How to develop and implement a Balanced Scorecard to tackle health inequalities
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For recipient's use
How to develop and implement a Balanced Scorecard to tackle health inequalities


FOREWORD

The Health Inequalities National Support Team (HINST) has chosen to prioritise the development and implementation of a Balanced Scorecard as one of its ‘How to’ guides for the following reasons:

- Inconsistent quality of primary care will deliver inequitable outcomes. In order to address this and have an impact at population level, approaches to development will need to be systematic and sustainable, and must address clinical and managerial systems and competencies.

- Specifically within the ‘Christmas tree’ diagnostic, it particularly addresses the following components:
  - local service effectiveness (2)
  - engaging the public (5)
  - known population health (6)
  - responsive services (9).

- Action in this area of work will help to contribute to the Quality and Productivity Challenge by providing a mechanism to develop systematically the quality and productivity of primary care.

- Successful adoption of processes similar to those outlined here would demonstrate good use of the following World Class Commissioning competencies:
  - primary care trusts (PCTs) as local leaders of the NHS (1)
  - patient and public engagement (3)
  - collaboration with clinicians (4)
  - stimulates the market (7)
  - performance management (10).
CONTEXT

The aim of this ‘How to’ guide is to produce a simple tool to help Spearhead areas to develop ways in which to measure the quality and capacity of primary care and deliver the 2010 Public Service Agreement target to reduce health inequalities. It does not provide new guidance but will draw on the findings/learning from areas where these tools are being used, and complements Primary Care & Community Services: Improving quality in primary care, particularly focusing on two of the seven identified elements: measuring quality and publishing quality information.1

This guide has built on the NHS Primary Care Commissioning (NHS PCC) paper Quality Development Methodology Using a Balanced Scorecard.2 It uses examples of and lessons from a number of PCTs who are at different stages in their development of a Scorecard. However, while these areas provide examples for this guide, local issues of quality may not be of the same order of magnitude or in exactly the same developmental areas; therefore a locally relevant and locally owned Scorecard process should yield the greatest benefit.

All residents need access to effective primary medical care, particularly in relation to the major contributors to early death. These are cardiovascular disease, cancer and respiratory disease, and all are especially relevant in terms of addressing health inequalities. Therefore, in order to achieve the 2010 PSA target, HINST regards rapid development of the quality of this sector as critical. Implementation of a Balanced Scorecard can improve both specific health inequality indicators targets and the quality of general practice more widely, which should have a positive impact on health outcomes.

A PCT has a legal 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 improved quality and productivity, and increased cost effectiveness of care. Strategically, the Balanced Scorecard can therefore support the delivery of the PCT’s quality and productivity agenda for the local population. The approach also demonstrates that the commissioners are working to achieve high levels of World Class Commissioning assurance and can use the evolving product as assurance evidence.

High Quality Care for All3 reinforces the NHS Next Stage Review vision of an NHS in which quality is the organising principle. This will help to ensure that improved quality and innovation can be realised. Its goal is for every provider of NHS services to systematically measure, analyse and improve quality. To support this, service commissioners will need to develop their own quality frameworks, combining relevant indicators defined nationally with those appropriate to local circumstances.

Most PCTs have now begun to develop Balanced Scorecards, the methodology of which has been evolving over the last couple of years. Balanced Scorecards are seen by PCTs as fundamental to ‘mapping the baseline’ in order to ensure that primary care is contributing to health outcomes within a community, and to inform commissioning decisions.4 However, this approach is not consistent across all PCTs, and for some this may be time for review, as all are being called to evidence quality and productivity in all areas of commissioning. The guide, it is hoped, will also help PCTs to review the purpose
of their Balanced Scorecards relevant to their current requirements, with regard to health inequalities and their processes of implementation.

The Balanced Scorecard will also support the Care Quality Commission’s planned registration of general practices from 2012; and the General Medical Council’s revalidation process of GPs. Ideally, there should be the aim of having this one dataset for many uses.

At whatever stage of its development, in those areas whose communities experience a high level of health inequality, the Balanced Scorecard should be set within the context of a primary care improvement plan or primary and community care strategy which aims to address health inequalities and improve life expectancy in the short term. NHS Next Stage Review: Our vision for primary and community care (www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085937) states that all PCTs should have a primary and community care strategy, which includes the primary care improvement plan.

To do this, indicators should focus on demonstrating, for example:

• that the numbers of people on primary registers and the predicted prevalence of a particular disease match (through case finding)
• that Quality Outcomes Framework (QOF) indicators are met or exceeded for chronic disease management
• that exception and exclusion reporting is at a minimum
• the level of health service access of particular communities who are likely to experience a higher level of health inequalities than the average for the population.

Examples of specific indicators are set out in Appendix 4.

A Balanced Scorecard for primary care is a collection of data from all general practices in a PCT area, across a range of locally relevant metrics. This will enable the management of performance and the identification of both developmental support needs and gaps in service provision.

ADVANTAGES AND CHALLENGES OF DEVELOPING AND IMPLEMENTING A BALANCED SCORECARD FOR HEALTH INEQUALITIES

Local leadership and ownership

PCT leadership and executive accountability for improving quality in primary care, together with effective clinical leadership and ownership, is crucial for the successful implementation of a Balanced Scorecard. This guide is premised on the fact that the PCT has clear commitment to improving quality in primary care and that it has expressed that a Balanced Scorecard approach is the best approach to measured, sustainable quality improvement. It has been identified that all successful programmes to improve primary
care quality that use a Balanced Scorecard have full Board sign-up and engagement. The Scorecard should complement other knowledge management tools, which themselves can populate further iterations of the Scorecard; for example, the Primary Care Commissioning Support (PCCS) application published by the Department of Health (DH) to support PCTs in assessing practice-level data, together with the NHS PCC quality and productivity calculator which looks at comparative PCT performance.

PCTs could also consider involving their equality and diversity leads to explore how this tool can be localised, incorporating other equality dimensions, national equality guidance and local equality policies.

**Clarity of purpose**

PCTS need to be clear of the purpose of having a Balanced Scorecard. Examples across the country have been as a developmental, performance management or commissioning tool, or (ideally) all three. More recently, following the introduction of World Class Commissioning, a number of PCTs have used a Balanced Scorecard to ‘stimulate the market’, using it as a way of ensuring adequate service provision in a local community and achieve agreed health outcomes described in the best practice guidance. NHS Northamptonshire used a Balanced Scorecard to support the production of an excellent primary care market management strategy. It can be used to determine key commissioning priorities and inform the wider primary and community care commissioning strategy.

**Examples of purpose from PCTs**

- Transparently assess the quality of general practice on an annual basis, and speed up the rate of improvement. (NHS Tower Hamlets, 2007)
- Address local issues and local need, addressing health inequalities, particularly in relation to access to primary care services and public health. (NHS Tower Hamlets, 2009)
- Provide a focus for supporting the development of primary care rather than performance management. (NHS Knowsley, 2009)
- Paint a picture of the practice and the context it is working in. The matching of deprivation and demographic data to public health indicators provides a useful context for performance and provides an insight into understanding what interventions may be appropriate. (Doncaster PCT, 2009)

However, there is a national move to focus on the performance of primary care through this methodology, rather than using it only as a developmental tool. This is described in the best practice guidance *Primary Care and Community Services: Improving GP services*. This publication describes how the PCTs can ‘map the baseline’ to begin a process of monitoring practice performance in a number of areas and support effective commissioning of primary care.
This may change over time, depending on the circumstances of primary care. For example, Tower Hamlets changed the Scorecard from a developmental tool to a performance/commissioning tool in 2008/09 – to strengthen commissioning, allowing practices to earn autonomy and improve the quality of service delivery and redesign.

Whatever the ultimate goal, a Balanced Scorecard can also fulfil a range of supplementary functions, including:

- to promote good quality, and support improvement in efficiency and effectiveness
- to detect falling performance early enough to prevent adverse consequences
- to identify appropriate capacity to deliver outcomes
- to identify areas where there is need for service redesign
- to provide commissioning data/information (for commissioning primary care and integrated services)
- to reassure patients in terms of the quality of service and published information, enabling patients to make robust choices about which primary care services they wish to access
- to demonstrate the value of primary care – making its role and impact visible
- to demonstrate that primary care is ‘fit for purpose’
- to unpick and improve the quality of data, which can reassure practices that they have the appropriate levels of investment
- to support the development of an effective, local, contractual performance framework where personal medical services (PMS) and alternative providers of medical services (APMS) contracts are in place.

*The process for implementation in itself is useful in identifying where there is a need to improve quality.*

**Example of practice**

Coventry PCT included practice resource and population need (age, percentage of South Asian ethnic origin – derived from Nam Pehchan surname analysis – and practice indices of multiple deprivation (IMD) score) in addition to performance measures. This was especially useful because it highlighted resource inequity and showed that ‘good’ performance could be achieved for deprived populations.

**Knowledge management, data quality and data reporting**

This is often a big issue. There can be different results from different data sources, for example in measuring cervical screening uptake using the quality management and analysis system (QMAS) or using public health submissions to DH. As a principle, as much data as possible should be sourced using the practice list of patients; where data is actually a projection or derived from a secondary source it may be more open to challenge, less reproducible and therefore seen as less reliable. Training, particularly in good coding, may be required to improve data quality.
There are other emerging tools, such as the quality and productivity challenge (QPC) calculator developed by NHS PCC, and the PCCS application developed by the DH, both of which aim to support commissioners in the effective use of information gained from existing primary care data to support quality and productivity. There has previously been a culture in some areas within primary care of not sharing information, but with the emergence of more effective tools and the development of the NHS Choices website, PCTs are beginning to be able to apply knowledge management much more effectively.

Ownership and better understanding of data by practices, through a process of verification of data-use and an agreement about which data sources are used, will also help in the sharing of data.

To support the sharing of data, the British Medical Association (BMA) advises effective co-operation between practices and the PCT:

*Much of the information that PCTs will seek to compile in the balanced scorecards is already in the public domain. However, there are some indicators which are not part of the routine contract data collected by PCTs, which practices will not wish to pass on, such as the access and capacity indicators.*

*However, paragraph 77(1) of Schedule 6 to the GMS regulations and paragraph 73(1) of Schedule 5 to the PMS regulations stipulate that practices must provide information reasonably required by the PCT. Moreover, the Freedom of Information Act 2000 states that all primary medical service providers are subject to requests of this Act, should they be made. It is therefore unfeasible for a practice to withhold this information from a PCT that requests it. Instead, GPs should proactively and collectively engage with PCTs, supported by their LMC [local medical council], to influence the local use of such information and to mitigate against potentially adverse consequences of its publication.*

The Scorecard can also serve as an effective quality accreditation scheme, allowing for standardised comparisons between practices, e.g. benchmarking. See the ‘How to’ guide, ‘How to develop a Taxonomy of General Medical Practices to support and encourage performance development’.

**Clinical engagement**

Clinical engagement is crucial for the successful implementation of this commissioning tool. The BMA states that it is essential that LMCs and practices engage with PCTs and the BMA throughout the development and implementation process. It needs to be seen as a collaborative approach, and it is vital that constructive relationships are sought. *“Practices should be working with PCTs, so that problems [in performance] are identified and addressed at an early stage.”* Clinical leadership from within the PCT is also crucial to success (for example, in NHS Knowsley the medical director leads the agenda), as is engagement with local clinical leaders at the early stages of implementation.
Examples of practice

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

NHS Coventry asked GPs to be involved in the weighting score for the banding scheme, which produced a very constructive debate.

NHS Suffolk has worked very hard to develop transparent and constructive relationships with their LMC through six-weekly negotiation meetings with PCT senior managers. Informal pre-meetings support this. These meetings also provide an opportunity to discuss the wider context within which the PCT is working, for example their financial position. The PCT keeps the LMC informed about poor performing practice, and the LMC has helped support the practice and facilitate improvement.

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 uses its Communities of Practice Groups\(^8\) to agree its Balanced Scorecard.

NHS Haringey works with its practice-based commissioning groups.

GPs are often concerned about their rating on each indicator – in particular when compared with peers. Therefore sharing results between clinicians can be a powerful motivator.

Examples of practice

NHS Suffolk produces monthly ‘performance packs’ for its GPs, which allow practices to see how they are performing compared to peers and against national, regional and local targets. This has been seen to improve performance.

NHS Stoke found that most practices were keen to improve when shown their performance against their peers. The use of ‘league tables’ was a more powerful motivator than money.

Public engagement

The NHS and other healthcare bodies are required to ensure that public engagement is at the heart of service delivery. A Balanced Scorecard would provide the public with a

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\(^8\) Members of the Community of Practice Groups are drawn from GPs and nurses in primary care, clinicians in secondary and community care, workers in public health, medicines management, information governance, education, intelligence and commissioning; and members of the public. In addition to the core membership, individual clinicians and other interested parties will join the community on an ad hoc basis. The Community Practice provides a forum for clinical dialogue and debate; responds to questions or issues identified by commissioners; clinicians and others with an interest in the quality of clinical care; utilises data to identify gaps in patient care and disease management; provides advice and support to inform the commissioning process; supports practices in delivering services in primary care; develops and disseminates guidance, pathways and treatment protocols; identifies and shares effective practice; provides support for clinical audit; develops patient education; and develops professional education and horizon scanning for new developments.
clear understanding of what is being measured and the context within which a practice is operating. In order to reinforce public accountability for quality, *High Quality Care for All* committed all healthcare providers to produce quality accounts. These will provide easily accessible information about the quality of services to patients. It is expected that providers of medical and dental care will be required to publish quality accounts between 2011 and 2012. The information produced through Balanced Scorecards could inform these accounts.

It is also important as part of the process of development, that practices engage with their patients to discuss their expectations and aspirations. This would enhance the choice agenda for the patient, help practices understand the best means of delivering care, improve access and responsiveness and support the delivery of care closer to home. This could also benefit practices by improving their GP survey scores.

Many PCTs are in the process of considering whether to publish practice performance information. As primary care performance management and development is not always well understood, it is important that a PCT seeks to ensure that the public understand what a Balanced Scorecard is saying, as it can be misrepresented in the media, which could lead to loss of public confidence. It is also crucial that a PCT board is fully supportive of publishing the results so that it is prepared for any public/media feedback, and can therefore manage its reputation as commissioners of health services. (See step 9, ‘Decide how to use the results’.)

**HOW TO DEVELOP A BALANCED SCORECARD**

**Step 1:** Develop a clear vision at the PCT of what constitutes good performance, acceptable performance and what constitutes unacceptable performance in primary medical care, within a strategic vision for local healthcare. This needs to be led with clear executive accountability.

The vision should be simple and functional, not structural. It should be about things that are important to patients, commissioners and service providers, including, but not exclusively:

- improving the health of the population and protecting them (e.g. vaccination programmes)
- corporate ambition around health inequalities
- access and responsiveness
- premises and primary care estate
- convenience
- safety
- quality
- productivity and capacity
- compliance with regulations and regulators
- local issues and concerns
- patient and public engagement.
Examples of practice

NHS Suffolk Board had a very clear mandate for the development of their general practice performance framework in supporting equalities of investment and care through local contracting.

NHS Northamptonshire also has a clear vision for quality improvement and development.

Tower Hamlets, in 2007, after discussion and agreement with the LMC, agreed with the PCT executive board the performance management of all GP contracts using the Balanced Scorecard. This ensured that there was unified understanding throughout senior management and avoided any potential confusion of divisions appearing in the stated approach.

**Step 2:** Develop the vision into a clear and agreed strategy for primary care, within which there is understanding of:

- what the health needs of the population and desired outcomes are
- what is acceptable or desirable activity in a primary care setting
- the place of performance improvement and role of the Balanced Scorecard
- performance management
- competition
- collaboration
- how choice and development fit within the overall strategy
- what tools and techniques will be deployed.

Examples of practice

The Tower Hamlets strategy is broadly defined under their Improving Health and Well-being Strategy 2006–2016.7

**Step 3:** Agree measurable indicators (these need to be referenced against those recommended by the organisations that develop the indicators such as the Royal College of General Practice, the NHS Clinical Governance Support Team or Care Quality Commission) and follow the quality standards set by NICE which underpin the vision.8

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

- describe good practice
- are agreed locally as a fair way of measuring practice
- aim to support quality improvement and to identify less effective performance
• can be banded into good, acceptable and unacceptable locally determined levels of care
• demonstrate productivity and value for money of services to support the QPC.

The indicators and locally determined levels of care must be:
• simple
• not too great in number
• clearly described
• based on every day practice
• measurable.

**Examples of practice**

NHS Haringey found it beneficial to separate the information it collects into the following three levels:
• a large database which is used for annual contract monitoring
• a more focused Balanced Scorecard
• information for each practice.

To support the retrieval of this data, NHS Haringey has developed a MIQUEST query form in order to extract the information required.

Tower Hamlets structures its Balanced Scorecard into three sections:
• Section 1 – contractual compliance
• Section 2 – key indicators
• Section 3 – developmental indicators.

A national indicator set is currently being proposed to ‘map the baseline’ (see Appendix 1). Development of new indicators can be highly technical, and it is often best to use indicators described elsewhere, to avoid problems with recording, reliability and reproducibility.

**Step 4:** Introduce a process of change management, to change ‘hearts and minds’.
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. This resource commitment must not be underestimated.

Examples of members of a PCT team include:
• prescribing advisers
• primary care finance lead (it is essential to include this – NHS Suffolk was supported by the full finance team, a crucial contributor to the overall programme of performance management)
• medical director
• estates manager
• primary care commissioning lead
• control of infection
• QOF indicators lead
• clinical governance lead
• lay assessor
• admin support.

HOW TO IMPLEMENT A BALANCED SCORECARD

Step 5: Develop a clear support programme.

Primary Care & Community Services: Improving quality in primary care⁹ states that the standard position for PCTs should be that they will assist GP practices in improving their services: "Direct support should be explicitly linked to the overall approach to managing performance... and PCTs should clearly define the circumstances in which they will provide support."

Support that PCTs could consider offering, when required, includes:

• providing PCT staff with specialist skills to work directly with practices
• sharing examples of best practice from other practices
• the establishment of local learning networks across practices
• brokering support for practices from support agencies.

Therefore the PCT needs to provide:

• a clear system of robust contractual management
• expert information management and analytical support
• trained assessors who can recommend and implement support to practices and provide educational packages for leading-edge and trailing-edge practices
• support arrangements for practices in difficulty
• facilitation and negotiation skills
• primary-care-specific financial skills.

In addition, the PCT needs to have policies and a support framework in place for education, development and performance improvement. These would be implemented as soon as possible when performance falls short of expectations and locally determined levels of care.
Examples of practice

NHS Suffolk funds a practice manager consultant from an established pool of local practice managers who will work alongside a primary care commissioning manager and the practice manager from a failing practice to support improvements identified in an agreed remedial action plan (prior to a Breach of Contract notice). NHS Suffolk also funds GP mentors to provide confidential support and customer service training packages for receptionists.

However, if practices continually deliver poor or unresponsive services to patients, PCTs may use the following formal contract levers once legal advice has been sought:

- decommissioning enhanced or additional services
- issuing remedial or breach notices
- terminating contracts.

Examples of use of remedial action

Tower Hamlets has developed a Contract Review Process that is linked to the number of red scores a practice has been given. Practices are required to produce action plans on each area of underperformance and are visited quarterly for review. Failure to achieve in these areas can form part of a remedial notice.

NHS Suffolk agrees a Specific Measurable Achievable Realistic Timescaled (SMART) remedial action plan with practices prior to a possible Breach of Contract notice.

Step 6: Consider setting up a Clinical Governance Group (CGG) as a subcommittee of the PCT (reviewing enables clear leadership from the board) in order to develop the agenda for quality and delivery. With appropriate membership and terms of reference the Clinical Governance Group can facilitate the development and delivery of the Scorecard.

The group itself needs to:

- include and be supported by senior managers and clinical champions
- be multi-disciplinary including PCT – commissioners, public health, finance, clinical governance, pharmacy and IT – and local clinicians’ and LMC representation
- 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
- have the power to recommend action to the PCT board
- reassess indicators
- review process
- introduce new indicators and agree to drop old ones.
Examples of practice

Tower Hamlets PCT has a joint LMC/PCT implementation group to work up indicators and other aspects of the Scorecard.

NHS Knowsley has set up Communities of Practice Groups (see footnote page 7) which provide an overview of a clinical area and are instrumental in supporting the implementation of the Balanced Scorecard (see also ‘Clinical engagement’ on page 6).

The context and the relationship with primary care and the clarity of expectations is really important for any of this to work.

Step 7: Develop a clear strategy and timetable for administration, the development of a Scorecard and for managing the results. The Department of Health has set out an illustrative timeline (see Appendix 2) for a performance cycle. The BMA states that it “would not expect this process to have an unreasonable impact on GPs’ time”. PCTs are encouraged to ensure that there is sufficient commissioner capacity committed to the development and implementation of the Balanced Scorecard.

Step 8: Undertake preliminary discussions on indicator developments. These need to include the following:

- a decision in principle on the areas for indicator development
- an examination of other scorecards against the following criteria:
  - relevance to the PCT
  - existing experience of other PCTs
  - ease of implementation
- a comparison of the indicators wanted with an assessment of how available the information is. The DH PCCS application may be a useful tool for this
- a comparison of the areas with national and local strategic priorities
- a review of how measurement might contribute to understanding and fulfilling the PCT strategic objectives
- a review of secondary uses of the data, for planning and commissioning as well as service development and improvement – NHS PCC Quality and Productivity Challenge Calculator can help support this process.

Contractual compliance can be rigorously checked but the need for practices to verify that they meet contractual, specified levels of care requires the development of more guidance/audit tools.
PCTs should ensure contractual, specified levels of care (such as for opening times) are being upheld fully before including more advanced indicators (based on the contract) in the Scorecard.

The following are examples of how contractual obligations are dealt with:

Tower Hamlets includes this in part A of its Scorecard as a self assessment that is verified by practices. Random indicators are checked for compliance at contract review meetings.

NHS Suffolk uses scorecard methodology to develop a performance framework to support the management of its local PMS contracts.

**Step 9:** Decide how to use the results from the Scorecard.

This should be done both at an individual practice level and en masse to inform primary care development.

Consider benchmarking information across to other local practices or across other PCT areas (refer to the ‘How to’ guide, ‘How to develop a Taxonomy of General Medical Practices to support and encourage performance development’).

The following table sets out ways Balanced Scorecards can be used and highlights issues for consideration if they are used in these ways.
## How to develop and implement a Balanced Scorecard to tackle health inequalities

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<th>How to use the results</th>
<th>Considerations</th>
<th>Examples of practice</th>
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| **Banding scheme**     | A Balanced Scorecard scores practices only on broad categories. The bands are the foundation of investments and sanctions. | NHS Haringey determines level of performance locally for different priorities, with specific levels expected by poorly performing practices.  
NHS Stoke sets initial lower levels of care for poorly performing practices.  
NHS Northamptonshire has produced a scoring system which allows both a snapshot of a practice’s overall level and also groups of metrics. It demonstrates movement within that level even if the overall level has not changed. The trust also has two-year trend data. |
| **Support for delivery** | Performing 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. Good support and development mechanisms to achieve improved levels of care need to be seen as incentives for this group. | Achievement in Tower Hamlets leads to ‘earned autonomy’ which means a lighter touch by the PCT.  
In Stoke, practices had to meet a number of prerequisites before being able to join a development programme. This includes a set of exemplary levels of care over and above the QOF indicators requirements as a means of achieving best possible, rather than average, practice. Funding has been allocated to support the programme, which includes a support programme for practices. |
| **Sanctions against poor performance** | Remedial action may be required for contractual, specified levels of care; the Balanced Scorecard scheme should neatly fit into performance management. | Tower Hamlets has clear sanctions and uses the Balanced Scorecard in new service contract specifications. These require practices to meet Balanced Scorecard requirements before they are able to contract for new services. |
### How to develop and implement a Balanced Scorecard to tackle health inequalities

#### Considerations

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<tr>
<td><strong>Publication of results</strong></td>
<td>This depends on confidence in the results, the quality of the data and confidence in practices, although none of the data should be patient specific or not in some way in the public domain already. It is the way it is treated that makes the difference. The public also need to understand the context within which the practice is operating in order to fully appreciate the outcomes of the Scorecard. Several levels of publication are possible, for example as an aggregated result to the PCT board and practices, or 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. Balanced Scorecards may be useful to fulfil the requirement for practices to develop quality accounts by the Care Quality Commission in 2012.</td>
<td>NHS Westminster publishes 80% of its Scorecard results to help patients make decisions on where to access primary care services. See its website: <a href="http://www.westminster-pct.nhs.uk">www.westminster-pct.nhs.uk</a> and follow the ‘Find a GP’ link. NHS Westminster used its communications and patient and public involvement (PPI) leads to ensure the commentary on the comparators is user friendly. There is also a feedback section on the website for users to inform of improvements.</td>
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<tr>
<td><strong>Investment for change</strong></td>
<td>Depending on results, the PCT might find that there needs to be investment across the board (ie in other services as well as GP practices) in, for example, access, childhood immunisations, improving the patient experience and prescribing, as well as investment in practices that require development.</td>
<td>NHS Northamptonshire uses the Balanced Scorecard as a way of understanding and stimulating the market in order to identify areas for further investment. Balanced Scorecards are used in NHS Suffolk to review and renegotiate PMS contracts.</td>
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</tbody>
</table>
Step 10: Decide on the infrastructure to standardise operations of the Scorecard system.

<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, e.g. QMAS, but with consideration of novel data extracts as in the QOF Assessor Toolkit.</td>
</tr>
<tr>
<td>Documents</td>
<td>Detailing, for example, of local audits, should be managed electronically where possible, using standard templates.</td>
</tr>
<tr>
<td>Analysis</td>
<td>The ‘translation’ into scores should be agreed and automated where possible. It is crucial that the information is produced with a clear description of meaning and context.</td>
</tr>
</tbody>
</table>

Step 11: Decide on a framework for the objective measures and indicators.

It is important to ensure the framework employs the right indicators.

Appendix 1 provides the suggested national indicator set, and Appendix 3 provides examples of the domains used by a sample of PCTs.

Step 12: Decide when to report the outcomes and when/if to discuss the findings with board members.

This is probably only once the development team is confident in the shape of the policy, in the Scorecard itself and has agreed the outcomes that the team wants to see.

Step 13: Develop a collaborative approach with the LMC and local clinicians.

When the elements of the policy and the shape of the framework are clear, it needs to be shared with the Professional Executive Committee (PEC) and the LMC as soon as possible.

Developing a good relationship with LMC is sighted by all areas with an effective Balanced Scorecard as crucial to taking this work forward. To gain support, commissioners need to be able to describe the benefits for patients, but more importantly the benefits for practices and the support available to improve practice performance. The meetings with the LMC are likely to be a principled negotiation – one where you have realistic but stretching objectives and clear bottom lines.

The BMA advocates that LMCs need to make contact with PCTs on behalf of their practices as soon as the PCT begins to undertake the Balanced Scorecard development. This will enable the LMC to advise on how the collected data will be used, to ensure that indicators are expressed with clear reference to the context in which the care is provided, and that they are robust and balanced.
**Step 14:** Take stock.

Step 9 can be very time-consuming. It is not a single meeting. Framework development, ie the earlier steps, should proceed in parallel.

**Step 15:** Develop a joint implementation group with the LMC.

This is recommended on an ongoing basis to ensure consultation on each stage of development and review.

**Examples of practice**

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

This group would be valuable in agreeing when results will be published in the public domain. Before this happens, practices could be sent a letter showing their results compared with others.

**Step 16:** Present at a public session of the PCT board.

This will ensure absolute sign up and onward commitment.

**Step 17:** Organise a launch event with the purpose of engaging partners, including local authority officers and overview and scrutiny committee members, for example.

This will provide further demonstration of commitment. Detail offered at the event should include firm dates for each stage and the consequences for practices and the PCT if X or Y happens.

**Step 18:** 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 very poor or dangerous performance shows unexpectedly. The implementation group will be invaluable in taking this step forward.

**Step 19:** Act on the year-end results and action plan.

The broad outline of the Balanced Scorecard will already have been agreed with the board and LMC.

The action plan needs to be agreed overall and with each practice.

There should be an opportunity to celebrate success.

**Step 20:** Review and change the framework on an annual basis, if required.
APPENDIX 1: MAPPING THE BASELINE (TAKEN FROM PRIMARY CARE & COMMUNITY SERVICES: IMPROVING GP SERVICES$^5$)

National indicator set

**Capacity**, including:
- number of GP and nurse consultations per 1,000 weighted population
- length and quality of all primary care consultations
- average patient list size per GP practice
- number of whole-time equivalent GPs and other clinical staff (e.g. practice nurse, nurse practitioner, healthcare assistant) per 1,000 weighted population.

**Quality**, mapped across three areas:
- organisational quality (including safety)
  - practice accreditation
  - premises
- effectiveness
  - achievement in the clinical domain of the QOF indicators
  - exception rates and comparisons between reported prevalence and expected prevalence of long-term conditions
  - local data, e.g. prescribing, referrals and clinical governance
- patient experience: GPs, practice nurses, reception staff, communications systems, parking, quality of premises, etc, combined to make up the overall experience. PCTs may use the new GP patient survey, or other forms of patient feedback or an analysis of complaints received to measure this.

**Access and responsiveness**, as described by the specific DH guide on this issue, to be published soon. Measurements will include:
- patient satisfaction with access
- practice opening hours for clinical appointments
- disability access
- consultation languages
- choice of male and female GPs
- uptake of extended opening hours
- use of premium rate telephone number
- attendance at A&E or walk-in centres as a proportion of list size.
Patient choice, including choice of hospital, choice of practice and personalised care planning.

Value for money, including GMS and PMS spend per head, referral and prescribing data.

Premises, including compliance with national standards.\textsuperscript{10}

Demand, including:

- emergency referrals/spells per 1,000 weighted population
- A&E activity per 1,000 weighted population
- activity within out-of-hours settings, particularly for routine or planned care
- Better Care, Better Value indicators for ambulatory care sensitive emergency admissions
- Better Care, Better Value indicator on surgical thresholds
- Better Care, Better Value indicator on out-patient referrals.

Enhanced services, including access and uptake of these services.
### APPENDIX 2: EXAMPLE TIMETABLE

<table>
<thead>
<tr>
<th>When</th>
<th>What</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Jan–Feb</strong></td>
<td>Negotiate objectives and development plan for the next year, ensuring that there is an appropriate blend of qualitative and quantitative objectives. Agree any contract variations. Objectives linked to PCT’s strategy, such as incentives to tackle high priority areas like coronary heart disease, will be common to all providers. Others will be specific to individual practices (e.g. extend opening hours from X to Y, or increase patient satisfaction by X%).</td>
<td>Draft agreement for each practice.</td>
</tr>
<tr>
<td><strong>By Mar 31</strong></td>
<td>Sign off agreement/contract variations with each practice.</td>
<td>Written plan/contract variation, signed by both parties.</td>
</tr>
<tr>
<td><strong>May</strong></td>
<td>Formal, senior-level accountability review with every practice, assessing performance over previous 12 months. Ensure that any balancing payments/clawbacks relating to the previous year are agreed.</td>
<td>Annual letter to practice, to be shared at PCT public board meeting. This could include an overall ‘traffic light’ assessment of performance. Practice to receive clear statement of performance.</td>
</tr>
<tr>
<td><strong>July</strong></td>
<td>Publish Q1 key performance metrics for each practice.</td>
<td>Data published on PCT website.</td>
</tr>
<tr>
<td><strong>Oct</strong></td>
<td>Formal mid-year review with every practice. Publish Q2 key performance metrics.</td>
<td>Letter outlining main points of review meeting. Data published on PCT website.</td>
</tr>
<tr>
<td><strong>Nov–Dec</strong></td>
<td>Review of performance framework and metrics.</td>
<td>Revised framework (if appropriate) published.</td>
</tr>
<tr>
<td><strong>Jan</strong></td>
<td>Publish Q3 key performance metrics.</td>
<td>Data published on PCT website.</td>
</tr>
<tr>
<td><strong>April</strong></td>
<td>Publish Q4 key performance metrics.</td>
<td>Data published on PCT website.</td>
</tr>
</tbody>
</table>
APPENDIX 3: EXAMPLES OF THE DIFFERENT DOMAINS USED BY PRIMARY CARE TRUSTS (PCTS)

**Doncaster PCT**
- Clinical performance
- Safety
- Organisational processes
- Quality

**NHS Knowsley**
- List size/GP whole-time equivalent
- Life expectancy
- GP access
- Partnerships in Health
- Clinical quality
- Expected prevalence
- Unplanned care
- Education
- Patient and Public Involvement

**Coventry PCT**
- Activities
- Disease and need
- Administrative processes
- Prescribing
- Teamwork, training, employment

Additional possibilities:
- Numbers removed from list and why
- System to alert out-of-hours service to patients dying at home
**NHS Haringey**

Existing commitment

National requirements:
- Waiting times
- Hospital acquired infections

National priorities:
- All age all cause mortality
- Cardiovascular disease mortality
- Cancer mortality
- Suicide and undetermined injury
- Smoking
- Obesity
- Immunisation
- Breast feeding
- Children and adolescent mental health services
- Chlamydia screening
- Access to drug misuse services
- Self-reported experience of NHS
- NHS staff satisfaction
- Primary dental services

**Tower Hamlets PCT**

**Section A – Contractual and statutory requirements and compliance**
- Contractual compliance
- Business continuity planning
- Healthcare commission standards
- Response to Central Alerting System alerts

**Section B – Key indicators**
- Patients able to get an appointment within 48 hours if they wish
- Cervical screening
- Childhood immunisations
- Pre-school boosters
- Pneumococcal immunisation for over-65s
Section C – Developmental/quality indicators

Access:
Range of enhanced services
Patient profiling local enhanced services – ethnicity recording
Patient profiling local enhanced services – language recording

Patient experience:
Composite Ipsos/MORI score

Public health:
Influenza immunisations for over-65s
Breast screening
Body mass index recording – aged 16 years and over in previous 15 months

Prescribing
APPENDIX 4: SPECIFIC METRICS THAT PROVIDE A HEALTH INEQUALITY PERSPECTIVE

A Balanced Scorecard is a generic scorecard balancing different metrics and domains for a practice, but these would be the ones particularly of interest for addressing health inequalities:

**Capacity and accessibility**
- Number of face-to-face GP appointments per year per patient
- Number of trained nurse appointments per year per patient
- Extended hours offered (outside core hours)
- Patient experience – using patient surveys
- Disability access
- Consultation languages
- Cultural sensitivities
- Uptake of enhanced services to map availability and uptake by population to ensure accessibility

**Prescribing**
- Use of statins
- Ratio of ACE inhibitors to angiotensin-II antagonists >75% (excluding combination products)

**Public health targets**
- Percentages achieved for cervical screening, childhood immunisations, breast screening
- Flu vaccine uptake
- Coronary heart disease, cancer and infant mortality
- All age all cause and life expectancy level (male and female)

**Value for money**
- Value for money prescribing indicators – prescribing costs versus outcomes for diabetes; hypertension management; status
- Urgent and elective referrals per 1,000 weight population compared across practice Super Output Areas (SOAs)
Quality and Outcomes Framework indicators

- Prevalence – actual identified against predicted
- Exception reporting – reasons why
- Work being done to treat those above the QOF indicators target
- Diabetes – HbA1c achievement
- Cardiovascular disease management – blood pressure control, treatment and distribution
- Chronic pulmonary obstructive disease management
- Cancer referrals – early diagnosis, urgent versus non-urgent, two-week referrals (and diagnosis ratio)

Local targets

- Smoking cessation – effectiveness

Local context

- Indices of Multiple Deprivation score (IMD)
- Demographics: population aged over 75 years
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