonstrating – or simply stating - that they are meeting contractual standards. It is therefore important that PCTs develop further guidance and use audit tools (examples can be found on the NHS PCC website).

Whether contractual standards should be part of a quality scorecard also deserves consideration. PCTs should act to ensure that regulatory and contractual requirements are met in any case – in which case there may be no point in including them again.
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Service providers are often concerned about their ratings against different quality score indicators, particularly when compared to their peers. Effective benchmarking tools can be a powerful motivator for improving quality.

Data and data quality are big issues. There are now several tools on the market which PCTs can access to obtain local and national data sets, but it is the translation of this data into useful information which can be both challenging and time consuming. Organisations such as NHS PCC, individual Public Health Observatories, NHS Comparators and NHS Benchmarking are actively seeking to support PCTs in developing data sets to inform commissioning, quality impact, contractual monitoring and performance of providers. Some examples of these are set out in more detail below. PCTs should assess what is available and how best they can use it locally. This data can inform a quality scorecard approach allowing, for example, standardised comparisons between practices.

Principles for successful use

1. Developing a vision

The first requirement for the quality scorecard user is to establish a clear vision from within the PCT of what constitutes good, acceptable and unacceptable performance in primary care, within a strategic vision for the local population. The vision should be simple and functional and structured around things that are important to patients, commissioners and service providers. These might include:

- Access
- Premises
- Convenience/responsiveness
- Safety
- Quality outcomes of service delivery
- Improvements in the population, directly linked to public health priorities (eg vaccination campaigns)
- Compliance with regulations and regulators
- Corporate priorities and ambition in relation to reducing health inequalities
- Local priorities, issues and concerns

The vision should develop into a clear and agreed strategy for primary care aims and achievements within which there should be an understanding of:

- What is acceptable and desirable
- The place of performance improvement
- Performance management
- Assessment of the provider market and the benefits and risks of market competition
- Collaborative working, such as integrated care initiatives with local authorities
- Choice and development fit within the overall strategy
- What tools and techniques will be deployed

This should be linked with the priorities and guidance contained in Our vision for primary and community care, which highlights PCT strategy within the wider primary care agenda.
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NHS Coventry included practice resource and population need (age structure, percentage South Asian) in addition to performance measures. This meant that commissioners were able to highlight resource inequity and show that good performance could be achieved for deprived populations.

2. Scorecard characteristics

The quality scorecard should contain measurable and reproducible indicators. These should not simply reflect corporate priorities but should also be acceptable to modern standards-setting bodies such as the Care Quality Commission and the RCGP. Delivery mechanisms that improve care should underpin the vision. The indicators and standards must be:

- Clearly described
- Measurable
- Already recorded and collected for another purpose
- Examples of universal practice to allow for effective benchmarking

Some examples of indicators of where PCTs can source suitable indicators include:

- **Primary Care Commissioning Support Application** has publicly available data on 101 different metrics. It also allows PCTs to enter additional data about their practices
- **NHS Benchmarking** has developed a Quality and Productivity tool, which allows PCTs to measure the their efficiency of services and a Health and Outcomes tool, which allows PCTs to see how they perform in terms of programme budgeting outcomes.
- **NHS Information Centre** provides data on QOF achievement, prevalence and exception reporting
- **NHS Comparators** compares aspects of local activity, costs and outcomes
- **Public Health Observatory** community profiles enable PCTs to understand the wider determinants of health so they can consider where to allocate resources to tackle health inequalities

The development of a quality scorecard assessment process itself will represent a significant change in approach, culture and relationships between commissioners and service providers, and must be supported like any other change management process. This includes the engagement and involvement of senior PCT staff, PCT clinical leads and public health leads. The organisations must build relationships with the service providers by effective engagement, regular communication methods and protected time for evaluation and discussion.

**NHS Haringey have used the following three levels of information:**

1. A large database used for annual contract monitoring
2. More focused balanced scorecard
3. Practice dashboards

**Tower Hamlets PCT structures their scorecard into three sections:**

1. contractual compliance
2. key indicators
3. developmental indicators
Quality scorecard approach to measurement

The vision of quality and performance is the foundation of what the PCT might want to measure through:

- A set of indicators
- Good practice
- Locally agreed fair metrics for practice
- A demonstrable way of supporting quality improvement through the identification of best and less good performance
- Banding system to measure good, acceptable and unacceptable levels of quality

PCT responsibilities for delivering the quality scorecard

To administer the scorecard effectively, the PCT should:

- Develop best practice in contract management
- Ensure there is expert information management and robust analytical support
- Appoint trained assessors who can work with, support and, where necessary, challenge performance
- Introduce incentives and educational packages of support for leading edge and struggling practices
- Support arrangements for practices in difficulty, such as providing locum support
- Have a dynamically managed performers list to ensure that the problems of poor performance do not just transfer within the locality, or indeed outside the area where performers chose to travel to work.
- Have a decommissioning process to be used as a last resort to protect patient care
- Effective appraisal systems, a supporting framework for performance improvement and education and succession planning strategy should also be applied.

Delivery mechanisms

If this does not already exist, the PCT may wish to consider the establishment and role of a clinical governance group as a sub committee of the PCT in order to develop the agenda for quality and delivery. This group should:

- Include and be supported by senior managers
- Operate across all professional disciplines in primary care
- Use authority as a subcommittee of the PCT with the appropriate accountability
- Have access to public health information, service provider information and existing PCT data to support their decision making processes
- Be supported by technical data analysis expertise
- Have the power to recommend action to the PEC and PCT Board.

Deliverables required from the quality scorecard itself can be overseen by this group to ensure effective benchmarking, reporting on strategic analysis and delivery of operational interventions as and when required.
**Action planning**

Wherever the strategic responsibility lies for decision making within the PCT, this should be underpinned with clear policy and timetable for administration of the scorecard and managing the resulting outcomes. The following steps support an effective action plan:

1. **Preliminary PCT discussion**
   - Decide in principle on the areas for indicator development
   - Examine other scorecards against criteria of relevance to the PCT, experience of others and ease of implementation
   - Compare the indicators identified with the availability of information
   - Compare the areas with Standards for Better Health/Care Quality Commission requirements and those contained in the operating framework
   - Look at how measurement might contribute to understanding and fulfilling the PCT strategic objectives
   - Look at the secondary uses of the data, for planning and commissioning, as well as service development and improvement

2. **How to use quality scorecard results**

Informed commissioning priorities for service development depend on how the results are used. Ideally, the scorecard should both benchmark trends across the PCT region and support individual practice development.

Banding schemes, incentives for delivery, sanctions against poor performance, effective publication and investments schemes to deliver change can all be informed by using the scorecard methodology as outlined below:

<table>
<thead>
<tr>
<th>Banding scheme</th>
<th>A balanced scorecard actually does score practices; but to suggest that this should be in anything other than broad categories is spurious. The bands are the foundation of rewards/incentives and sanctions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incentives for delivery</td>
<td>Good practices will wish to take part but also expect to receive development support; practices needing development may not see the merit, especially if they score badly. But there can be both a stick shaped incentive for this group in the support and development mechanisms to achieve Improvement standards.</td>
</tr>
<tr>
<td>Sanctions against poor performance</td>
<td>Remedial action may be required for contractual standards; the balanced scorecard scheme should neatly segue into performance management – whilst remembering this will not be the prime objective of the scheme, or it would be unsaleable.</td>
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</tbody>
</table>
### Publication of results

This depends on confidence in the results and confidence in practices, although non of the data should be patient specific or not in some way in the public domain, it is the way it is treated that makes the difference. Several levels of publication are possible; as an aggregated result to the PCT board and practices; as separate practice results to the PCT board and own results to each practice; in general, publication might be limited in the first year of the scheme.

### Investment for change

Depending on results, the PCT might find that there should be investment across the board (ie in other services as well as GP practices) in, say, access, childhood immunisations, improving the patient experience and prescribing, as well as investment in practices that require development.

### 3. Decide on the infrastructure to operationalise and operate it.

<table>
<thead>
<tr>
<th>Administration</th>
<th>The scorecard approach demands good communication and timetabling, timely responses and clear accountability.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data</td>
<td>Collection should be electronic where possible, using existing channels eg QMAS but with consideration of novel data extracts (as in the QOF assessor toolkit).</td>
</tr>
<tr>
<td>Documents</td>
<td>detailing, say, local audits, should be managed electronically where possible, in standard templates</td>
</tr>
<tr>
<td>Analysis</td>
<td>and “translation” into scores should be agreed and automated where possible</td>
</tr>
</tbody>
</table>

### 4. Decide on a framework for objective measures and indicators

There are a number of examples of quality frameworks now being actively shared – numerous examples are to be found on the primary care medical pages of the NHS PCC website – but what is most important is that the quality scorecard reflects local priorities and requirements.

### 5. The role of the PCT board

The right time to seek board approval and sign-off for the process is when the primary care strategic team is confident that the shape of the policy, the primary care strategic priorities and scorecard itself have clear outcomes. Regular highlight reports and updates on the outcomes need to be shared with board members to ensure executive engagement with the process.

### 6. Development of a collaborative approach

When the elements of the policy and shape of the quality framework are clear, this needs to be shared with the Professional Executive Committee (PEC) and then with the LMC (LDC/LPC etc). Clinical engagement is crucial for the successful implementation of a quality scorecard and PCTs who have already introduced a quality scorecard process believe that this is the most critical step.
Initial meetings with professional bodies should be managed in a non-confrontational way emphasising the need and value for collaboration. However the strategic leads must have the courage of conviction to be able to effectively describe the benefits for patients, the benefits for service providers and the support mechanisms that can be put into place to deliver an increase in quality of service. Details of incentives, financial and developmental, clear service objectives and timescales need to be clearly communicated.

Tower Hamlets PCT has a joint LMC / PCT implementation group to work up indicators and consider aspects of the scorecard. Final reports are sent to the LMC for ratification.

In NHS Medway, a Quality Development Framework has been developed with the support of Kent LMC, who recognised that PCTs would be required to produce a “mapping the baseline” tool and advised practices accordingly in their newsletter.

NHS Knowsley use their Communities of Clinical Interest Groups to agree their Balanced Scorecard.

7. Take stock

The development of collaborative approaches, methodology and implementation processes can be time consuming and demanding. There will be a requirement for several meetings and regular updates and discussions with service providers. It is important to regularly evaluate progress, update the board in inclusions and amendments and ensure that all are aware of any changes that are made to scoring methodology and content.

8. The value of joint implementation groups with the LMC

Implementation is a process of discussion, negotiation and support. It is essential that teams on both sides behave with professionalism and are prepared to consider all views and value all contributions.

It is important that PCT staff are well trained in facilitation and negotiation and feel supported at all levels within the organisation.

9. Presentation of results

It may not be appropriate for the results to be published externally in year one, but the PCT should have a clear position that this will be the case in year two. Organisations that have already undergone the process suggest writing to individual service providers showing their results compared to others.

Year two results should be presented to a public session of the PCT board to ensure full signup and onward commitment to the process for the PCT, service providers and public. Outlying issues can be referred to performance advisory groups, clinical governance teams and clinical leads within the PCT as required.

10. Learning exchange/launch event

To further embed commitment and engagement with the ongoing quality scorecard process, PCTs who have already introduced the process have seen great benefits from a learning exchange event, to reflect, review and reinvigorate the process. This can be done by hosting a facilitated workshop for all stakeholders, with defined objectives and outcomes. The event can showcase best and emergent practice and detailing incentives and support mechanisms for future implementation. The content can also include a review of timescales and amendments to future frameworks.
11. Quality scorecard implementation
Once the scorecard is introduced there must be continuous monitoring and process reviews with a commitment to swift and definitive responses from the project team and strategic leads. The PCT should be prepared to act at any time during the scorecard implementation process if poor quality performance is exposed and where risk to patients is evident.

NHS Suffolk funds a practice manager consultant from an established pool of practice manager consultants to work alongside a primary care commissioning manager, to support improvements that have been identified in an agreed remedial action plan. NHS Suffolk also funds GP mentors to provide confidential support and customer service training packages for receptionists.

12. Year-end results and future local action planning
The release of results should be agreed in advance with the PCT board and confirmed with the LMC. Resulting action plans should be developed and agreed with each service provider as a result of these outcomes. There should be opportunities to celebrate success but also swift action taken to assure patients and the public that quality standards are being met.

13. Improving the system
The framework can be changed in year two to include national and local policy strategic and operational priorities. Indicators that do not improve quality can also be refined and if necessary removed from the scorecard.

Further information and examples of balanced scorecards can be found on the NHS PCC website at: www.pcc.nhs.uk/346

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