

**Primary Care Contracting  
Commissioning  
Paper PCC/C/QDM/WB/0508**

## Quality Development Methodology using a Balanced Scorecard

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### Introduction

1. A PCT has a responsibility for ensuring delivery of primary medical care to the whole resident population. In discharging this responsibility, the PCT can expect to invest time, expertise and other resources to secure **improvement and increased cost effectiveness** of care – practically, and quality.
2. As part of a process of improvement, one method of *measurement* is through a balanced scorecard approach. **Implementation of the balanced scorecard should include a strategy to deal with the quality improvement issues that will arise where quality of practice is measured.**
3. The balanced scorecard approach is to measure and grade general practices; the purpose of the scorecard is to:

*“transparently assess the quality of general practice on an annual basis, and speed up the rate of improvement.” (Tower Hamlets PCT, 2007)*

A balanced scorecard *can*

- Promote good quality and support improvement in efficiency and effectiveness
- Detect *falling* performance early enough to institute preventive action
- Detect *falling* performance and therefore a first move towards preventing the consequences
- Imply where there is good capacity
- Imply where there may be a need for remodelling
- Provide commissioning data (for commissioning primary care and integrated services)
- Reassure patients.

4. There are other advantages - and drawbacks.

The **process of implementation is itself useful in improving quality** – but very time consuming.

Contractual compliance can be rigorously checked but the need for practices to verify that they meet contractual standards requires the **development of more guidance/audit** tools eg in relation to Medicines Act.

There must be clear thinking on whether to include contractual standards as part of the scorecard – none compliance forces the PCT to act, often in difficult circumstances.

GPs are concerned about their rating on each indicator - and in particular when compared with peers. It is a **powerful motivator**.

It is useful in **driving forward achievement** on indicators which are QOF rewarded, but where professional motivation is not enough to reach public health targets eg child immunisation. But it is tempting to put in too many indicators - especially those which are not currently financially rewarded, in order to meet national or PCT priorities.

**Data and data quality** is a big issue, eg cytology screening achievement. There will be different results from different data sources, in this case using QMAS (including exception reporting) or using public health submissions to DH.

The scorecard is an effective alternative **quality accreditation scheme**, allowing for standardised comparisons between practices

5. This paper is premised on the broad intention that the PCT have expressed that a balanced scorecard approach is the best approach to measured, sustainable quality improvement. The paper uses the example of and lessons from Tower Hamlets<sup>1</sup> who are in the second year of a scheme. However, whilst Tower Hamlets provide a template, local issues of quality may not be of the same order of magnitude or in exactly the same developmental areas; a **locally relevant and owned scorecard process** should yield the greatest benefit.

### Principles for successful use of a balanced scorecard

6. The first requirement is for a **clear vision at the PCT of what constitutes good, acceptable and unacceptable performance in primary medical care**, within a strategic vision for local health care.

7. **The vision should be simple and functional**, not structural; about things that are important to patients and commissioners, including, but not exclusively:

- access
- premises
- convenience/responsiveness
- safety
- quality
- improving the health of the population and protecting them (eg with vaccines)
- compliance with regulations and regulators

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<sup>1</sup> Whilst the Tower Hamlets balanced scorecard is a public document, PCC are grateful for permission to refer to it in this paper

- corporate ambition around health inequalities
- any local issues and concerns.

8. The vision should develop into a clear and agreed strategy for primary care aims and achievements, within which there is understanding of

- what is acceptable or desirable
- the place of performance improvement
- performance management
- competition
- collaboration
- choice and development fit within the overall strategy
- what tools and techniques will be deployed,

9. **Measurable indicators**, (acceptable to a modern, standard setting body such as RCGP, NCGST or HCC) and delivery mechanisms (to improve care) should underpin the vision. The indicators and standards must be:

- clearly described,
- based on every day practice,
- measurable
- already recorded and collected.

10. This is a process of change management. The approach must be backed up by PCT investment in senior staff time for primary care commissioning and contract management, including a strong programme of visits to each practice.

### Balanced scorecard approach to measurement

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

- a set of indicators
- of good practice
- agreed locally as a fair way of measuring practice
- aiming to support quality improvement and to identify less good performance, therefore
- banded into good, acceptable and unacceptable.

### Responsibilities of the PCT in delivering the scorecard

12. In order to administer a scorecard the PCT should develop

- Best practice in contract management
- expert information management and analytic support
- trained assessors who can also intervene in practices

- incentives and educational packages for leading edge and trailing edge practices
- support arrangements for practices in difficulties, such as drop in locums
- contract exit strategies as a last resort.

13. In addition, the PCT should have existing policies and a support framework, for education, development and performance improvement.

### Delivery mechanisms

14. The PCT may wish to consider the role of/setting up a clinical governance (CG) group as a sub committee of the PCT in order to develop the agenda for quality and delivery. The group itself should

- include and be supported by senior managers,
- be multiprofessional,
- use authority as a subcommittee of the PCT (and therefore also have accountability),
- be able to request information from public health, practices or elsewhere in the PCT,
- be supported by analytic capacity and
- have the power to recommend action to the PCT Board.

15. With appropriate membership and ToR the CG group can facilitate the development and delivery of the scorecard

### Action plan

16. Wherever responsibility lies, the PCT will have a clear strategy and timetable for administration of a scorecard and for managing the results.

17. **Step 1:** Preliminary PCT discussion.

- Decide in principle on the areas for indicator development.
- Examine other scorecards against criteria of
  - relevance to the PCT
  - existing experience of others
  - ease of implementation.
- Compare the indicators in them with availability of information.
- Compare the areas with standards for better health.
- Look at how measurement might contribute to understanding and fulfilling the PCT strategic objectives.
- Look at secondary uses of the data, for planning and commissioning as well as service development and improvement.

18. **Step 2:** Decide how to use the results from the scorecard

This is at an individual practice level and en masse, to inform PCT investment in development.

<b>Banding scheme</b>	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.
<b>Incentives for delivery</b>	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.
<b>Sanctions against poor performance</b>	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.
<b>Publication of results</b>	This depends on confidence in the results and confidence in practices, although none 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.
<b>Investment for change</b>	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.

19. **Step 3:** Decide on the infrastructure to operationalise and operate it.

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

20. **Step 4:** Decide on a framework for the **objective measures and indicators**

There is no good reason to start from the ground up; however, using the full blown Tower Hamlets framework is a big step.

Ensure the framework employs the right indicators, eg proposed appointments available per week per 1000 patients rather than GP whole time equivalent (wte) as a more meaningful measure of capacity, as Tower Hamlets decided this year.

21. **Step 5:** Decide when to **take it to the PCT board** – probably only when the development team is confident in the shape of the policy, the scorecard itself and the outcomes that the team wants to see.

22. **Step 6:** Develop a **collaborative approach**

There is **no point in unilateral implementation** from the PCT.

When the elements of the policy and the shape of the framework are clear, share with the PEC and then share with the LMC. Tower Hamlets directors believe that this is **the most critical step**.

Be well prepared for the initial meeting with the LMC. Whilst it should not in any way be confrontational (ie it *is* a collaborative approach), the team must have the courage of conviction. Describe the benefits for patients, but more importantly the benefits for practices, support for better practice and any incentives, including financial. Carry out a principled negotiation – one where you have realistic but stretching objectives and clear bottom lines.

23. **Step 7:** Take stock.

Step 6 can be exhausting and time consuming. It is not a single meeting. Framework development, ie earlier steps, should be proceeding in parallel.

24. **Step 8:** Develop a **joint implementation group with the LMC**.

Be prepared for attrition but have bottom lines. Behave with absolute professionalism. Don't try to negotiate everything on day one; remember a negotiation isn't over until it is over.

**Do negotiating training!**

Agree not to publish results in first year (but make clear you will in year two) Instead practices should get a letter showing their results compared with others.

25. **Step 9:** Present at a public session of the PCT board

This is for absolute sign up and onward commitment.

26. **Step10:** Launch event.

More commitment and a good send off! Detail at the event should include firm dates for each stage and the consequences for practices and PCT if X or Y happens.

27. **Step 11:** Run the process.

There must be **continuous monitoring and review of the process with swift responses** from the project team/owner. The team should be prepared to act at any time if really poor or dangerous performance shows up (unexpectedly).

28. **Step12:** Year end results and action plan.

- The broad outlines will already have been agreed with the board and LMC.
- The action plan should be agreed overall and with each practice.
- There should be an opportunity to **celebrate success**

29. **Step13:** Change the framework in year two.

That that may happen may be agreed, before the start of the first year, to manage in the latest obsessions and manage out indicators that do not work for the PCT.

*PL/NHS PCC  
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