The Health Foundation

Indicators of quality of care in general practices in England

An independent review for the Secretary of State for Health

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About this report

The Health Foundation, an independent health care charity, was asked by the Secretary of State for Health to review indicators of the quality of general practice in England. We looked at how they could be made better to support improvements to care, including how they are selected and presented.

Within the short timeframe available for the review (June to September 2015), the Foundation consulted with a wide range of organisations and individuals with an interest in general practice and information. We assessed the available literature and analysed current indicators as well as the websites on which they are published.

Our review focused on publication of indicators for the purposes of supporting local improvement of care, patient choice and voice, and the accountability and performance management of general practices.

While our review was commissioned by the Department of Health, the Health Foundation did not receive any funding for completing the work. The Health Foundation retained full editorial control of the report's content.

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It should be noted that the report's conclusions as well as any errors or omissions are solely those of the Health Foundation.

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Executive summary

Background

There is widespread consensus in the UK and internationally that developing information on the quality of health care is essential to help make improvements to care; that making such information publicly available ('transparent') can have benefits; and that the wealth of information and the cost of collecting it demands intelligent attempts at simplicity. In the NHS there are already a lot of data collected and indicators published on the quality of care. Key questions are how can that data be best used and developed, and could greater parsimony allow us to see '*the signal from the noise*' as well as reduce the burden of collection, development and presentation?

In June 2015, the Secretary of State for Health announced two short independent reviews on how quantitative indicators of the quality of health care could be best used and developed in England. The first review covered care provided by general practices.[1] It was carried out by the Health Foundation and is reported here. The second review focused on the quality of care and health outcomes for the local populations for which clinical commissioning groups (CCGs) are responsible.[2] It was carried out by The King's Fund.[3] For general practices, it was initially thought that the development of a 'scorecard' could be useful, possibly using composite indicators (made up of a selection of measures). The Department of Health subsequently agreed that the terms of reference for the review would focus on indicator development more broadly, rather than focusing specifically on the development of a 'scorecard'.

Alongside the announcement of the review covering general practice, the Secretary of State made a number of major announcements focused on a 'new deal' for general practice which related to taking steps to grow the general practice workforce, improving infrastructure, improving access, reducing bureaucracy and enhancing quality.[2] These announcements occurred at a time when general practice is facing well publicised challenges relating to workforce issues and morale, with funding for general practice falling at an average rate of 0.3% per year between 2009/10 and 2014/15 (2015/16 prices).[4]

Terms of reference

The terms of reference for our review were to:

- identify the main purposes for which indicators can be developed
- take stock of the current indicators available on different aspects of the quality of care in general practice and assess whether they can give a valid picture of the quality of care
- consider the extent to which current information might be used to give meaningful information about specific population groups: people over 75; people under 75 with long-term conditions; maternity, children and young people; mental health; and the generally well
- consider how information could be complemented and developed in future to give a better picture of the quality of care, including identifying any gaps, for the main purposes identified

- engage with professional and patient stakeholders, and the Department of Health's arm's-length bodies to ensure that the recommended approach to indicator development will be meaningful and credible to patients and professionals
- draw on best practice from the NHS and other comparable health systems.

As part of the review we also considered the extent to which it might be possible to construct a meaningful composite indicator to indicate the overall quality of care provided for each general practice in England and the quality of care for the five population groups in the terms of reference. We explored whether this could be done for the indicators to be published on the MyNHS website by March 2016.

The timescale for the review was short – July to September 2015. Because of the limited time available, the supporting evidence used in this report is illustrative rather than comprehensive.

Methods

We used the following methods to gather intelligence for our review:

- Engagement with key stakeholders (described in more detail in Appendix B), including:
  - discussions and roundtable events with all main stakeholders and representatives of relevant arm's-length bodies
  - an online consultation exercise. This was open between 20 July and 24 August 2015 and was available via our consultation platform https://engage.health.org.uk. Over 600 responses were received, of which 361 were from practising GPs.
- Public focus groups (8) and polling (of 1,731 people) conducted by insight agency BritainThinks (see http://britainthinks.com/Health-Foundation-GP-data).
- Discussions with selected international stakeholders.
- Discussions with a Technical Advisory Group (described in more detail in Appendix A).
- Analysis of currently available indicators for all general practices in England and identification of the websites where they are published.
- Consideration of relevant national and international literature (grey and peer reviewed).

Findings

Purposes of publishing indicators

For published indicators on the quality of care in general practice to be most useful, it is important to clarify their purpose/s and intended audiences. As well as transparency often being seen as an important end in itself, we identified four main purposes of publishing indicators, with associated audiences:

- **Improvement:** to support improvement of care (for example, by general practices).
- **Choice and voice:** to support 'choice' and 'voice' (for example, to enable patients and service users to make informed choices or argue more effectively for improvements to be made).
- **Accountability and performance management:** to provide data for accountability to another organisation/group (which may then 'performance manage' the general practice). For example, accountability to the local CCG, to a regulator, to the public or to politicians).
- **Research:** to provide data for third party research (for example, by universities, think tanks and others).

The review focused on the first three of these purposes.

The process for selecting indicators and presenting them to different audiences depends critically on their purpose. Indicators selected for one purpose may not be appropriate or most helpful to achieve another. In particular, indicators to boost accountability and choice and voice may need to be more robust and unambiguous, and smaller in number, than indicators for improvement. Humility is needed when coming to a 'judgement' about the overall care provided: the more generalist nature of care provided in general practice means that interpretation of many indicators is not likely to be straightforward and local context is important in explaining findings.

Existing websites with indicators and how they are used

Existing websites

There are already several websites in the public domain containing information about the quality of care for each general practice in England. These include: NHS Choices; the Care Quality Commission's (CQC) published ratings on general practices and indicators for intelligent monitoring; MyNHS; Public Health England's National General Practice Profiles; and a range of other information on the Health and Social Care Information Centre (HSCIC) website. The Primary Care Web Tool developed by NHS England, also contains a range of indicators on quality for each practice. The tool is password protected and viewable by large numbers of people working in the NHS.

Consolidation and tailoring of indicators

Many indicators on these sites are duplicated and some are similar but not identical, giving slightly different results. Their presentation and usability is highly variable, and usage is generally low considering the size of the potential audiences. The publicly available websites each appear to serve more than one purpose, yet are not tailored to different audiences. We recommend that the existing websites are eventually consolidated and tailored to different audiences, possibly using separate channels. We suggest there should be a professional-facing channel and a public-facing channel (or two distinct websites).

As this review recognises, the direction of government policy is towards establishment of MyNHS as the primary portal for information about the quality of health and care services.

If the current websites were to be consolidated, the MyNHS website is a likely candidate to host consolidated content. However, given some of the limitations with the website as it currently stands, it will be important to consider fully a range of options to ensure the most effective outcome. An alternative to developing a public and professional channel on MyNHS would be to re-focus MyNHS as a professional-facing website and use NHS Choices as the public channel, given the website's already high usage figures. More market research would be helpful to understand what would be of most value to different users, as well as exploring alternative ways of communicating information about the quality of care with patients and the public over and above online resources.

Consolidation will not be a quick process and careful design will be needed. For example, the functionality of Public Health England's National General Practice Profiles and the Primary Care Web Tool is, in our view, far superior to the current functionality of the MyNHS website. Over-rapid consolidation might risk a worse user experience for a professional audience – intelligent consolidation would need a forgiving timetable. Done well, the benefits could potentially be significant. Following consolidation of websites focused on publishing indicators of general practice quality, there may still be a need for additional websites that provide other valuable information or services.

For the public-facing channel or website, our review suggests that the public would favour a small set of indicators, including access and satisfaction levels. The public-facing channel should link to the professional-facing channel to ensure transparency.

For the professional channel, our review found that those working in general practice would prefer a larger set of detailed indicators (that take context into account) to help pinpoint where improvements are needed. We further recommend allowing users to self-select indicator groups of interest, for example to give a view on care for particular clinical conditions, population groups, or services.

Local vs national indicators

For many professionals working in general practice, it seems that locally available data are more useful than the national data available the websites we examined. In some areas, CCGs and practices have access to a wider range of data that are more timely (in part because of local agreements with practices and an automated way of extracting data electronically from GP computer systems) and have developed indicator 'dashboards' that are helpful to practices. Furthermore, local knowledge of context has helped to interpret the data more appropriately and helped to set priorities for improvement and support. It is likely for the foreseeable future that CCGs will have access to more comprehensive data from local systems than will be available nationally. The most advanced CCGs could increasingly inform the future development of national indicators and websites.

Accountability

We examined the extent to which indicators used for accountability purposes should be made publicly available. For accountability to the Department of Health and Secretary of State (and ultimately the public) we concluded that a very small set of streamlined 'sentinel' indicators (which would not be composites nor necessarily allow for ranking) could be useful on the public-facing channel. These could initially represent *'what matters most'*, going beyond the very small number of indicators for general practice care that are currently in the NHS Outcomes Framework. Such national indicators would be very specific, representing priorities, or a credible view of an area of care. They could be a 'positive indicator' of good care or a 'negative' indicator representing poor care to be avoided. These national indicators should not prevent local CCGs from developing their own set which reflect local priorities.

For national sentinels indicators, the question of '*what matters most*' should be decided among a wide range of stakeholders, including front-line professionals and the public. NHS England and CCGs would then need to encourage progress against these indicators using a range of approaches, including national Quality and Outcomes Framework (QOF) type payment incentives, local CCG payment incentive flexibilities, encouraging peer review, or other appropriate ways to support improvement. Progress in developing such 'sentinel' indicators could play an important role in reducing the burden of accountability and regulatory requirements in future.

Composite indicators and population groups

Composite indicators

Composite indicators have superficial allure because of their simplicity. In theory, this simplicity could help the public gain a rapid view of the quality of care in a general practice and help practices and others identify priorities for improvements more easily. It could also help organisations accountable for primary care to *'see the wood for the trees'*. However, we strongly recommend that composite scores (over and above the existing CQC rating) are not developed and published. There are six main reasons why:

- Composites aggregate information which can mask specific aspects of the quality of care, falsely reassure and thus be misleading.
- While a small set of indicators could be valuable for the public, there would be little value in publishing a composite score over and above the existing CQC rating. This rating is based on a wider range of information (quantitative data, qualitative intelligence and inspection findings) and is currently the better assessment of quality. Publishing a composite score as well as a CQC rating could confuse, especially if the results were conflicting.

- Patients and service users and health care professionals are not homogenous groups. A composite necessarily reflects a range of indicators that have been weighted according to someone's judgement: an individual patient or service user, or professional, might have preferences for information that do not tally with the priorities assumed when constructing the composite.
- The process of selecting and weighting indicators in a composite would be highly contentious – in particular, decisions about the extent to which an indicator really reflects care provided in general practice (the 'attribution' issue). To gain the necessary buy-in, an open, structured and transparent process would be needed. Given current pressures on general practice, such an engagement process may be more usefully deployed to develop new indicators where there are gaps and to make progress in developing better indicators on *'what matters most'*.
- The data on which a composite could be based are not robust enough to provide a credible picture of the quality of care. The number of robust indicators is extremely small and not comprehensive.
- For professionals, composite indicators (either overall or for population subgroups) are unlikely to be helpful because they do not provide enough detail to pinpoint areas for improvement and are less useful for assessing the impact of changes made. Composites are also less amenable to adjustment for relevant local contextual factors.

Population groups

These arguments about composite indicators also apply to developing composite measures for the five population groups noted in the terms of reference for this review (people over 75; people under 75 with long-term conditions; maternity, children and young people; mental health; and the generally well). In our consultation, however, the public appeared to like the concept of sub-dividing indicators into groups. The population groups suggested by the Department of Health offer one possible way of organising indicators. However, any choice of subgroup is arbitrary and this review could not ascertain clear preferences among the public or professionals either for population groups, grouping by clinical condition or by receipt of a particular service or care pathway. While the idea of presenting data by population groups is attractive, there are some significant disadvantages to using the five groups suggested in the review's terms of reference:

- The five population groups differ from the six population groups that the CQC currently uses. The CQC's set are more comprehensive and have been tested through a consultation exercise. While they still have limitations, using a slightly different set would be confusing.
- There are overlaps between the five population groups, but also significant gaps, for example end-of-life care.
- The data that are currently available are not robust enough to develop a credible composite score in the five population groups identified.[5]

If groupings are thought to be a helpful way of presenting data more simply, a better approach might be to allow users to self-select groupings from a menu of indicators. This flexibility is also likely to be important to professionals as new models of care develop.

The ability to use indicators meaningfully and with simplicity may be achieved in ways other than aggregation, which has significant drawbacks. For example, as discussed above, by developing functionality on a consolidated website to group the indicators together in bespoke ways or developing a few streamlined 'sentinel' indicators.

A leaner process for indicator development

Who should be involved?

Our review revealed the large amount of work on indicator development that is already in progress, both nationally and locally. There is considerable scope to improve the process for developing indicators on general practices at national level, for example by consolidating the number of groups working on these issues; ensuring the stakeholder groups represented are comprehensive; and identifying priorities for indicator development. Ideally, a credible, independent organisation such as the National Institute for Health and Care Excellence (NICE), would convene this process – perhaps similar to how indicators were developed in the US by the National Quality Forum[6] and the Institute of Medicine in its development of 20 'vital signs'.[7]

NICE already has a tested and respected process covering some of the areas of indicator development, with assurance of the robustness of the indicators by the HSCIC. Priority setting would need to involve a wide set of stakeholders and this is a routine stage of NICE's current process. Priority setting would not necessarily need to be led by NICE alone, but could be supported or led by the National Quality Board (or the National Information Board), and linked to an overall strategy to improve quality of care in general practices.

For the Secretary of State, the annual Mandate to NHS England is the vehicle for setting the main system priorities, and is the starting point to outline the priorities for selecting and developing indicators. But in reality there will always be a legitimate need for any process to respond more quickly to emerging ministerial or system priorities. Other bodies such as NHS England and CQC will also have priorities. For example, for the CQC, one priority is for a set of indicators to be developed that might give a more accurate picture of the quality of care to inform current inspections and help reduce the frequency of inspection in future.

Indicator development

Development of indicators should be informed by indicators' current use, the cost of collecting and analysing data, and their impact. It could formally draw upon the work of CCGs (and their associated commissioning support units (CSUs)) in developing dashboards using a wider range of locally available data. This process could also draw on the work being done across the country to develop better indicators to assess the progress of new models of care, including integrated and digital care. The priorities for indicator development should be set as part of a longer-term strategic view and 'roadmap' as to which indicators will be needed in the future (and which can be retired). Taking a longer-term approach is particularly important in the light of the increasing availability of data from GP IT systems and improved methodology for linking data sets, which offer enormous potential.

Throughout the engagement exercise, we heard concerns about a perceived lack of alignment at a national level. As much priority must be given to the alignment of actions within the strategy as designing the individual components. Progress towards developing a small set of shared indicators that assess what really matters might support a more coherent and consistent approach across the system.

Wider strategy for achieving improvement and public choice and voice

Publishing better indicators by themselves is not likely to be the most effective way to achieve improvement, choice and voice and accountability – the main purposes of publishing indicators, as discussed earlier. Better data are just one element of the wider coherent strategy that is needed to support progress in these areas. It is inefficient to dedicate resource and effort to developing indicators if they are not used for their intended purpose.

For the purpose of improvement, the key element of a strategy is to create an environment for learning not fear. This means indicators should be less used as a blunt overall 'judgement' and more as a device to learn and measure progress. This could be supported by a range of mechanisms, for example peer review (based either on locality or shared characteristics), as well as local and national payment incentives to encourage change.

To achieve the purpose of strengthening public choice and voice, there is much more scope to engage with the public on what matters most to them about the quality of care. Further thought should be given to a range of complementary methods for displaying information, as well as online resources.

Recommendations

This review initially appeared to be a relatively discrete and fairly technical task but was in fact a complex and largely strategic one. This is why we touch on so many different issues in this report. In the time available we could not do justice to all the issues raised. However, we believe our recommendations are a solid place to start and would be supported by stakeholders.

Throughout the course of our review, we have linked with colleagues from The King's Fund who have been undertaking a parallel review for the Department of Health on measuring the performance of local health systems.[3] Several conclusions are common to both of these reviews, including the recommendations to select a small set of headline indicators to present key performance information to the public, avoid the use of aggregate scores based on performance indicators alone, consolidate the disparate array of websites presenting information to the public and NHS, and have NICE and others continue to play a leading role in indicator development and assurance for indicators relating to quality and outcomes.

In our review, there was almost unanimous support among stakeholders for the concept of transparency and developing information on quality of care. The amount of work done to date in this area and the obvious goodwill is ample testimony of this. Relative to other countries we examined, the NHS in England is very advanced in its development of information, particularly in general practice. But as people regularly told us during the review, what is needed is intelligent transparency, not *any* transparency. If transparency is undertaken in a collaborative and intelligent way, it has the potential to support improvements to health care services for the population of England.

We believe the following practical recommendations will help achieve intelligent transparency faster.

Consolidation

The number of national websites with indicators on the quality of care in general practices, and all underpinning activity, should be consolidated. Key national bodies (possibly through the National Quality Board) would need to collaborate to achieve this, in particular the Department of Health, NHS England, Public Health England and the Care Quality Commission (CQC).

As this review recognises, the direction of government policy is towards establishing MyNHS as the primary portal for information about the quality of health and care services. If the current websites were to be consolidated, and this content were hosted by the MyNHS site, it will be important to consider carefully this review's findings, conduct further market research and fully appraise a range of options. This is particularly important given some of the limitations of the MyNHS website as it currently stands. An alternative option to developing public and professional channels on MyNHS would be to re-focus MyNHS as a professional-facing website and use NHS Choices as the public-facing channel, given the website's higher usage figures (driven by other content such as information about health and illness). Intelligent consolidation would take time to do well as the functionality of some of the existing website is currently superior to that of MyNHS.

The website consolidation we are recommending would be for the purposes of publishing general practice indicators. Following consolidation, there may still be a need for additional websites to provide other valuable information or services.

Clarity of purpose and audience and market research

The purposes of, and main audiences for, publication of indicators should be made explicit. Further market research should be done to identify who the different audiences are, what they would value most with respect to indicators and their presentation, as well as other factors that could increase usage.

Indicators for the public

Much of the information likely to be of interest to the public is already available, including indicators of access to care, patient experience of care and the CQC's rating, where available. This rating provides a better assessment of overall quality than currently available quantitative indicators alone. There is considerable scope to raise awareness among the public of the information that is already available and further thought should be given to a range of complementary methods for displaying information, as well as online resources. Such activity may be more effective around a 'trigger point', such as someone moving house. For members of the public interested in more detailed information, there could be clear links to a professional-facing channel.

Indicators for professionals

The term 'scorecard' is divisive - we recommend avoiding this terminology if a key purpose is for improvement. There appears to be low awareness, among GPs in particular, of the main websites currently containing quality indicators for general practices. We recommend consolidation of the existing websites and additional market research and engagement to understand how those working in general practice make use of online information. In the short term, quick wins would include raising awareness of existing sites and making some currently restricted indicators from the Primary Care Web Tool available in the public domain (although this tool is already available to large numbers of people working in the NHS, so potential benefits here would relate to transparency). In the longer term, as noted above, we recommend careful consolidation of websites such as Public Health England's National General Practice Profiles, the General Practice Patient Survey and the Primary Care Web Tool into one website or channel aimed specifically at professionals.

Composite scores and population grouping

We strongly advise against composite measures for a public or professional audience. We suggest users should be able to select from a full menu of indicators by various groupings. Such an approach could readily be seen as responsive to the needs and aspirations of patients themselves, and thus offer additional credibility with the public. Such groupings could include age groups or other population groupings, or groupings by clinical condition or service. Selection could also include comparison with similar practices, allowing in part for context. If population groups are to be pre-defined by the Department of Health, we recommend that there should be alignment between the population groups used for MyNHS or other websites and those used by the CQC to avoid confusion and additional burden.

Future process

For the future, a more efficient process is needed to select priorities and design and develop indicators for general practice. This should involve all key stakeholders – the public, professionals and organisations accountable for the quality of care. The process that NICE uses to develop indicators is useful and we suggest this could be developed further, for example by:

- testing the development of indicators in areas where CCGs have access to a wider range of data
- advising on how data may best be presented statistically (including adjustment for local context and 'value added' measures to estimate the impact of a general practice)

- developing meaningful groupings of indicators or a small set of 'sentinel' indicators
- developing a strategic roadmap with milestones for the next five years.

A key task would be to decide which existing or new indicators are the most valuable and which can be retired. Such a process might also serve other system priorities better. For example: reducing the burden of regulation through effective surveillance of risk; encouraging the development of new models of care by developing better measures of integrated and digital care; improving safety in general practice care; developing shared decision making or self-management support; improving productivity or value for money; and developing indicators that reflect a practice's engagement with quality improvement.

Sentinel indicators

To develop intelligent simplicity, we suggest that an indicator development process might consider the development of a small number of 'vital signs' or 'sentinel' indicators to assess progress on what matters most to the public, front-line professionals and those bodies accountable for the quality of care in general practices in England. It is important that these collectively would not pretend to give a summary picture of the overall quality of care in general practice or be ranked in any way. Nor could they (to be credible) be selected outside a process involving all key stakeholders to decide what is important. But they could help identify *'the signal from the noise'*, at a national level, and be particularly useful for purposes of making improvements and for accountability.

We recommend a follow-up to this review which would involve comprehensive engagement with front-line professionals, stakeholder organisations and the public focused on developing sentinel indicators.

Strategy to support improvement

Publishing data on a website by itself is unlikely to result in progress towards the key purposes (improvement, choice and voice for patients, and greater accountability) without other mechanisms to prompt change. We recommend the development of a national quality strategy for general practice, and for primary care more broadly, to give focus to improvement activity and indicator development to serve intelligent transparency.

We recommend that attention is given to improving the capacity of the system to analyse and respond to data and information on quality of care. This would include organising practical and technical support for general practices, federations and CCGs in improvement and in addressing the underlying problems that make improvement more challenging. Such support should seek to build internal capacity within organisations rather than relying on external interventions. The role of the CCGs in interpreting data and supporting practices locally is vital – we recommend that local innovation should be supported.

More broadly, the Secretary of State for Health's annual report could be used more effectively to produce a comprehensive and transparent assessment of progress in improving quality of care in general practices (as well as across the NHS) and reducing inequalities.

1. Introduction

Background

There is widespread consensus in the UK and internationally that developing information on the quality of health care is essential to help make improvements to care; that making such information publicly available ('transparent') can have benefits; and the wealth of information and the cost of collecting it demands intelligent attempts at simplicity. In the NHS there is already a lot of data collected and published on the quality of care. Key questions are how can that data be best used and developed, and could greater parsimony allow us to see 'the signal from the noise' as well as reduce the burden of collection, development and presentation?

In June 2015, the Secretary of State for Health announced two short independent reviews on how quantitative indicators on the quality of health care could be best used and developed in England. The first review covered care provided by general practices.[1] It was carried out by the Health Foundation and is reported here. The second focused on the quality of care and health outcomes for the local populations for which clinical commissioning groups (CCGs) are responsible.[2] It was carried out by The King's Fund.[3]

Alongside the announcement of the review covering general practice, the Secretary of State made a number of major announcements focused on a 'new deal' for general practice.[2] Following the announcement of the review, the Secretary of State wrote to those working in the NHS about the new deal for general practice and referred to the concept of a publicly available general practice 'scorecard', stating that the scorecard *'would help support quality improvement by providing unprecedented transparency about the quality of primary care'*[8] The Department of Health subsequently agreed that the terms of reference for the review would focus on indicator development more broadly rather than focusing specifically on the development of a scorecard.

Terms of reference

Taking account of these concerns, the final terms of reference for the review of general practice made no mention of the development of a 'scorecard'. The terms of reference were to:

- identify the main purposes for which indicators can be developed
- take stock of the current indicators available on different aspects of the quality of care in general practice and whether they can give a valid picture of the quality of care
- consider the extent to which current information might be used to give meaningful information about specific population groups: people over 75; people under 75 with long-term conditions; maternity, children and young people; mental health; and the generally well
- consider how information could be complemented and developed in future to give a better picture of the quality of care, including identifying any gaps, for the main purposes identified

- engage with professional and patient stakeholders, and the Department of Health's arm's-length bodies to ensure that the recommended approach to indicator development will be meaningful and credible to patients and professionals
- draw on best practice from the NHS and other comparable health systems.

The timescale for the review was very short – July to September 2015. Because of the limited time available, the supporting evidence in this report is illustrative rather than comprehensive – we have not conducted a systematic review of the literature.

As part of the review we also considered the extent to which it might be possible to construct a meaningful composite measure (made up of a selection of indicators) to indicate the overall quality of care provided for each general practice in England and the quality of care for the five population groups in the terms of reference. We explored whether this could be done for the indicators to be published on the MyNHS website by March 2016.

Methods

This review used the following methods to gather intelligence:

- Engagement with key stakeholders (described in more detail in Appendix B), including:
  - bilateral discussions and roundtable events with all main stakeholders and representatives of relevant arm's-length bodies
  - an online consultation exercise which was open between 20 July and 24 August 2015. This was available via our consultation platform https://engage.health.org.uk/ Over 600 responses were received of which 361 were from practising GPs.
- Public focus groups (8) and polling (of 1,731 people) conducted by insight agency BritainThinks (see http://britainthinks.com/Health-Foundation-GP-data).
- Discussions with selected international stakeholders.
- Discussions with an expert Technical Advisory Group (detailed in Appendix A).
- Analysis of currently available indicators on all general practices in England and identification of the websites they are published on.
- Consideration of relevant international and national literature (grey and peer reviewed).

More detail on the engagement methodology can be found in Appendix B and further information on the responses to our consultation exercise can be found in Appendix C.

The structure of the report is as follows:

- Chapter 2 explores the purposes of indicator development.
- Chapter 3 outlines the different websites available to access information on the quality of general practice.
- Chapter 4 considers the advantages and disadvantages of composite summaries and grouping data by population groups.
- Chapter 5 considers the process for indicator development.
- Chapter 6 explores how data can complement a wider strategy for achieving various objectives.
- Chapter 7 offers broad conclusions and recommendations.

Each chapter ends with a short summary of our conclusions.

2. Purposes of publishing indicators

Main purposes

A key aspect of this review's terms of reference was to identify the main purposes of publishing indicators of quality of care for general practice. As well as transparency often being seen as an important end in itself, we identified four main purposes of publishing indicators:

- **Improvement:** to support improvement of care (for example, by general practices).
- **Choice and voice:** to support 'choice' and 'voice' (for example, to enable patients and service users to make informed choices or argue more effectively for improvements to be made).
- **Accountability and performance management:** to provide data for accountability to another organisation/group (which may then 'performance manage' the general practice). For example, accountability to the local CCG, to a regulator, to the public or to politicians).
- **Research:** to provide data for third party research (for example, by universities, think tanks and others).

For this report we have primarily focused on the first three purposes. The potential purposes are not mutually exclusive. For example, choice and voice are not only important because of the intrinsic value to an individual but also can be powerful drivers of improved care.

Transparency and openness have become crucial building blocks for the interaction between the NHS and public and individuals.[9] Throughout the course of the review process, there was widespread support for the principle of transparency of information (making information publicly accessible) – as an end in itself as well as for the benefits it could bring.

Increased public reporting of performance information in health and other sectors is an international trend[10] and there are well recognised potential benefits and risks. As part of the consultation, we asked what stakeholders thought were the potential advantages or disadvantages of publishing indicators in the public domain. Table 1 overleaf summarises the results.

Throughout our engagement exercise, stakeholders were supportive of the concept of 'intelligent transparency' and an approach to publication of information that would enhance the advantages and minimise the disadvantages suggested in Table 1. The factors thought to increase intelligent transparency include:

- robust data (for example, data are timely, accurate, complete, stable and unambiguous)
- appropriate selection of indicators to be meaningful and useable for the intended audience
- a set of indicators that cover key domains of quality
- a set of indicators that reflect care attributable to the general practice
- a clear presentation of indicators
- appropriate interpretation of indicators.

Table 1: Potential advantages and disadvantages of transparency in general practice quality indicators based on consultation feedback

Advantages	Disadvantages
Increase transparency, openness and accountability	May mislead if indicators are not robust, taken literally and used to 'judge'. May mislead if indicators do not take into account the context in which the practice is providing care
Enable patient and public choice	Information could be misinterpreted by the public, media and politicians
Support quality improvement and organisational development	Using indicators that are not robust, or are insufficient in scope, to judge practices will demoralise staff, increase stress and lead to defensive behaviour that is unhelpful in developing a learning culture
Support patients to understand better the quality of care provided	Cause concern for the public or undermine trust in general practice (particularly if data are inaccurate)
Support benchmarking	Could increase administrative burden or require increased funds to collect, publish or analyse the data
Facilitate candid discussions and incentivise practices to take action	Provide a limited or crude reflection of quality or encourage an overly simplistic view of general practice
Encourage better data quality	Focus only on data quality for published indicators and neglect other areas
Help identify shortfalls in resourcing and provision	Make it difficult to recruit staff in deprived areas
Encourage patients to take more responsibility for their health	Could encourage a target driven culture/gaming at the expense of spending time on patient care
Could raise demand and patient expectation	Could raise demand and patient expectations

How indicators are appropriately selected and presented to different audiences depends critically on their purpose.

For example, indicators for accountability (which implies a judgement and for which consequences such as performance management may follow) need to be robust. Indicators to help patients make a meaningful choice between practices are likely to be very different to those used by clinicians for improvement and smaller in number. Indicators used for improvement need to be more numerous and at a more detailed level for practices to be able to interpret the data, make specific changes to care and monitor improvement.

Table 2 outlines some characteristics of indicators used for achieving accountability (which requires a 'judgement') and those used for encouraging improvement.

Full transparency (for example, publication of indicators on a public website) may make little or no distinction between the purpose intended by mixing indicators for accountability, improvement and choice by the public. This increases the risk of the disadvantages outlined in Table 1. During our engagement events, a number of people challenged the traditional view that data for improvement purposes could be less robust than those data used for judgement and also suggested that as soon as data were published, there were risks of unintended consequences. Conversely, characteristics of improvement data were seen as being important for judgement. For example, allowing for context and using data as a tool for learning and improvement.

Table 2: Characteristics of indicators used for judgement and improvement

Judgement	Improvement
Interpretation should be unambiguous	Interpretation could be variable
Attribution should be unambiguous	Ambiguity is tolerable
Definitive marker of quality	Can be a tool for screening issues
Statistical reliability is required	Statistical reliability is preferred
Data quality should be robust with good quality risk adjustment	Data quality is less critical and partial risk adjustment tolerable
The focus is on judgement which might include punishment or reward	The focus is on learning and changes to practice
Data for public use	Data traditionally for internal use
The data stands alone	Allowance for context
Risk of unintended consequence is high	The risk of unintended consequences is lower
Source: Raleigh and Foot, 2010.[11]	

Indicator burden and finding the signal not the noise

There are currently hundreds of indicators available which reflect the care provided in general practices in England (although the indicators may not always be good quality). The many indicators may create benefit but they also use up resources to develop and maintain and may create a burden on data collectors (many of whom are providing front line care) and require significant resource to analyse and process. Furthermore their sheer number may make it difficult to see the 'signal from the noise'. Fundamental questions include: do all these indicators need to be collected, and are there others that need to be developed? In short, what matters most for different purposes and audiences, and is it possible to be more streamlined, given the burden of data collection, analysis and presentation? While not the main subject of this review, we return to it in Chapter 3.

Defining quality

Defining quality of care in general practice was beyond the scope of this review. In reality for whatever branch of health care, only a small amount of its quality is measureable. Therefore, humility is needed when coming to a 'judgement' about the overall care provided. Assessing quality provided by general practices has its own challenges, not least because of the nature of care provided: '*the generalist sees health and ill-health in the context of people's wider lives, recognising and accepting wide variation, in the way those lives are lived, and in the context of the whole person*'.[12] Given the more generalist nature of care provided in general practice, the interpretation of quantitative data can be challenging and local context is important. This is a big challenge when providing indicators on public-facing websites, particularly if the indicators are intended (or used) to add up to an overall simple 'judgement'. The King's Fund's 2011 inquiry into quality in general practice found it difficult to identify a set of indicators that reflected the key dimensions of the quality of care in general practice as these dimensions do not always lend themselves to quantitative measurement.[13]

Furthermore the concept of quality and the indicators generated to assess it are generally defined from the health professionals' point of view,[14] despite there having been many studies identifying what patients' value most when receiving health care.[15,16] The individual needs, preferences and circumstances of patients should determine what is considered to be good quality care. These may not always align with what is considered to be the best outcome from a clinical perspective.[14]

Both of these points suggest that any set of indicators purporting to assess the quality of care can only be a starting point for further investigation. But assessment has to start somewhere. There can be no improvement without measurement and assessment and indicators should be developed to support more effective assessment over time. How best to do that is the underlying question addressed in subsequent chapters.

Summary and conclusions

For any indicators on quality of care in general practice to be most useful, it is important to clarify their purpose/s and the intended audiences. As well as transparency often being seen as an important end in itself, we identified four main purposes of publishing indicators, with associated audiences:

- **Improvement:** to support improvement of care (for example, by general practices).
- **Choice and voice:** to support 'choice' and 'voice' (for example, to enable patients and service users to make informed choices or argue more effectively for improvements to be made).
- **Accountability and performance management:** to provide data for accountability to another organisation/group (which may then 'performance manage' the general practice). For example, accountability to the local CCG, to a regulator, to the public or to politicians).
- **Research:** to provide data for third party research (for example, by universities, think tanks and others).

In our review we focused on the first three of these purposes.

There is widespread support for transparency, but for 'intelligent transparency'. How indicators are appropriately selected and presented to different audiences depends critically on their purpose, and indicators selected for one purpose may not be appropriate or most helpful to achieve another. In particular, indicators for the purposes of boosting accountability and choice may need to be more robust, unambiguous and smaller in number than indicators for improvement.

There are hundreds of indicators available which have bearing on the quality of care provided by general practices. Fundamental questions are: Do all these indicators need to be collected, and are there others that need to be developed? In short, what matters most for different purposes and audiences, and can we be more streamlined given the burden of data collection? We return to this issue particularly in Chapter 3.

Defining quality of care in general practice was beyond the scope of this review. In reality, for whatever branch of health care, only a small amount of its quality is measureable. This must signal that humility is needed when coming to a 'judgement' about the overall care provided. The more generalist nature of care provided in general practice means that interpretation of many indicators is not likely to be straightforward and need much more attention to local context. This is a major challenge particularly if published indicators are intended (or used) to add up to an overall simple 'judgement'.

The next chapter examines the information already published on websites in the public domain on the quality of care of general practices in England.

3. Main national websites available and how they are used

Overview of websites

A range of national public websites already contain information about the quality of care in all general practices in England. These draw on a range of data sources including: the Quality and Outcomes Framework (QOF); the general practice patient survey (GPPS); the Health and Social Care Information Centre's (HSCIC) Indicator Portal; and indicators and ratings from the Care Quality Commission (CQC).

Table 3 overleaf gives an overview of some of the current national websites containing indicators on quality. In addition, there are separate websites for accessing indicators from the source data (for example, QOF indicators, indicators from the GPPS, and a range collected by the HSCIC). The CQC provides a rating for each general practice in England which is informed not only by a set of quantitative indicators, but also by information from inspections and other local qualitative information. Appendix D gives a more detailed overview of these websites and includes screen shots.

One of the websites, NHS England's Primary Care Web Tool (PCWT), aims to support measurement across practices for the purposes of improvement and accountability, and is the only website shown above not available to the public. Instead it is accessible via a password to people working in general practices, NHS commissioners and other approved stakeholder organisations.[17] The PCWT contains information from the GP High Level Indicators (GPHLI) and the GP Outcome Standards (GPOS).

As Table 3 shows, there are very many indicators and many websites, and each website often serves more than one purpose (and audience). For example, the MyNHS website states:

> *'on this site we have one place where organisations, professionals and the public can compare the performance of services across health and care, over a range of measures, and on local and national levels.'*[18]

Looking more closely at the indicators used, many are duplicated across sites, some are similar but not identical, and the presentation and usability is highly variable. Usage figures also vary enormously. The public-facing NHS Choices website routinely receives millions of visits each week (for example, between 31 August and 6 September 2015 there were 10.6m visits[19]) but its remit extends well beyond information on quality to include information on symptoms and signs of common illnesses. By contrast, the MyNHS website (focusing predominately on information about quality across all sectors) received 261,539 visits in total between 19 September 2014 and 2 August 2015.[20] Web analytics data from the PCWT show that, for Quarter 4 2014, data had been viewed for 80.3% of practices.[21]

Table 3: Overview of websites for accessing information about quality of general practice

Website	Purpose	Audience	Publicly available	Information included/indicator domains	No. of indicators
NHS Choices	Choice/voice Transparency	Public	Yes	Key facts, Online facilities, Patient experience, Patients with long-term conditions	30
MyNHS	Performance Improvement Transparency Accountability	Public Professionals	Yes	Practice workforce. Safe & Effective, Caring, Responsive, Care of over 75s, Chronic disease management, Diabetes, Cardiovascular disease, Cancer	48
Primary Care Web Tool	Improvement Accountability	General practice staff, CCGs and area/regional teams in NHS England	No	Preventing people from dying prematurely Enhancing quality of life for people with long-term conditions Helping people to recover from episodes of ill health or following injury Ensuring people have a positive experience of care Treating and caring for people in a safe environment and protecting them from avoidable harm	72 (General Practice Outcome Standards and GP High Level Indicators
Public Health England's National General Practice Profiles (PHE's NGPP)	Commissioning support Transparency	NHS and local authority commissioners and staff	Yes	Practice Summary, Estimated disease prevalence, Variety of different conditions, Other conditions, Secondary care, Child Health	266
CQC Intelligent Monitoring reports	Accountability Transparency	Public GPs	Yes	Effective, caring, responsive	33
CQC rating of general practices	Accountability Transparency	Public GPs CCGs, NHS England	Yes	Safe, effective, caring, responsive, well-led	N/A
GP Patient Survey (GPPS)	Improvement Choice/voice	Public Professionals	Yes	Appointments, GPs, Nurses, Reception, Out-of-hours care, Waiting time, Opening hours, Overall experience	58 (excluding dentistry related indicators)
QOF (2015/16)	Improvement Accountability Research	Professionals	Yes	Clinical (various disease groups) Public Health	77

The wealth of data (and potential for conflicting indicators) risks confusion of interpretation, particularly by the public. This and the underpinning time and cost to develop and maintain each website suggests there would be value in rationalisation and consolidation of websites – a conclusion also reached by The King's Fund in a review in 2011.[13]

This was supported by a number of respondents to our online consultation exercise. Respondents expressed confusion over the number of websites available and said they failed to give an adequate picture of quality.

> *'One of the problems I and the practice faces is that there are just too many websites…and each contains different bits of information.'*

> *'There should be one location for the public to obtain key information about providers, and one other that contains all the technical information and reports.'*

> *'We need one overarching website for accessing data on quality of care in general practice.'*

We recommend working towards consolidation of these websites into one single website in the public domain. Consolidation would be in line with the longer-term direction of travel to develop a single web portal for health and social care information. The National Information Board has suggested that MyNHS has been:

> *'established as the nexus of a much more ambitious transparency initiative… effectively creating a single point of access to information across the health and care system, which will become the single go-to place for professionals and the public to find what data is available and where to pursue it, depending on what level of detail they need.'*[22]

There has been progress but there is clearly some way to go.

While consolidation has significant potential benefits, it raises a number of practical issues that would need to be considered. Firstly, at present the PCWT is restricted and there are four major issues which contributed to the decision to restrict access to it. These are:

- inclusion of data based on small numbers of patients
- restrictions imposed by data providers
- data presented needing to be understood in the local context of the practice
- the tool currently includes analysis that would not normally be published in the public domain, including practice ratings and outlier identification.

Its status as a restricted website has previously been considered by a task and finish working group, established at the request of NHS England's National Primary Medical Services Assurance and Quality Improvement Steering Group. The working group concluded that it could be feasible to make publicly available the GPOS, GPHLI modules and the national dementia prevalence calculator.[23] There are strong arguments for putting data where possible into the public domain. Indeed, GPOS are already available in the public domain in the London region's public-facing website, MyHealthLondon (see page 34 for more details).

There are a number of different options which would enable PCWT content to be published in the public domain nationally. These include giving the general public access to the tool, sharing cuts of data with other websites and providing copies of practice data reports as PDF files.

In our view, it would be preferable to share cuts of data on a consolidated website (be that MyNHS or another) rather than opening up the PCWT to the public. While it would be possible to place some PCWT indicators into the public domain, it is likely that some information may need to remain on a restricted portal for professionals (and the bodies general practices are accountable to) to allow for additional analysis and functionality as well as containing more information on local context. This could potentially result in some duplication rather than achieving full consolidation.

The second challenge to consolidation is ensuring that functionality is appropriate for different audiences. As noted above, the existing websites include different numbers of indicators and may be used for different purposes and by different audiences. If all the websites were to be consolidated, the MyNHS website may be the most likely candidate to host the content, given the broader objective to develop this website into the 'go-to place' for health and social care information. However, the functionality of Public Health England's National General Practice Profiles (PHE's NGPP) and the PCWT are, in our view, far superior to the current functionality on the MyNHS website. Consolidation might risk a worse user experience (particularly for a professional audience) if not designed and implemented carefully.

We believe that there should be a distinction between publicly available indicators and indicators that are designed specifically for the public in mind. MyNHS is currently intended to serve both public and professional audiences. However, we are concerned that if additional indicators are included on MyNHS (such as from the PCWT) without additional effort to tailor content for specific audiences, the data might be overwhelming for a public audience. One approach could be to have separate channels on MyNHS for the public and professionals which present information tailored to these audiences, something which would add value.[13] An alternative option would be to reframe the MyNHS website as a website for professionals.

Consolidation and tailoring the current websites to the key intended audiences then would need careful design and implementation. While not a quick fix, the potential advantages could be significant.

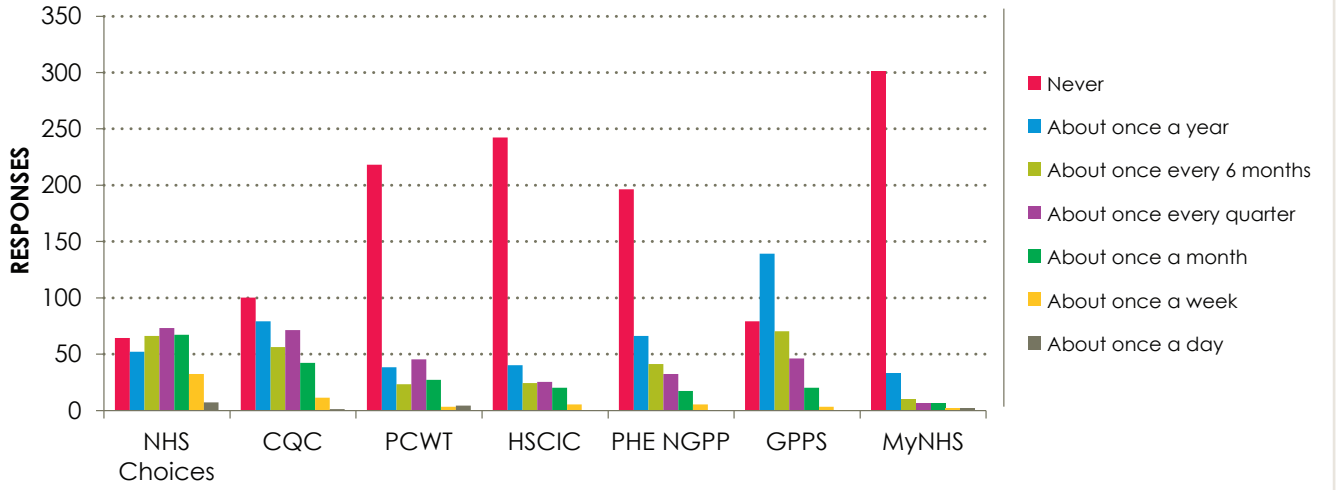
Use of websites: professionals

Our online consultation revealed a general lack of knowledge, and use, of key national websites by staff working in general practice.

Staff in general practice – for improvement

A key purpose of information on quality of care for staff in a general practice is to compare with others and to target areas for improvement. In the online consultation, respondents were asked how often they used national websites to find information on the quality of care in their or another practice. Chart 1 shows the responses by practising GPs (n=361).

Chart 1: Frequency of use of national websites: Respondents to the online consultation who were GPs

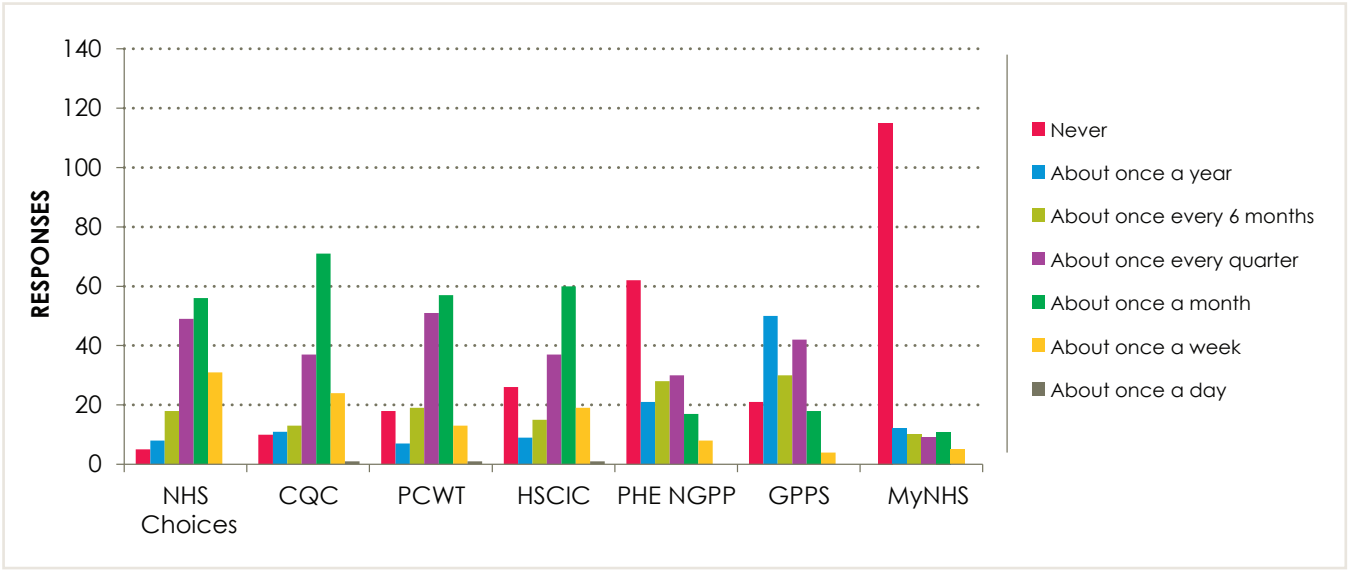


The chart shows that by far the majority of GPs responding to the consultation never use MyNHS, PCWT, HSCIC or PHE's NGPP and a minority use NHS Choices, CQC and GPPS. This was also reflected in the stakeholder engagement discussions, which suggested that GPs and practice staff tended to use indicators from the local CCG for improvement. The reasons cited were that local indicators were often more detailed, timely, easy to understand and could be interpreted more appropriately by CCGs because of having more information (formal or informal) on local context to more appropriately interpret the data or indicators. As respondents put it:

> *'All the current measures are iceberg measures – just measuring a visible tip with no understanding about what lies beneath.'*
>
> *'[The] majority of information is old and out of date and not published in real time, thereby making it inaccurate.'*
>
> *'Each practice is quite individual and comparison is not always easy/straightforward. The information can be out of date and is only relevant if it is kept updated.'*

In contrast, staff working in a general practice who were not GPs (n= 167) tended to use the national websites more frequently (see Chart 2 below). It is not possible to tell from the online survey the extent to which non-GP staff are accessing the data from online sources to repackage information for colleagues including GPs.

Chart 2: Frequency of use of national websites: Respondents to the online consultation who were not GPs



While the results are unlikely to be fully representative, they do point to a lack of awareness of existing data and information sources. Respondents who reported using online resources were asked why they did so. Table 4 shows that the responses were quite varied and ranged from improvement purposes to being able to respond to patient feedback online.

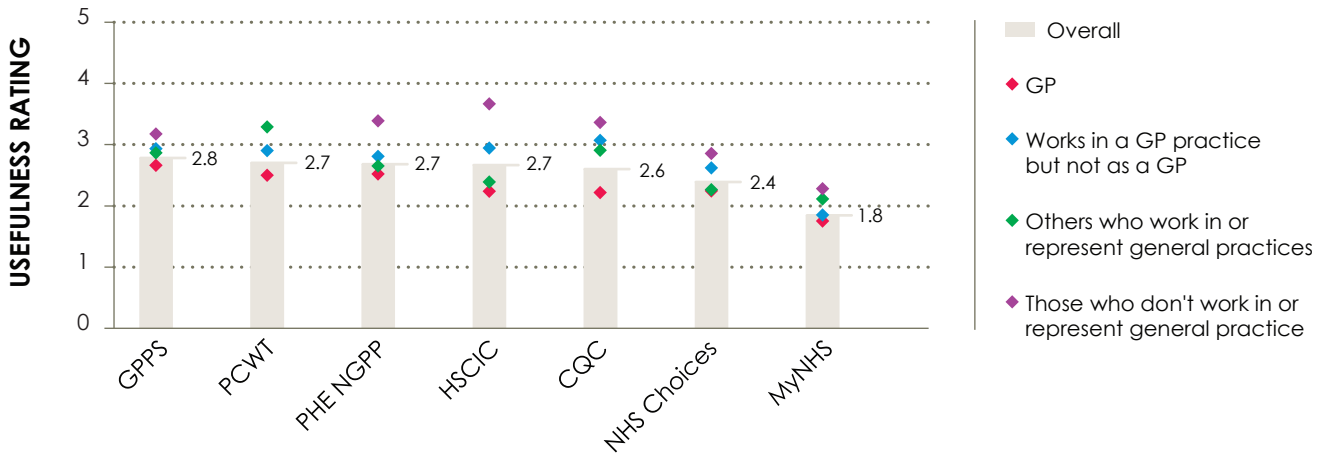
Table 4: Consultation responses: reasons for looking at online sources of information about quality of general practices

Theme	Specific reasons for looking at online sources
Information	• To look at the quality of a GP as rated by others. • To see how a GP's own practice is comparing with other practices, and what services are being provided by other practices (sharing good practice). • To determine how a GP's own practice is viewed externally when trying to recruit staff or maintain/grow the patient list. • To look for signs that a practice is in difficulty.
Patient feedback data	• To address and respond to patient views - to keep updated of negative comments posted by patients on NHS Choices and to thank patients for kind comments. • To inform patient participation groups. • To see what external information patients are receiving about general practices.
Appraisal or regulation preparation	• To gather supporting information for the GP appraisal process. • To find out what is needed to pass CQC inspection.
Improvement	• To help inform the design of research and service improvement projects. • To consider population approaches to problems. • To develop audits to support identification of patients at risk. • To look at best practice and recreate it. • For ideas about quality improvement. • As a tool to assess the variation in quality of general practices across the area.
Business planning	• To inform contract discussions with NHS England and the relevant CCG. • To check guidance for the QOF. • To plan staffing and care appropriate to general practice population demographics. • To business plan for the year in line with resource planning.

As well as suggesting a range of uses for online information, respondents were asked how useful they found the various websites on a scale of 1-5 (where 1 was the least useful and 5 the most useful). Chart 3 shows the responses by GPs, other staff working in general practice and others.

The number of respondents who answered 'don't know' or 'N/A' varied considerably – just 8% for NHS Choices but 69% for MyNHS. For all websites, the response of 'don't know' or 'N/A' was consistently lower among those who work in general practices compared to GPs themselves, perhaps reflecting their varying engagement with such websites. The overall usefulness scores for all the websites were consistently low (averaging between 1.8 and 2.8 – see Chart 3). Those who didn't work in or represent general practice responded most positively, followed by those who work in general practices but weren't GPs. GPs themselves consistently gave the lowest score for each website.

Chart 3: assessment of usefulness (by respondent) (excluding NA and don't know responses)



While the results of the consultation may not necessarily be representative, they do pose questions about the utility of these websites for staff responsible for making improvements to frontline care for patients, particularly by practising GPs. The results also suggest that practice staff may be a key audience to consider when targeting information for improvement. Much more careful engagement is needed with both groups on identifying the indicators likely to be useful for improvement and how they can best be presented.

Qualitative responses suggested why the usefulness scores of national websites might have been so low. Key themes that emerged were:

- **No time to look at and make sense of information**: there were already too many indicators and a major barrier to consulting online resources was staff time.
- **Not a meaningful picture of quality**: the existing indicators were thought not to give a true representation of the quality of care provided in general practice, were too high level, were not adjusted for local context, and it was felt that quality in general practice could not be reduced to measureable indicators or numbers. As some respondents to the online survey put it:

  'Measurements are essentially tick box outcomes and fail to capture the time, appropriate effort and quality of care that is applied.'

  '[The websites show] lots of performance data but limited quality data.'

  'What matters, can't be measured. What can be measured, doesn't matter.'
- **Demotivating**: public online resources were reported to dishearten some working in general practice, particularly those working in practices deemed to be 'struggling'.

If practice staff are not using national websites to help improve quality, what other information are they using? Mainly local sources were highlighted in responses to the consultation. In particular:

- **CCGs:** local quality dashboards, locality or practice information packs, CCG referral and admission rate web tools and local indicators.
- **Feedback:** direct feedback from patients, in-house patient surveys, patient complaints/compliments, feedback from colleagues and peers.
- **Internal resources:** in-house data collection.
- **External resources:** QOF data, the Electronic Prescribing Analysis and Cost (ePACT) service, NICE guidelines and the Friends and Family test.

Our online consultation had some respondents who classified themselves as not working in general practice. The sources they tended to use for information on local general practices were:

- **informal networks:** feedback on a general practice from people that they knew – such as friends and neighbours, or by word-of-mouth – was important
- **local resources:** information from local medical councils or locally produced data
- **external resources:** the PCWT, QOF, Friends and Family test. Respondents referenced the following websites as useful sources of information:
  - *iWantGreatCare.org*
  - primarycare.nhs.uk
  - health journalism websites (PULSE, BMA news, NHS Network News)
  - www.practiceindex.co.uk
  - Healthwatch.

Could indicators on national websites be made more useful to staff in general practice for improvement?

The stakeholder meetings suggested that, to make improvements in the quality of care, a wide range of indicators would be needed with enough detail to help pinpoint what changes could be made, and for practices to be able to measure tangible improvements. Highly aggregated indicators were not viewed as helpful as they could not help pinpoint tangible areas for improvement, could give a misleading picture of quality (for example, they could mask areas of poor quality care) and efforts to improve care may not readily alter an aggregate score.

There was a consensus that, to be useful for improvement, indicators would need to:

- cover a comprehensive range of care to avoid being misleading
- measure aspects of care within the gift of general practice to change
- draw upon sufficiently robust data. Where possible indicators should be stable to allow for comparison over time.

It was felt that indicators should be complete, timely, accurate, stable (not show undue volatility) and be unambiguous in what they were purporting to measure. If comparative indicators were to stimulate action to improve care and not inappropriately demotivate practice staff, it was thought important to make some allowance (whether through quantitative adjustment of data or some other means) for local context.

> *'Most variation between practices is due to the variation in population rather than the quality of care.'*
>
> *'There is no differentiation between the huge differences in patient demographics, social circumstances, services available to practices, funding variables etc.'*

Many general practice stakeholders consulted for this review said they would value the ability to compare with their peers who are working in a similar context. It was recognised that context comparisons were complex and that currently there was not adequate quantitative information to be able to adjust the indicators for context beyond very basic characteristics. Public Health England is already doing work in this area and has identified a number of characteristics that could be considered, including age, socioeconomic deprivation, geographic location, proportion of the registered population of different ethnic groups, registered list size, proportion living in nursing/residential homes, proportion of men registered, estimated number of Disability Living Allowance claimants per practice, a measure of staff capacity, training and/or dispensing status and the proportion of the population with long-term limiting illness.[24]

As an extension of peer group comparison, we discussed with stakeholders the possibility of developing a value-added score in a similar fashion to education. This is likely to be a longer-term objective – value-added scores were piloted extensively in education and it took a number of years to develop the methodology. From 1998, there was piloting of methodologies to assess the value of the last two years of secondary education prior to GCSE exams but it wasn't until 2004 that a value-added score could be published that covered the whole period of secondary education.[25]

In assessing value, Better Value Health Care has suggested that value should cover personal value (delivery of services informed by what matters to the individual), technical value (determined by how well resources are used within services) and allocative value (how resources are allocated to services for different purposes).[26]

The alternative to having a long list of indicators on quality available nationally would be to support CCGs to develop local dashboards of indicators, where many practices turn to first for information about the quality of care. While it was acknowledged that some CCGs were very advanced in developing and using dashboards, others were not, and should be encouraged to do so. Some CCGs might need to depend (initially at least) on a set of nationally available indicators (for example, on MyNHS). Furthermore, there was some acknowledgement that in developing dashboards many CCGs were expending avoidable energy 'reinventing the wheel', and using different definitions to collect and describe data. Supporting the creativity of CCGs is important but there may be scope to share learning and develop a more consistent framework to support local areas.

It was also recognised that taking into consideration local context was very important when interpreting the indicators. Given the limitations of quantitative adjustment, CCG's informal, tacit local knowledge was thought important in supporting practices to improve.

> *'Allow CCGs to develop their own quality indicators and support this development. It is pointless comparing a Practice in Liverpool with one in Surrey as the demands are completely different.'*

Use of websites: the public

For the public, a key purpose for information on quality of care by general practices is to help them make informed choices, for example to choose or switch practices, or to give them evidence to argue more effectively for improvements to be made ('voice').

There is evidence to suggest that the quality of care in a practice may impact on the choice of practice by patients. For example, a 2008 study surveyed patients (n=1,193) from six practices with patients choosing between primary care consultations that differed in attributes such as ease of access, flexibility of appointment times, continuity, thoroughness of examination and multiple aspects of person-centred care. Patients appeared to place a high value on the thoroughness of examination and continuity of care based on stated preferences.[27] Other studies have shown that patients had high expectations around access and continuity of care.[15] More recently, Santos and colleagues looked at data from 2009 on the choices of 3.4m patients from 994 practices. Patients were more likely to choose practices nearer to their home, with a higher proportion of GPs qualified in Europe, a higher proportion of female GPs, and a lower average GP age. Given other practice characteristics, patients were more likely to choose practices that earned more quality points under the QOF pay for performance scheme. QOF points appeared to predict practice choice better than other measures of quality such as patient satisfaction.[28] There is also evidence to suggest that practices with low levels of patient satisfaction (particularly for doctor-patient communication) are more likely to experience high rates of disenrollment.[29]

But despite there being wide variations in the quality of care in general practices, evidence suggests that patients are not routinely using published information to make informed choices, but instead rely almost exclusively on subjective and informal sources (word of mouth, reputation and personal recommendations from other patients).[13,30,31,32]

This was echoed in a recent survey and report by Monitor, which found that patients were aware of and valued their ability to choose their general practice, and that they would consider broader issues rather than location, such as clinical quality and ease of making an appointment. Further, Monitor found a difference between the stated and revealed preferences of patients.[33] In reality most patients chose their practice on the basis of location and did not look for information to help choose on the basis of quality.

The report found that fewer than 3% of all patients used published comparative information available online as their main source of information to compare the practices available to them. Of the minority of patients who had compared practices, 15% had used the NHS Choices website, and 5% the GP Patient Survey results. When people were asked how their practice compared with other local practices, only 4% of patients based their response on the information published online about performance of their own and other general practices (eg NHS Choices or GPPS).

Monitor concluded:

- Although patients' ability to make an informed assessment is key to effective patient choice, transparency does not necessarily mean that patients will engage with the information and make choices based on that information.
- The fact that most patients do not use the available information about differences between general practices appears to stem, to some extent, from their difficulties in accessing and understanding that information. However, the main reason that patients do not make full use of available information appears to be because they are not looking for it.
- There was significant scope for more patients to base their choices on objective information.
- Information about general practices can be useful for patients if it is based on impartial and robust information, adequately captures what matters to different patients, and is effectively communicated to patients (including vulnerable patients who might otherwise not seek information).[33]

Monitor's findings reflect the results from eight public focus groups* that were conducted by insight agency BritainThinks on our behalf as part of this review. It should be noted that (although the sample size and methodologies were not comparable) the focus group participants' awareness that they had a choice of a practice appeared low in contrast with Monitor's findings. For example:

> *'I thought I had to go to the nearest one.'*
> Male, Southampton

Just a minority of participants had switched practice and the trigger for this was moving house. Just one participant had switched because they were dissatisfied with their previous practice. In addition, many felt that, in reality, choice was limited by the number of practices in the area. This was felt particularly strongly in rural areas.

> *'You don't have a choice here, the next one is a half-hour drive away.'*
> Female, Diss, Norfolk

* Eight focus groups were conducted in four locations across England. Sample composition was structured to ensure findings could be analysed by gender, age, health and environment (urban, suburban and rural). Fieldwork was conducted from 11–17 August 2015.

A perception among some participants that the services delivered in all practices were broadly the same meant that they struggled to see the value of choice.

> *'I think the service is the same at every GP, isn't it?'*
> Male, Diss, Norfolk

Even among those who had switched, almost no-one had compared information about different general practices before making their decision. When moving house, most had simply chosen the practice nearest to their home or one recommended by friends or family. Most participants struggled to think what information might be available, other than the location of practices. Older participants found this particularly difficult.

> *'I switched when I moved. My girlfriend said hers was good, so I just go there.'*
> Male, Manchester

> *'I don't really know where I'd go [to find information]. I guess I'd just go on Google.'*
> Female, Southampton

However, when participants were made aware of the availability of information comparing practices, most felt strongly that it was important that such information was available. The focus groups found that the public would be most likely to look for information if they were dissatisfied with their current practice, or had recently moved house.

Participants' major concern about general practice care was access. The information they suggested would be most useful was: how easy it would be to get an appointment, and with their preferred GP; and practical issues such as whether there was an online prescription service. Participants also felt that information about patient satisfaction would help. There was low awareness of the Care Quality Commission, but on understanding the role of CQC, there was a feeling that CQC ratings could assume a similar role to Ofsted ratings for schools.

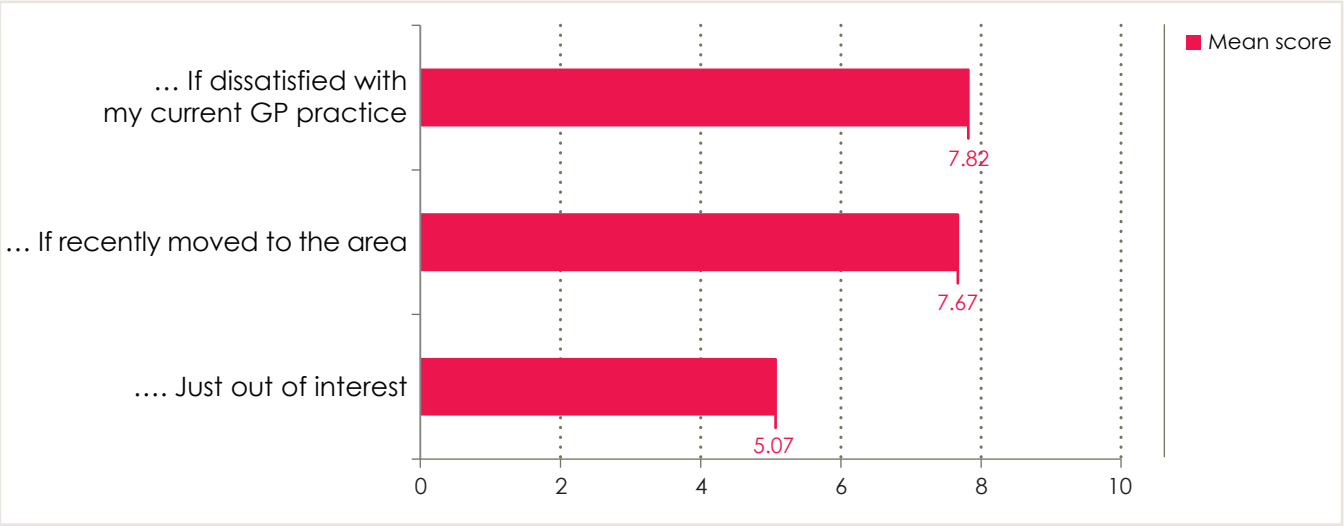
In addition to the focus group work, BritainThinks conducted a quantitative survey with data weighted to be representative of the adult English population. 1,723 online interviews were conducted from 19–21 August 2015. Participants were asked the following question:

> *'There is publicly-available information which allows patients to find out more about general practices in their local area. As well as address and location, this includes other types of information about each practice. Please state how likely or unlikely you are to look for additional information (ie not just address) about general practices in the local area in each of the following situations.'*

Chart 4 (overleaf) outlines the responses. Insights from BritainThinks' work suggest that demand from the public for comparative information about general practices may be higher when moving house or when dissatisfied with a general practice.

Demand may be limited by extremely low awareness of the availability of comparative information as suggested by our focus groups. However, there is potential for greater public engagement with comparative information, particularly if signposted when individuals move house.

Chart 4: Likelihood of looking for information (other than location) about general practices in the local area…



How might online information for the public be presented more effectively?

The evidence suggests that consumers focus on a few key criteria to make choices and that they risk being overwhelmed by a large set of indicators.[30] The UK Statistics Authority (UKSA) notes that published statistics are not sufficiently accessible for use by the public and the presentation of statistics often appears to be designed for performance management purposes for expert users. The UKSA was also clear that many users (whether in the NHS or members of the public) require further interpretation, guidance and summary.[34] Similarly the consumer organisation Which? has recommended that online information on health care for the public should be provided in a range of formats with different levels of detail to cater for varying needs.[30]

Clearly, how data are presented on publicly-funded websites, such as MyNHS, should be subject to effective market research. But this review process has shed some light on how indicators could be presented most effectively for the public audience.

Through the focus groups conducted by BritainThinks, participants were given screen shots of information displayed on NHS Choices, MyNHS and the CQC rating. The NHS Choices website was strongly preferred because:

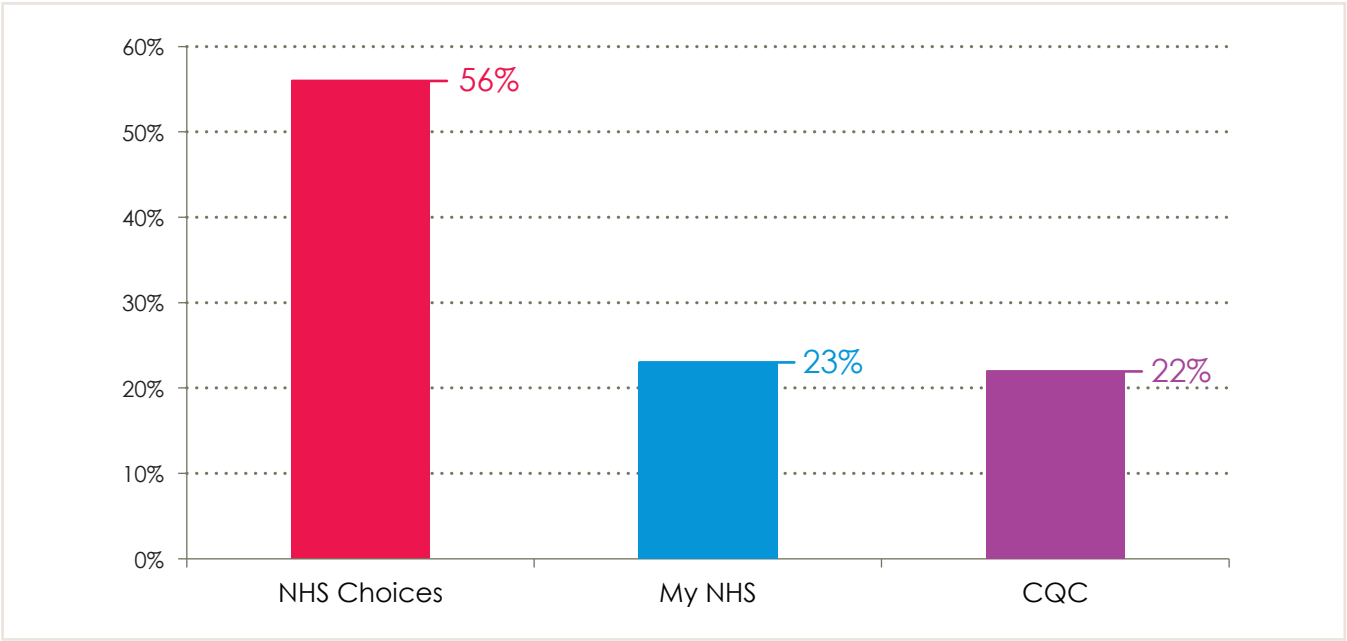
- it was well laid out, with key information easily identifiable
- the combination of percentages and 'traffic lights' was easy to understand and gave depth of information (although for professionals this may be viewed as too simplistic)
- the focus on practical information was in line with what participants felt would be most useful to them.

There was a concern that the categories used on the CQC's website (safe, caring, effective, responsive, well-led) were too vague. Many found MyNHS hard to navigate and thought that the percentages would be difficult to interpret for many. While a minority liked the use of a large number of statistics, most wanted a few.

> *'There's too many figures [sic]. Sometimes when you see too much information you think, 'I can't be bothered!'*
> Female, Manchester

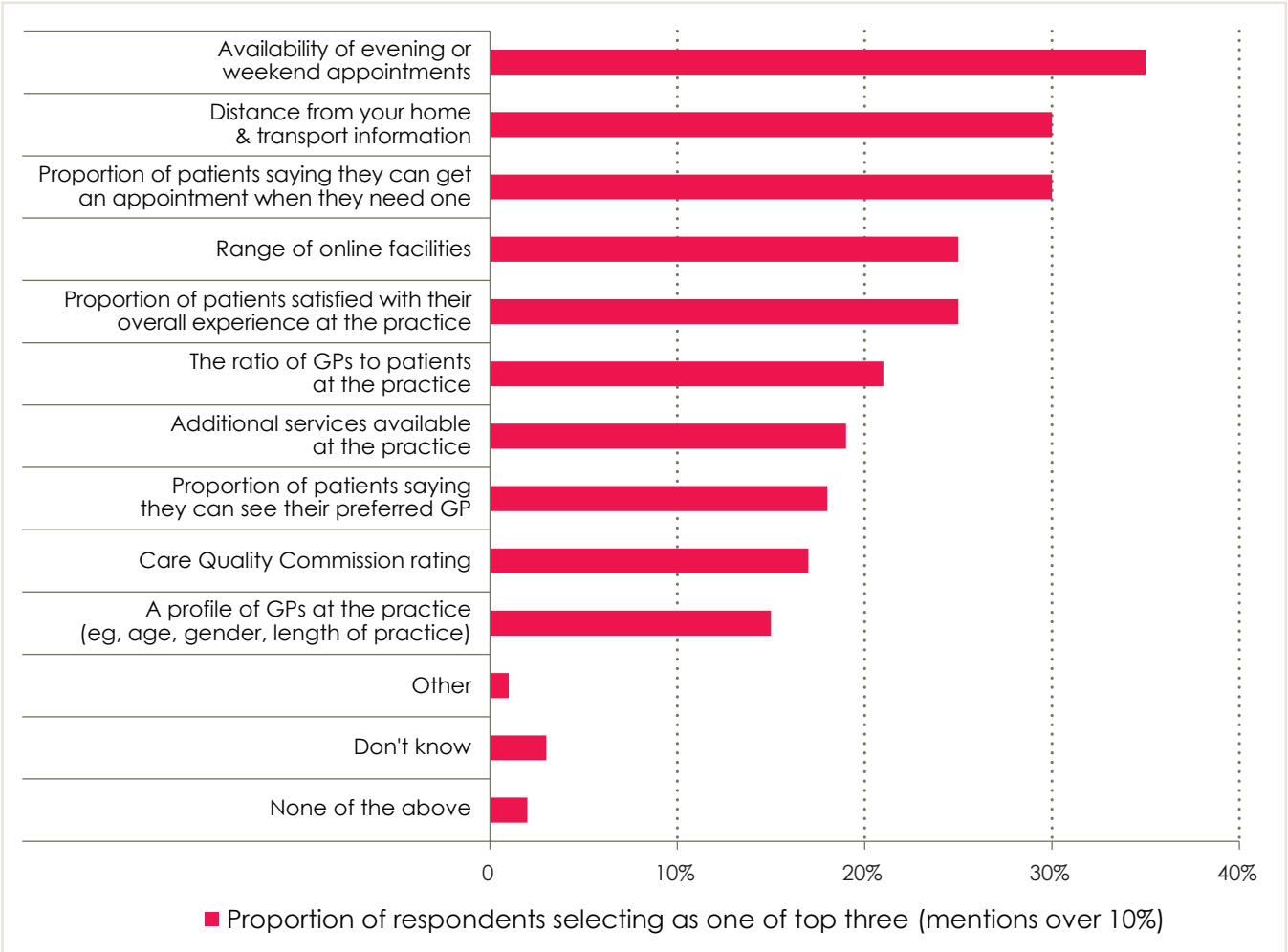
The qualitative insights from the focus groups were supported by the BritainThinks survey. Participants were asked to indicate which website they would prefer to use if they were finding out about or comparing general practices. Again, there was a clear preference for the design and format of NHS Choices (56%) compared to MyNHS (23%) and CQC (22%).

Chart 5: Proportion of respondents selecting each website as their preferred option (N=1,723)



As part of the survey, we also asked respondents about the types of information they would find most useful to know about their current general practice or to compare alternative practices. The results are shown in Chart 6.

Chart 6: Proportion of respondents (N =1,723) selecting as one of top three (mentions over 10%)



The results in Chart 6 suggest that, again, indicators relating to access and satisfaction were people's highest priorities (although the list was limited and other studies suggest that interpersonal care is a key determinant of satisfaction[35]). Information on access and satisfaction is currently available on the NHS Choices website. There is therefore a question about the role that MyNHS is expected to play as a resource for the public, who may struggle to engage with the more complex presentation of data on the MyNHS website.

There is considerable scope to improve the MyNHS website for public use. Initial steps that could be taken to improve the functionality include:

- ensuring that information is clearly presented and easy to navigate
- developing more visual clues such as colour-coding (albeit there are risks to this approach if appropriate contextual information is not included)
- including more explanatory information on why indicators are important and what they mean
- selecting a smaller sub-set of indicators for the public or allowing the public to self-select
- designing a channel for the public and a channel for professional use in the public domain.

However, there may be more value in developing the MyNHS website as a professionally-focused website that is publicly available, or developing a specific public-facing channel that tailors data more specifically to the needs of a non-professional audience.

Alternative options for presentation of publicly available data

As part of the review process, we looked at a range of publicly available websites internationally. We were particularly impressed by the presentation of performance data in Minnesota.

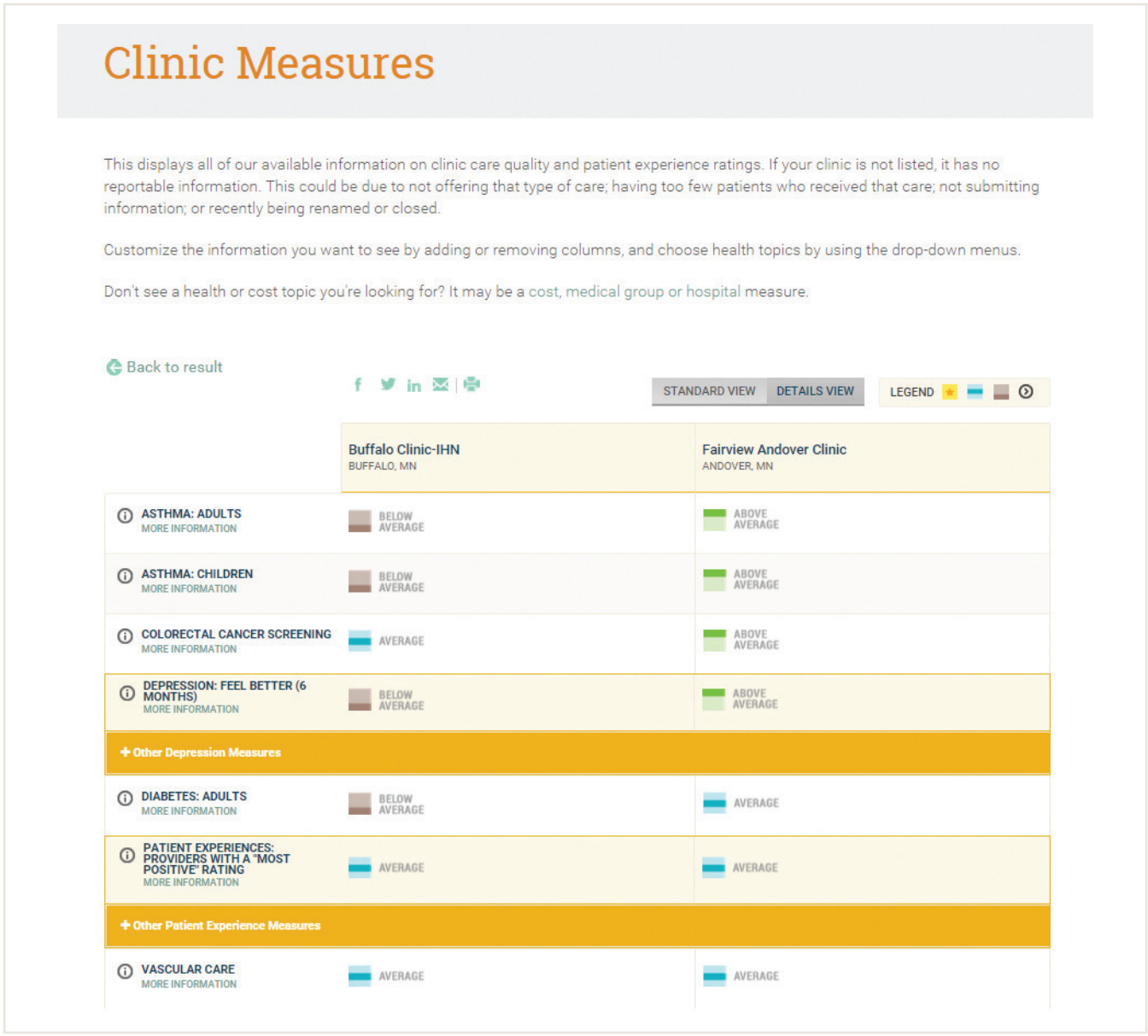
MN Health Scores, Minnesota, US

MNHealthScores is a public facing website where patients can find unbiased, trustworthy information on the quality of medical clinics, patient experience and cost information.[36] Further detail can be found here: www.mnhealthscores.org

MNHealthScores is facilitated by MN Community Measurement, a non-profit community organisation. Their aim is to provide health care data as transparently as possible. From 2002 medical data have been collected and since 2004 the data were published online. As of August 2015 more than 1,400 clinics, 535 medical groups and 140 hospitals in Minnesota and surrounding states were listed with experience and indicator based information online. Since 2008 MN Community Measurement has facilitated the State of Minnesota's mandatory health care reporting programme.[37]

On the site, users can find a clinic by location, doctor or clinic name and the website permits customisation for indicators and has the functionality to compare functions between clinics. Users can select a standard or detailed view. These features allow flexibility and autonomy for users to review information of personal interest. There is clear explanation about each measure and '*health score ratings*' are used to help interpret the data. Performance is shown as: Top, Above Average, Average, Below Average and Not Reportable. Indicators are colour-coded for ease of understanding but do not use traffic light 'rag' (red amber green)-rating. For those looking for more information, the detailed report for each indicator presents confidence intervals. The inclusion of confidence intervals was something that has been requested via our consultation exercise. Figure 1 shows an example of how the website can be used to compare practices.[38] On the website, the more detailed view explains expected performance for an indicator.

Figure 1 Screenshot comparing Buffalo Clinic-IHN Buffalo, MN with Fairview Andover Clinic Andover, MN. From the MNHealthScores website © 2015 MN Community Measurement, All Rights Reserved.



Although there is no overall composite score by clinic, or by population group, indicators for two specific service areas (diabetes* and vascular health) have been grouped into an overall percentage score and an indication of whether the clinic is average or above or below average.

One of the challenges of adopting a similar approach within the English context might be that 'below average' performance might actually represent a very high level of absolute performance (for example considering performance of practices against QOF targets). Therefore this might be misleading to the public unless absolute figures of achievement are also clearly published. However, in principle, MyNHS could use similar functionality to show relative and absolute performance against individual indicators and adopt the approach of providing different degrees of detail for different audiences.

* The Diabetes 5 composite measure covers the following indicators: Blood pressure is less than 140/90 mmHg; LDL or "bad" cholesterol is less than 100mg/dl; Blood sugar (A1c) is less than 8%; Being tobacco-free; Taking an aspirin daily, if appropriate

Other websites within the UK

As well as the international sites, there were some websites from within the UK that had useful features, including the following two examples.

My Local Health and Social Care (http://mylocalhealthservice.wales.gov.uk/#/en) aims to increase the transparency of the quality of NHS and social care services in Wales.[39] Information is available on health boards, general practices, hospitals and social care. In contrast to the general practice information on MyNHS there is the option to view data as a chart comparing the practice to national and local averages. Also, each indicator is explained in an accessible way and further information about the condition is provided. There are no composite scores for overall care or by population group.

MyHealthLondon (www.myhealth.london.nhs.uk/compare-data-result/general-practice/gpos/07Q#na) has the functionality to view practice data in a graph and offers an accessible explanation on why the selected indicator is important (this includes information on whether higher values are better or not, but does not go as far as providing data on a local or peer average for benchmarking purposes). The tool allows users to search for GPs, see what services they offer and how they compare against others across a range of indicators. Users can also select from a large range of indicators and view the results for all the GPs within a selected London borough. Indicators are either shown in a data table, with the latest year-on-year data or as a bar graph. Again, there are no composite scores for overall care or by population group.

Use of information about quality: accountability

For national bodies, including NHS England, local commissioners and the Department of Health, a key purpose of information on quality is to hold general practices to account for the care they provide.

The different bodies are likely to have different information needs for accountability. NHS England and local commissioners (in the case of co-commissioning) are likely to need more detailed information on performance for the NHS funds expended. The Department of Health and Secretary of State are likely to need a high-level, streamlined set of indicators to show progress against some key priorities, for example, as set out in the NHS Mandate or the NHS Constitution. The CQC, which regulates against agreed standards, is likely to need a larger set (at least initially) to test models that may allow more proportionate risk-based inspections in future, as well as to provide enriched information to identify key lines of enquiry in an inspection (for example, on domains of care or for population groups).

National: Department of Health/Secretary of State

Through the Health and Social Care Act 2012, the Secretary of State for Health retains ultimate accountability for the health service and has a responsibility to secure the provision of services.[40] The Department of Health uses the NHS Mandate to hold NHS England to account for the quality of its direct commissioning including its role in commissioning primary care services.

Assessment of progress against requirements set out in the NHS Mandate is made through the NHS Outcomes Framework of indicators, some of which refer to general practice, such as patient experience of general practice care.[41] There are very few indicators directly relating to general practice in the NHS Outcomes Framework (see the HSCIC Indicator Portal).

By themselves these indicators do not give the Department of Health much information on the quality of care in general practice. But accountability for the performance of general practice for NHS funding runs indirectly to the Department through NHS England. The NHS Outcomes Framework is cascaded down to CCGs via NHS England's CCG Outcomes Indicator Set,[42] which includes indicators that can be assessed at CCG level.

However, there may be scope to move beyond the few general practice indicators in the NHS Outcomes Framework by making progress in developing a streamlined set of meaningful indicators. These indicators would not be a composite representing a summary verdict on the overall quality of care in each practice, but they could be a set of individual 'sentinel' indicators on aspects of care that matter most. Sentinel indicators are often defined as indicators that identify individual events that trigger further analysis and investigation. However, in the context of this report, our meaning of sentinel is different. A sentinel indicator could represent a very specific priority. Alternatively, while being specific it could offer a credible view of an area of care, or could be a 'positive indicator' of good care or a 'negative' indicator representing poor care to be avoided. Progress in developing a small set of such national indicators could play an important role in reducing the burden of accountability and regulatory requirements, and focus efforts in a coordinated way. These national indicators should not prevent local CCGs from developing their own set which reflect local priorities.

Clearly to be credible and have impact, selecting sentinel indicators to be *'what matters most'* would have to be done by a wide group of stakeholders, including the public and professionals as well as national bodies (we return to this point in Chapter 5). The indicators should be very robust, and be small enough in number for progress across all to be feasible. Support would be required from commissioners and others to help practices make the necessary progress. This could include national QOF or local incentive payments (under locally enhanced schemes), or locally encouraged peer review activity or other support (we return to this in Chapter 6).

When agreed and developed, these sentinel indicators might usefully be published for the public alongside other information the public say they want, such as indicators on access and patient satisfaction plus the CQC rating. However, this should all be subject to adequate market research.

The Health and Social Care Act 2012 introduced a new duty requiring the Secretary of State to publish an annual report on the performance of the health service in England. That report must include the Secretary of State's assessment of the effectiveness of the discharge of their duties as to improvement in quality of services and reducing inequalities.

The first annual report suggested that future reports would include three core components: (1) performance of the health service (2) assessment of the Secretary of State's duties (3) assessment of health service bodies and the execution of their duties.[43] The annual report for 2014/15 was a seven page report submitted as part of the annual departmental annual report and accounts and contained very limited information on primary care.[44] There is scope for the report to offer a more compelling narrative on the quality of care in general practices (and the NHS more broadly).

NHS England and CCGs

The Health and Social Care Act 2012 places a duty on NHS England* to secure the provision of primary medical services in England. However, the Secretary of State retains a number of functions that relate to specifying the detail of what must be included in the contract for primary medical services with general practices. Furthermore the Secretary of State may direct NHS England in any of the functions of the Secretary of State relating to the provision of primary medical services.[45]

NHS England holds primary care providers to account through three types of contract:

- General Medical Services (GMS) contracts (a nationally-directed contract between NHS England and a general practice)
- Personal Medical Services contracts (a local contract agreed between NHS England and the practice)
- Alternative Medical Services contracts (allows NHS England to contract with a broader range of suppliers).[46]

* Referred to as the NHS Commissioning Board in the legislation

NHS England regional teams are expected to understand the strengths and weaknesses of commissioned services such as general practices, through the provision of effective support mechanisms and, where necessary, intelligence-led performance management, supported by local medical committee (LMC) representation. To help do this, NHS England uses the general practice outcome standards (GPOS) and the general practice high level indicators (GPHLI) (both available via the Primary Care Web Tool (PCWT)). Other sources of information that may be relevant in the context of managing and monitoring general practice contracts include: QOF, complaints information, serious untoward incidents, referral data and patient experience data.[47]

As well as holding practices to account using this range of indicators, NHS England uses the QOF (part of the GMS contract introduced in 2004) to provide core funding to pay for practice staff and to provide financial incentives to practices to improve care in priority areas, where progress is measured by specific indicators. The scheme is voluntary but almost all practices take part.[48,49]

In May 2014, NHS England announced plans for CCGs to be able to take on additional responsibility for commissioning care from general practices – so called co-commissioning. This can take three forms:

- **Greater involvement in decisions affecting the commissioning of primary care:** NHS England retains statutory responsibility for decision-making.
- **Joint commissioning arrangements:** CCGs assume responsibility for jointly commissioning primary medical services with their area team (now regional team), either through a joint committee or 'committees in common'.
- **Delegated commissioning arrangements**: CCGs assume full responsibility for commissioning general practice services. Legally, NHS England retains the residual liability for the performance of primary medical care commissioning.[50]

Regardless of their co-commissioning status, CCGs have a responsibility under the Health and Social Care Act 2012 to assist and support NHS England in discharging its duty to secure continuous improvement in the quality of primary medical services. CCGs are expected to provide evidence of benchmarking on outcome indicators for primary medical care, state their commitment to openness and sharing of information and have a clear approach to peer review and conversations about improvement across practices.[51]

However, as co-commissioning models become more developed, those CCGs taking on delegated commissioning are taking responsibility for contracting, and under delegated arrangements CCGs would have the ability to offer general practices the opportunity to participate in locally designed contracts.[50] This includes flexibilities for CCGs to develop local financial incentives to encourage practices to improve care in priority areas, for which practices must report data.

The role of the CCG in developing, interpreting and acting on information about performance figured highly during the consultation process. A few CCGs were reported as being very advanced in this area, in particular where they have access to a wider and timely set of data drawn from the clinical computer systems in local practices, and have expertise in analytics. A number of respondents emphasised the need to support CCGs to have the opportunity, headspace and resources to develop their own quality indicators and to support practices to use data for improvement.

A number of CCGs approached us during the consultation period to share their progress in developing quality dashboards:

- **City and Hackney CCG** is developing a primary care quality dashboard so the CCG can identify areas where practices may need additional support and so that practices themselves are able to see how they perform compared to their peers. The CCG selected the indicators by asking each of their programme boards (Primary Care Quality, Mental Health, Planned Care, Children, Maternity, Urgent Care, Integrated Care, Long Term Conditions, and Medicines Management) to put forward indicators that would be important to them to be monitored at a practice level. For as many indicators as possible, the CCG also collected Office for National Statistics (ONS) London Cosmopolitan cluster CCGs (City and Hackney, Brent, Haringey, Lambeth, Lewisham, Newham and Southwark), London and national data to use for benchmarking.
- **Gloucestershire CCG** has established a clinical quality review group to oversee the development of quality and safety in general practice. To support the work of the review group, the CCG has developed a quality framework containing a range of indicators and evidence that will support a local assessment of the overall quality of primary care. The framework covers three main headings – planning for quality, quality improvement and assuring quality.
- **Tower Hamlets Clinical Commissioning Group** has made significant progress in developing and linking data between primary and secondary care at a person level and has been supported by North and East London Commissioning Support Unit.

North and East London Commissioning Support Unit

North and East London Commissioning Support Unit (CSU) has worked to develop a central 'data cube' that supports the Waltham Forest and East London and City integrated care pioneer programme. The cube shows live hospital attendance data. Real-time, day-by-day integrated performance data shows managers immediately when spikes in activity occur, enabling investigation and action to be taken on the spot and on the day.

The CSU has also worked with Tower Hamlets CCG to link data sets between primary and secondary care to enable practices to see which of their patients are in hospital at a given time based on a model originally tested by NHS Bolton. The tool supports prioritisation of clinical intervention by determining whether patients are eligible or enrolled with the integrated care programme. The tool combines data extracted from general practice systems and live hospital data (which is timely but not comprehensive) with national secondary uses services (SUS) data (which is slower to update but gives richer clinical information).

A key question for this review is, would there be benefit in putting the data used by NHS England and CCGs for accountability purposes into the public domain?

As noted earlier, we believe there is scope to make public some of the indicators that are on the restricted PCWT.

However, we suggest that it is legitimate for analysis of the data (for example, internal analysis to highlight outliers) for assessment of performance by NHS England not to be published if used for operational management or internal reporting mechanisms. If there are serious and repeated concerns about quality then this would clearly trigger an inspection of the practice by the CQC, with the result recorded publicly. This would not necessarily preclude the publication of other analysis showing the relative performance of different practices on specific indicators.

Many CCGs are already using the PCWT, for example, in Quarter 4 2014, data for 94.3% of CCGs had been viewed on the PCWT and 8,256 reports had been downloaded in 2014 for GPHLI.* CCGs are also developing local dashboards with variable development, definition sets and coverage, alongside the production of consolidated reports for practices. It is important that individual practices feel able to participate in open and honest conversations with CCGs about their performance and as such, we do not suggest that local dashboards are published on MyNHS.

* Data supplied by NHS England.

There is a separate and important issue as to how effective development and use of dashboards by CCGs (or their CSUs) could be accelerated across England for effective scrutiny. This should be considered as part of a broader quality strategy for general practice (see Chapter 7).

Regulators

Here, we consider briefly only the CQC, as the regulator of quality of care for providers of health and social care in England. The CQC regulates general practices. It makes an assessment of quality against published standards, publishes the assessment, and has statutory powers to enforce improvements if quality is lacking.[52]

The CQC uses at least three groups of information in its work to assess general practices:

- quantitative indicators on the quality of care (including those for 'intelligent monitoring')
- qualitative information such as complaints or informal information
- inspections of general practices.[53]

The quantitative indicators on the quality of care and qualitative information influence the timing and lines of enquiry in an inspection. Inspections of general practice began in 2014 and all practices are due to have been inspected by September 2016.[54] Where inspections have taken place a practice receives a rating as either inadequate, requires improvement, good or outstanding. This is, in effect, a 'verdict' based on a composite of different information. Between 1 October 2014 and 16 July 2015, 1,290 GP and Out Of Hours inspection reports with ratings had been published: 46 (3%) outstanding; 1,039 (81%) good; 154 (12%) requires improvement; and 51 (4%) inadequate.

With respect to quantitative indicators, the CQC uses 33 for intelligent monitoring. The indicators are not comprehensive in scope (see appendix D) because of significant data limitations and so by themselves cannot yet give an adequate picture of the quality of care. The overall rating received by practices is therefore based on a more comprehensive assessment, mainly inspection.

At present, the CQC cannot rely upon quantitative indicators without inspections to assess quality of care for accountability purposes and it faced significant problems with the initial publication of intelligent monitoring data. St Thomas Medical Group, Exeter offers a powerful example of the potential for discrepancies between composite scores based on existing data and the overall inspection judgement. The practice was identified as among the highest risk practices based on the CQC set of intelligent monitoring indicators but, once inspected, the practice was rated as outstanding.[55] The best available estimate as to overall quality at present is the current CQC rating and not quantitative data alone.

Summary and conclusions

There are already several websites in the public domain which contain information about the quality of care for each general practice in England. These include: NHS Choices; CQC's published ratings on general practices and indicators for intelligent monitoring; MyNHS; Public Health England's General Practice Profiles, and a range of other information on the Health and Social Care Information Centre website. There is also a website, that is password protected and viewable by NHS staff, containing a range of indicators on quality for each practice – the Primary Care Web Tool developed by NHS England.

Many indicators on these sites are duplicated; some are similar but not identical and thus give slightly different results. Their presentation and usability is highly variable and, with the exception of NHS Choices, usage is generally low considering the size of the potential audiences. The publicly available websites each appear to serve more than one purpose, yet

are not tailored to different audiences. Far more market research is needed to understand what would be of most value to different users, as well as exploring alternative options for communicating with patients and the public. Our engagement process suggests that staff working in general practice would prefer a larger set of detailed indicators (that account for context) to help pinpoint where improvements are needed. The public appeared to favour a far smaller set to include access and satisfaction levels to facilitate choice and voice.

We recommend that the existing websites are eventually consolidated and tailored to different audiences possibly through developing separate channels. We suggest there should be a professional-facing channel and a public-facing channel (or two distinct websites).

As this review recognises, the direction of government policy is towards establishment of MyNHS as the primary portal for information about the quality of health and care services. If the currently available websites were to be consolidated, the MyNHS website seems the most likely candidate to host consolidated content. However, given some of the limitations of the website as it currently stands, it will be important to fully consider a range of options to ensure the most cost-effective outcome. An alternative to developing public and professional channels on MyNHS would be to re-focus MyNHS as a professional-facing website and use NHS Choices as the public channel, given the website's high usage figures.

Consolidation will not be a quick process and careful design will be needed. For example, the functionality of PHE's NGPP and the PCWT are, in our view, far superior to the current functionality on the MyNHS website. Over-rapid consolidation might risk a worse user experience (particularly for a professional audience) – intelligent consolidation would need a forgiving timetable. Done well, the potential benefits could be significant.

For many professionals working in general practice, it seems that locally available data are more useful than data available nationally on the websites we examined. In some areas CCGs have access to a wider range of data that are more timely (in part because of local agreements with practices and an automated way of extracting data) and have developed indicator 'dashboards' helpful to practices. Furthermore, local knowledge of context has helped interpret the data more appropriately, to help set priorities for improvement and support. It is likely that, for the foreseeable future, CCGs will increasingly have better access to data from GP IT systems than is available nationally. What is possible in the most advanced CCGs should increasingly inform the future development of the national indicators and websites and broader assurance processes at a national level.

We examined the extent to which indicators used for accountability purposes should be made publicly available on the MyNHS website. For accountability to the Department of Health and Secretary of State (and ultimately the public) we concluded that a very small set of 'sentinel' indicators – not a composite – could be useful on the public-facing channel. These would go beyond the very small number on general practice care that are currently in the NHS Outcomes Framework and would represent '*what matters most*'. These sentinel indicators could not and would not be a composite representing a summary verdict on the overall quality of care in each practice, but they could be a set of individual indicators. Such indicators could be very specific, system priorities. Alternatively, these indicators could offer a credible view of an area of care, or could be a 'positive indicator' of good care or a 'negative' indicator representing poor care to be avoided. National sentinel indicators should not prevent individual CCGs developing their own indicators based on local priorities.

For national sentinels, the question of '*what matters most*' should be decided among a wide range of stakeholders including front-line professionals and the public. NHS England and CCGs would then need to support and encourage progress against these indicators using a range of approaches including national QOF-type payment incentives, local CCG payment

incentive flexibilities, encouraging peer review, or other appropriate ways to support improvement. A list of 'sentinel' indicators could play an important role in reducing the burden of accountability and regulatory requirements.

We do not suggest that analysis performed by CQC or NHS England as part of their accountability or regulatory functions needs to be published on a publicly available website. Nor should local, CCG level dashboards be published. However, there is scope to put some of the indicators currently on the restricted PCWT into the public domain.

The next chapter considers whether the development of composite indicators – overall, and for the five population groups – would be valuable for the purposes of improvement, choice and voice and accountability.

4. Composite indicators and population groups

The previous section referenced the potential barriers and challenges that the public face when accessing information about quality. As part of the review process, we considered whether it would be possible to construct a meaningful composite measure (made up of a selection of indicators) to indicate the overall quality of care provided for each general practice in England, and the quality of care for five population groups.*

An overall composite to assess quality of care in a general practice?

Composite or aggregate scores may have advantages, for example, their simplicity, but they also have drawbacks. Table 5 outlines some potential advantages and disadvantages.

Table 5: Advantages and disadvantages of presenting data as a composite

Advantages	Disadvantages
System performance is given prominence in the policy arena.	A composite is a simplistic summary based on a limited number of components for what is often a complex service. Composite measures may disguise serious failings but may also conceal excellent performance on specific elements of performance.
Can offer a rounded assessment of system performance.	As measures of performance become more aggregate, it becomes increasingly difficult to know how to attribute poor performance.
Enable judgements to be made.	The individual elements within a composite may be contentious.
Facilitate communication with the public and can promote accountability.	A composite that seeks to be comprehensive may need to rely on opaque or weak data.
Indicate priorities for improvement efforts (ie lower performers) and identify high performers.	Unintended consequences and behavioural distortions such as gaming, distortion of priorities and neglect of areas not included in the composite.
Could stimulate efforts for better data collection and analysis.	The methodology for calculating weighting within a composite may be inadequate or highly contested.
	The process of weighting within composites is centralist and reflects a particular set of preferences.
Source: Adapted from Smith, 2002[56]	

* People over 75; people under 75 with long-term conditions; maternity, children and young people; mental health and the generally well.

The objections to composite indicators hinge mainly on:

- the principle of aggregation itself
- the contested nature of selecting and weighting indicators.

On the first objection, it is a statistical fact that aggregating quantitative indicators effectively masks variation in the component indicators. If presented in the public domain for choice, voice or accountability, a composite indicator risks a misleading judgement on the quality of care in a general practice. If used to aid improvement by practices, a composite covering the overall quality of care in a practice may be less helpful to professionals than individual indicators because indicators have been too aggregated to identify where improvements could be made.

On the second objection, the principal issue arising from the review is that there are too few good quality indicators to select. A comprehensive set of indicators is not yet available to give a meaningful assessment of quality.

Earlier this year, NHS England commissioned a rapid exercise to assess potential indicators that could form part of a GP scorecard for publication on the MyNHS website. Dr Foster, a health care analysis organisation, critically considered 72 of the most promising indicators identified by NHS England and their fitness for use in a composite measure. The criteria for appraisal included, among several others: were data available; were data robust; were the indicators unambiguous; were timely data available; did indicators overlap with others; was the indicator fit for purpose.

Of the 72 appraised, Dr Foster found only 16 indicators that appeared to be reasonable measures to include in a GP scorecard basket. Dr Foster concluded that the set of indicators would not provide a fair index of the quality or effectiveness of general practice services although the indicators could provide a fair index of patient experience. The overall finding was that:

> *'Whilst we are of the view that a GP Scorecard may be a viable goal, it will require the creation and publication of new indicators, as well as work to refresh currently published indicators. Relying on currently published indicators is unlikely to yield a set of indicators that can underpin a Scorecard which is widely accepted, or progress further a robust overview of GP performance.'* [5]

Our Technical Advisory Group agreed with the analysis and conclusions by Dr Foster.

If the quality of currently available data cannot support a meaningful composite measure (as was the finding of the CQC with intelligent monitoring), then there seems little value in publishing a composite on overall quality of care in general practice when there is a rating published by CQC that draws on a richer set of information (inspection, qualitative information as well as quantitative indicators). Another composite in addition to the CQC rating could give conflicting results and be confusing to the key audiences, in particular the public and staff working in general practice.[57]

In future it may be that better data will provide richer insights and be the basis for more effective surveillance than the current CQC inspection regime, and thus help reduce the burden of inspection on general practices. To accelerate progress it will be important to learn from the CCGs that are most advanced in developing indicators based on a wider set of data than is currently available nationally (for example, using data drawn from electronic clinical records from general practices using local data sharing agreements). This is in addition to developing the national process by which indicators are developed and published. This is discussed further in Chapter 5.

Even if there was a wide set of robust indicators available, selecting and weighting them in a composite measure would be highly contentious. This is because stakeholders are likely to value indicators differently. Recent analysis on how to assess multiple dimensions of performance in health care concludes that it is not feasible to construct a composite indicator appropriate for all audiences. Instead a dominance approach (a structured way of assessing performance across a range of dimensions) is suggested as a way to assess performance.[58]

We therefore strongly recommend that the Department of Health does not pursue plans to compile a composite score (over and above the existing CQC rating) for general practice based on the current set of indicators.

A composite rating for population groups?

We were asked to consider whether a composite could be developed in a meaningful way for the following population groups:

- people over 75
- people under 75 with long-term conditions
- maternity, children and young people
- mental health
- the generally well.

Are population groups a useful concept?

The first question must be are population groups (however defined) a meaningful organising principle for indicators? Currently the CQC does use population groupings to focus regulatory activity in general practice, but these groupings may not necessarily be useful for improvement, to help the public choose between practices, or for wider accountability.

The short timescale for the review precluded a full analysis of this specific question but the review process identified some initial points to consider:

- **The public**: In the public focus groups conducted by BritainThinks,[59] participants recognised that there was a tension between ensuring that everyone could find the information they needed and not overloading people. They concluded that grouping information was a sensible way to ensure that individuals could access information that was relevant to them.
- **Professionals**: A number of respondents to the online consultation suggested that population groups were not useful or necessary in the context of quality indicators, due to the individual requirements and conditions of patients. Some respondents felt it would be unfair to judge the quality of care given in a general practice by the experience of particular population groups:

  'I am not clear that indicators by group are helpful. It needs to be patient centred not group centred.'

  '[Patients are] going to fall into one of the 'groups' throughout their lives, so they're going to want to know the care is the same no matter the stage of their life. If you must categorise then do it by clinical diagnoses, and not age.'

Are the five population groups the right ones?

The second question must be, are these the appropriate population groups to be useful for the three main purposes of publishing indicators – improvement, choice and voice and accountability?

The population groups identified by the Department of Health are similar to those that the CQC uses in its inspection of general practices. However, they are worded slightly differently and there is an additional grouping used by the CQC which considers people whose circumstances may make them vulnerable. Table 6 compares the two sets of population groups.

Table 6: Comparison of the population groups suggested by the Department of Health and those used by the CQC

Population groups proposed by the Department of Health	Population groups used by the CQC
People over 75	Older people
People under 75 with long-term conditions	People with long term conditions
Maternity, children and young people	Families, children and young people
Mental health	People experiencing poor mental health (including people with dementia)
The generally well	Working age people (including those recently retired and students)
	People whose circumstances may make them vulnerable

The CQC consulted on their population groupings as part of a broader consultation on the provider handbook for general practices and out-of-hours services. While online respondents to the CQC consultation largely understood the population groups, issues raised included:

- doubt as to how relevant or useful population groups were as a basis for inspection
- some population groups may be less relevant to certain practices depending on demographics
- concern about the overlap between groups
- concern that young people should be in a separate group from babies and children as their needs were different
- originally, CQC had referred to 'mothers' rather than 'families' and there was concern that this might exclude fathers, carers etc
- gaps, such as people with dementia, people receiving end-of-life care, people with autism, people with a learning disability, students and people with alcohol or substance misuse issues.[60]

Like the CQC, our consultation identified a number of gaps in coverage including end-of-life care. In total, over 30 other groupings were suggested by participants, which suggests that the current selection of population groups is not comprehensive enough for the public. Further suggestions (see Appendix E) ranged from requests for disease-specific groupings (such as dementia or cancer care) to additional population groups such as those living in care homes. In addition, our engagement process highlighted the fact that people with long-term conditions are not a homogenous group and that, if possible, it would be useful to sub-categorise populations with long-term conditions into those who were stable and those who required frequent intervention. Further, there may need to be a more sophisticated approach to including age boundaries. For example, Barnett and colleagues 2012 extracted data on 40 morbidities from a database of 1,751,841 people registered with 314 medical practices in Scotland as of March, 2007. They found that the absolute number of people with multi-morbidity was higher in those younger than 65 years.[61]

That said, as Table 7 shows, the population subgroups that were tested through our focus groups were generally well-received by the public (with the exception of 'the generally well').

Table 7: Focus group feedback on population subgroups

People over 75	Participants felt that this was an appropriate grouping, given the particular health needs of this group. However, some felt that additional age bands would be appropriate
People under 75 with long-term conditions	Participants felt that this was an appropriate grouping given the particular health needs of this group
Maternity, children and young people	Participants felt this was a sensible grouping but some questioned the inclusion of young people who they felt would have had very different needs, such as sexual health
Mental health	Younger participants in particular welcomed this grouping
The generally well	This was the least-well received of the groupings. Participants were unsure what 'generally well' meant, and felt that this was too subjective to be helpful

To what extent can measures of care for population groups be attributable to general practices?

In the review, stakeholders, particularly from general practice, repeatedly pointed out that using any broad categories or groupings raises issues of attribution: general practices provide only part of the care to whatever groups are selected.

For example, it may not be meaningful to give a composite score to general practice for maternity services when many women self-refer to a midwifery service, or for screening in a population as general practices are not commissioned to provide screening procedures (with the exception of cervical cytology).

As a further example, the Public Health Outcomes Framework includes an indicator on breast cancer screening coverage.[62] It could be argued that practice staff could influence screening rates by providing advice and information on the role of screening. However:

- the organisation and publicity of the breast screening service is outside of the direct control of general practices
- update of screening procedures is influenced by wider factors including ethnicity[63] and socio-economic circumstances[64]
- many of the women being screened will be in the 'generally well' population category and might not have an appointment with their GP in the interval between receiving their invitation to attend a screening session and their appointment. This would reduce the opportunity to pro-actively discuss the screening process
- there is no guarantee that a discussion about the pros/cons of screening would increase uptake. For example, patients might become more aware of potential disadvantages and choose to decline screening.

If the attribution argument has validity with respect to services, it has stronger validity with respect to the health and care outcomes for whole population groups. To complicate matters, throughout the review we heard different viewpoints as to whether general practice should be actively improving the health of the populations they cover (as opposed to the care provided to the patients coming forward). Two quotes below typify the contrasting views we heard.

> *'[to make indicators] more relevant and related to practice achievements, not about local public health or factors beyond the practice control.'*

> *'Our overarching view is that general practice needs to strengthen its public health role if it is to improve whole population outcomes (including premature mortality, morbidity, hospital admissions, time lost from work, patient satisfaction).'*

Recent strategy documents have pointed to general practices taking on a wider role. For example, in *Improving general practice – a call to action* it is suggested that one of the ambitions for general practice should be to engage differently with communities to improve health outcomes and reduce inequalities.[65] And the Secretary of State for Health, in a recent speech outlining a new deal for general practice, emphasised the need to empower general practice to play a bigger role in public health, as well as the importance of breaking down barriers with other sectors such as social care or mental health providers.[2]

NHS England's Standard General Medical Services Contract 2015/16 states that the contractor must provide appropriate ongoing treatment and care to all registered patients and temporary residents taking account of their specific needs including the provision of advice in connection with the patient's health, including relevant health promotion advice.[66]

It is clear that general practices can be assessed and accountable for the extent to which they are providing advice, as relevant, on health promotion and the quality of that advice. However, it is not clear at present that an individual general practice is or should be held accountable for overall population outcomes. It is ultimately the duty of CCGs to have regard to the need to reduce inequalities between patients with respect to the outcomes achieved for them by the provision of the health service. It is the duty of the relevant local authority to take such steps as it considers appropriate for improving the health of the people in its areas.[45]

While the nature of general practice is beyond the scope of the review, this question does have an impact on the strategy for how data for general practice are developed, presented and used – and how data for CCGs are presented.

Are there adequate quantitative indicators to construct a composite for the five population groups identified?

The analysis by Dr Foster referred to earlier also assessed whether meaningful composites of indicators could be developed for population groups. The conclusion was that the currently available data were not robust enough to do so.[5]

We tried to map currently active QOF indicators (because these are widely available, considered robust and are used in other indicator sets such as GPOS) against the five population groups listed in Table 7. Firstly, most of the QOF indicators appeared to be most relevant to people under 75 with long-term conditions but could potentially be applicable to other groupings. In addition, there were very few indicators that fitted primarily under the 'generally well' or the maternity, children and young people categories. Several indicators could be mapped across more than one population grouping. The current state of indicator development represents a considerable barrier in producing something that is credible and robust across the population groups due to the lack of indicators for some of these groups. See Appendix F for more details.

Other considerations

New models of care

Given the move towards more integrated models of care as outlined in the NHS Five Year Forward View, and being pursued across the NHS, it may be that indicators grouped by a clinical (clinical condition or care service) pathway for population groups covered by the new models may be more meaningful for improvement purposes than just for population groups in an individual practice. The attribution of performance then to a practice may not strictly indicate the quality of care provided by that practice, but may indicate the extent to which the practice is collaborating with others to improve care along a pathway, which is worth encouraging. Examining international websites publishing indicators on the quality of care, we did not find composites for population groups – if anything (as shown in the Minnesota example in Chapter 3) any grouping of indicators were for clinical conditions (eg, diabetes) or particular services (eg, vascular care).

Other ways of grouping

Other existing groupings could be considered, for example the OECD framework for health care system performance (as referred to by The King's Fund in its report on CCGs[3]) takes a life course approach and looks at:

- staying healthy
- getting better
- living with illness or disability
- coping with end-of-life.[67]

Summary and conclusions

Given the number of possible indicators that could be used to assess the quality of care, composite indicators have allure because of their simplicity. In theory, this simplicity could help the public gain a rapid view as to the quality of care in a general practice and could help practices and others identify priorities for improvements more easily. But we strongly recommend that composite scores (over and above the existing CQC rating) are not developed and published at this stage. There are six main reasons why:

- The data on which a composite could be based are highly limited, do not cover enough areas of care and are not robust enough to provide a credible picture of the quality of care.
- Composites aggregate information which can mask specific aspects of the quality of care, falsely reassure and thus be misleading.
- While a small set of indicators could be valuable for the public, there would be little value in publishing a composite score over and above the existing CQC rating, which is based on a wider range of information (quantitative data, qualitative intelligence and inspection findings) and is currently the better assessment of quality. Publishing a composite score as well as a CQC rating could confuse, especially if the results were conflicting.
- For professionals, composite indicators (either overall or for population subgroups) are unlikely to be helpful because they do not provide enough detail to pinpoint areas for improvement and are less useful for assessing the impact of changes made. Composites are also less amenable to adjustment for relevant local contextual factors.
- Patients and service users are not a homogenous group. A composite necessarily reflects a range of indicators that have been weighted according to someone's judgement. An individual patient or service user might have preferences for information that do not tally with the priorities assumed when constructing the composite.
- The process of selecting and weighting indicators in a composite would be highly contentious – in particular decisions about the extent to which an indicator really reflected care provided in general practice (the 'attribution' issue). To gain the necessary buy-in, an open, structured and transparent process would be needed. Given current pressures on general practice, such an engagement process could be more usefully deployed to develop new indicators where there are gaps and to make progress in developing a small set of indicators on *'what matters most'*.

These arguments also apply to developing composite measures for the five population groups noted in our terms of reference. The population groups suggested by the Department of Health offer one possible way of organising indicators and the public appeared to be broadly supportive of the idea of grouping indicators. However, any choice of subgroup would be arbitrary and this review could not ascertain clear preferences for either population groups, people grouped by clinical condition or by receipt of a particular service or care pathway.

While the idea of presenting data by population groups is attractive, there are some significant disadvantages to using the five population groups suggested in the review's terms of reference:

- The five population groups differ from the six groups used by the CQC, and the use of a slightly different set would be confusing.
- There are overlaps between the population groups, yet significant gaps, for example, end-of-life care.
- By using population groups (as opposed to other groupings) the 'attribution' issue is significant.
- The data that are currently available are not robust enough to develop a credible composite score in the five population groups identified.[5]

If groupings are thought to be a helpful way of presenting data more simply, a better approach might be to allow users to self-select groupings from a menu of indicators. This flexibility is also likely to be important to professionals as new models of care develop.

Underlying the request for composites and population groupings is a desire for simplicity. Meaningful simplicity using indicators may be achieved in other ways than aggregation, which has significant drawbacks, as noted. This should be examined further, including the value of a few 'sentinel' indicators on what matters most.

5. Process of indicator development

In this review we identified a widespread consensus that: information can help accelerate improvements in health care, transparency is important, and that the process to develop better information should be accelerated. There was also a dominant view that there were already many indicators available, it was often too difficult to see the '*signal from the noise*' and that, given the burden of data collection, analysis and presentation, the time was right to review the cost and benefit of the current set of indicators.

In our terms of reference we were asked to '*consider how information could be complemented and developed in future to give a better picture of the quality of care, including identifying any gaps, for the main purposes identified*'. Because of the huge area this covers, we focused on identifying what might be a better process for developing indicators now and in the future.

Streamlining current activity

This review found considerable duplication of activity to select and present indicators and develop the underlying information to support them. We also noted the considerable number of websites with indicators purporting to show the quality of care provided by general practices. Chapter 3 concluded that some consolidation of websites and streamlining of effort is needed.

It is clear that thousands of hours have been dedicated to developing better indicators in general practice and good progress has been made, for example by the following working groups:

- NHS England and Public Health England: National Network of Quality in Primary Care Measures and Indicators Group
- Care Quality Commission: The GP Intelligence Advisory Group
- Indicator Governance Board (IGB)
- The Outcomes Framework Technical Advisory Group (OFTAG)
- NICE: Indicator Advisory Committee (IAC)
- HSCIC: Standardisation Committee for Care Information
- The Clinical Information Advisory Group (NHS Choices)
- Informatics Assurance Group (IAG)
- National Information Board (NIB)
- Primary Care Data Delivery Board (now disbanded)
- Primary Care Data Transparency Technical Group (now disbanded)

- General Practice Extraction Service (GPES) Independent Advisory Group (now disbanded)
- National Primary Medical Services Assurance and Quality Improvement Steering Group (now disbanded).

A number of these groups or boards serve different functions (for example, information governance or assurance rather than development) and consolidation here may be inappropriate. However, there is scope to have a more unified, systematic and efficient process for the development of indicators generally, including a process for determining national priorities. As noted earlier, for this to have credibility in the face of the complex and contested nature of the subject, it will be important to have an open and entirely transparent process for setting priorities and developing, selecting and retiring indicators. This process will need to involve all key stakeholders, yet should be convened or chaired by a group with no obvious vested interest in the result who can weigh up arguments dispassionately. The amount of data available from general practice will increase if data from GP electronic patient records become available, and a robust process will be needed to set priorities for indicator development.

An open and impartial, inclusive process is the fundamental basis of, for example, the National Quality Forum (NQF) in the US. NQF is a well-respected not-for-profit, nonpartisan, membership-based organisation that works to catalyse improvements in health care. Specifically, NQF:

- convenes working groups to foster quality improvement in both public and private sectors
- endorses consensus standards for performance measurement
- ensures that consistent, high-quality performance information is publicly available
- seeks real-time feedback to ensure measures are meaningful and accurate.[68]

There are separate considerations of the multiple data streams of information in the NHS underpinning indicators, and the scope for rationalisation and efficiency. However, they are beyond the scope of this review.

A better process?

Table 8 gives a high level overview of steps that we think are critical in producing a successful process for developing indicators.

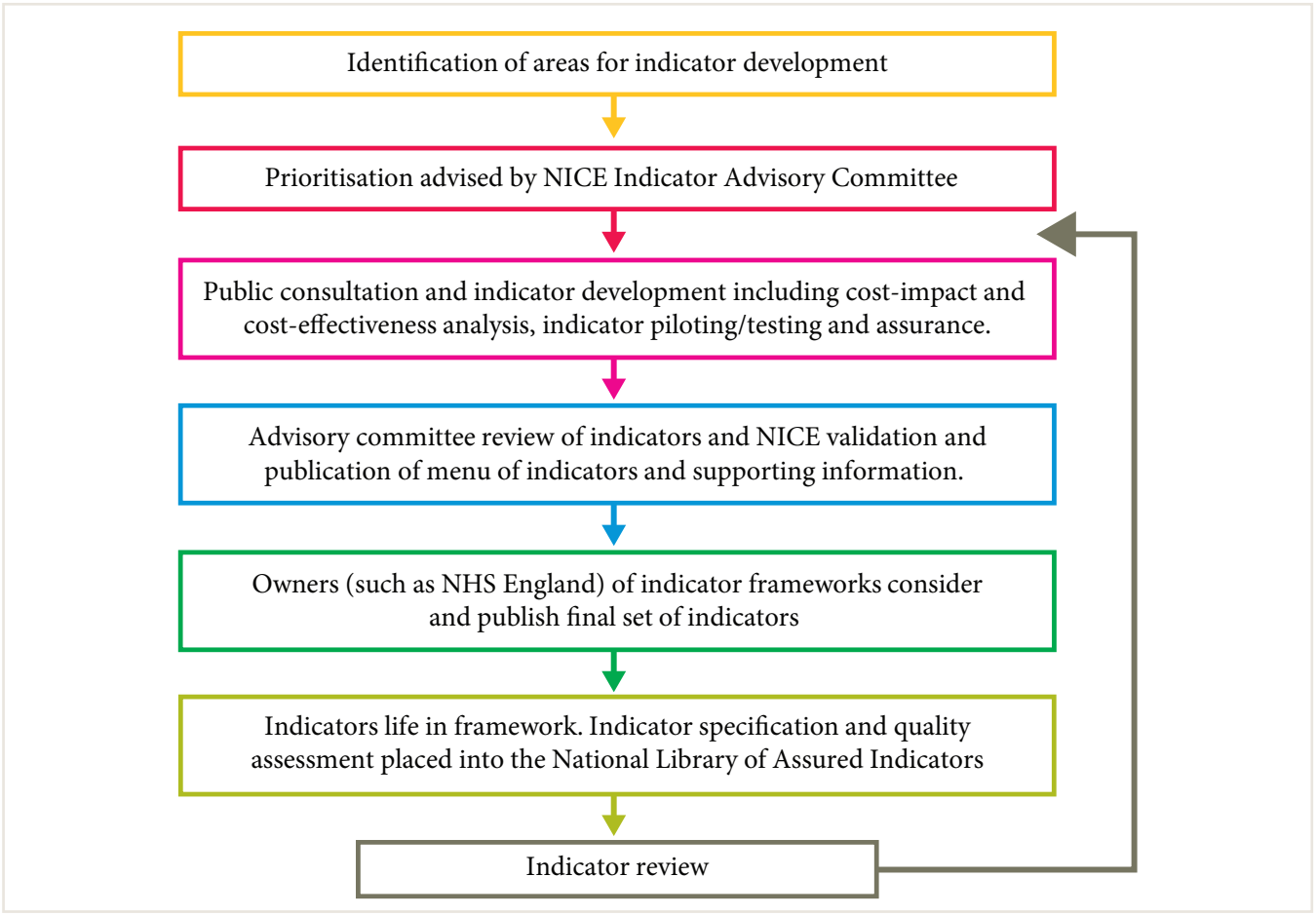
A critical part of this process is planning – identifying the purpose, audiences and priorities. Given the key audiences and purposes for indicators discussed in earlier chapters, it will be important that all key stakeholders are involved in setting strategic priorities and this activity is convened by a credible independent group.

The National Institute for Health and Care Excellence (NICE) has a tried, tested and trusted process for developing indicators[69] which contains most elements outlined in Table 8. The NICE process is robust, evidence-based and involves a high degree of stakeholder engagement (see Figure 2). While this process has been focused predominately on developing QOF indicators, NICE already looks at a broader set of indicators and collaborates with NHS England and Public Health England in establishing priority areas for indicator development.

Table 8: Indicator development process

Stage	Task
Planning	1. Identification of strategic priorities (including stakeholder engagement) and creation of a national strategy for quality, including data collection. 2. Identification of the objective of indicator publication and audience identification. 3. Agreement across relevant arm's-length bodies that the indicator is relevant and agreement as to how it would be used.
Development	4. Indicator development, including: • developing the indicator definition and methodology • consultation with relevant stakeholders and the public • indicator testing.
Execution	5. Collecting data. 6. Adjusting for context. 7. Developing a strategy for the presentation of the data, including assessing risks for each indicator of whether information can be included in the public domain.
Monitoring and development	8. Monitoring usage and impact (including identifying any adverse outcomes). 9. Developing and refining the data collection. 10. Indicator review.

Figure 2: Simplified version of NICE's process for developing indicators



Planning

The priorities set for indicator development would need to be based on a broader and more transparent set of criteria than for QOF, and involve a wide set of stakeholders, including the public, general practice staff, representative bodies such as the Royal College of General Practitioners and the General Practice Committee of the British Medical Association, the main accountable bodies (for example, CCGs and NHS England, the Department of Health and the CQC). This could include the priority to develop a set of sentinel indicators as outlined in Chapter 3, some of which could be linked to QOF payments or other initiatives to support practices to improve in these areas.

This priority-setting stage would not necessarily need to be led by NICE alone, but could be supported or co-led by boards such as the National Information Board or the National Quality Board.

For the Secretary of State, the annual Mandate to NHS England is the vehicle for outlining the main system priorities, and should be the starting point for selecting and developing indicators. But in reality there will always be a legitimate need for any process to respond more quickly to emerging ministerial or system priorities.

Other bodies, such as NHS England and CQC, will also have priorities. For example, the CQC would value a set of indicators that together may give a robust picture of the quality of care in a practice, to the extent that it may support reduced frequency of inspection through better targeting and thus reduce the burden of regulation. As described in earlier chapters, the current indicators available to CQC are not yet of good enough quality to be able to do this, or to predict risk accurately enough to help reduce inspection frequency for those identified as low risk.

The priorities should also be set as part of a longer-term strategic view and 'roadmap' as to what indicators will be needed in the future (and which can be retired) given changing models of care and expectations and the increasing availability of data from general practice clinical computer systems.

In our review, themes suggested as priorities for indicator development included:

- safety
- shared decision making
- self-management support
- productivity or value for money*
- the role of general practice as part of a broader system, for example the contribution of a practice to integrated care or to the development of new models of care
- culture and workforce climate – there was support for a GP staff survey
- indicators that reflect a practice's activity to improve quality.

Indicator development

To an extent, indicator development is a technical process, but for the reasons outlined earlier in this report, it still needs considerable stakeholder engagement as per the independent process currently carried out by NICE. This should clearly continue. NICE has a list of criteria for assessing indicators, including the cost of collection relative to the likely benefit of the information. This is established through the piloting of both the indicators and the data collection. NICE also links with the Health and Social Care Information Centre (HSCIC), which assures the statistical robustness of the indicators for publication.

* Sheffield University Management School are leading a 30-month study which intends to develop a measure of productivity in general practices in England) The study was commissioned by the Department of Health (through the National Institute for Health Research, Health Services & Delivery Research). The measure of productivity will be developed through a series of ProMES-based workshops with practitioners and patients and discussion with a panel of experts.

Execution

Here the NICE process would need to be developed to consider the extent to which adjustment of indicators is appropriate or feasible to account for local contextual factors, and provide adjusted indicators alongside unadjusted accordingly. How variations are assessed and presented should be consistent and informed by sound statistical advice, for example on how comparisons are made and presented, choice of comparison groups and reliability of underlying methodologies.

The 'execution phase' would also need to address some of the issues that were raised during our consultation process, including: the use of relative to absolute values; the use of confidence intervals; if and how local contextual information might be presented; the use of simple other ways to show variation, such as above or below the average, colour coding and so on.

It would then be for the main 'owners' of the indicator frameworks to sort out a rational way of presenting the indicators across different websites in the short-term, before the longer-term aim of consolidation of the different websites onto MyNHS might be achieved. It would also be for the owners to do the necessary market research to inform optimal presentation – again this could be a consolidated process, but would not have to be convened by NICE.

Monitoring and development

Clearly the indicator framework 'owners' will monitor usage of the indicators that are published, but there is a need for this to be done in the round more formally, which could be part of a NICE convened process. Development of indicators should be informed by their current use, the cost to collect and analyse data and their impact. It could also formally draw upon the work of CCGs (and their associated commissioning support units) in developing dashboards using a wider range of locally available data, and specifically the work across the country to develop better indicators to assess the progress of new models of care, including integrated and digital care.

Making progress more quickly

As part of this review, the experience of selected international health systems was reviewed, including Australia and Canada. We were able to scan websites, review literature and talk to international contacts, for example in several high performing health systems such as Virginia Mason (Seattle), Geisinger Health System (Pennsylvania) and Partners Healthcare (Boston, Massachusetts).

We found that all the systems assessed were grappling with complex issues similar to those raised in this review and no one health system was systematically more advanced in selecting and presenting indicators than the NHS. However, at least the following three initiatives from the United States are worth further consideration:

- The work of the Institute of Medicine to define a small set of 20 'vital signs' or sentinels to assess the progress of health care in America – the rationale, process and results.[7]
- Work in Massachusetts (involving PartnersHealthcare) to develop a smaller number (less than 10) of the most important indicators.
- The National Quality Forum's work to convene stakeholders, develop indicators and consensus standards for performance measurement.[6]

Our international review points to the unique potential of the NHS to generate a sophisticated set of indicators on quality. This is because:

- electronic data are collected in general practice and there is the possibility to assess data in near 'real time' (assuming progress can be made with Care.Data)

- linkages can be made with data from other providers of NHS-funded care and population-based information
- the NHS single-payer system allows data on all registered patients in practices to be considered together and across time. This data will increasingly allow a life course approach to measuring and understanding quality of care for populations, groups and individuals.

But the question remains, given the promise in the NHS, how best to accelerate progress towards better indicators, and their use? We believe a more streamlined and coherent process for national indicator development, as outlined above, with an agreed strategy (with milestones) is key. But equally so is making support available to practices to encourage and help them make improvements for patients. The 'improvement strategy' for general practice, and how CCGs can develop to carry this out, is beyond the scope of this review, although we offer some points on this in the next chapter.

Summary and conclusions

The review revealed a widespread consensus that: information on the quality of care was essential to making improvements, transparency was valuable, and that both should be progressed effectively in future. However, we heard that it was often too difficult to see the '*signal from the noise*' and that given the burden of data collection the time was right to review the cost and benefit of the current set with a view to reducing it.

We conclude that there is considerable scope to improve this process at a national level, for example by consolidating the number of groups working on these issues and developing a better process for planning (in particular identifying priorities for indicator development), development, execution, monitoring and review. Ideally, a credible independent organisation would convene this process, akin to how the National Quality Forum has developed indicators in the US[6] or the Institute of Medicine's development of 20 'vital signs'.[7]

NICE has a tested and respected process covering some of the areas of indicator development, with assurance of the robustness of the indicator by the Health and Social Care Information Centre. NICE could be tasked with expanding its role. Priority setting would need to involve a wide set of stakeholders. The priority setting part of the process would not necessarily need to be led by NICE alone, but could be supported or led by the National Quality Board (or the National Information Board), and linked to an overall strategy to improve quality of care in general practices.

For the Secretary of State, the annual Mandate to NHS England is the vehicle for outlining the main system priorities, and should be the starting point to outline the priorities for selecting and developing indicators. But in reality there will always be a legitimate need for any process to respond more quickly to emerging ministerial or system priorities.

The priorities for indicator development should also be set as part of a longer-term strategic view and 'roadmap' as to what indicators will be needed in the future (and which can be retired). This is particularly important given changing models of care and expectations, and the increasing availability of data from general practice IT systems and more sophisticated methodology for data linkages (which offer enormous potential).

Development of indicators should be informed by their current use, the cost of collecting and analysing the data that underpin them and their impact. It could also formally draw upon the work of CCGs (and their associated CSUs) in developing dashboards using a wider range of locally available data, and specifically the work across the country to develop better indicators to assess the progress of new models of care, including integrated and digital care.

6. Wider strategy for achieving key purposes

Publishing better indicators by themselves will not be the most effective way to achieve the three purposes we focus on in this review (improvement, choice and voice and accountability) but only one element of what should be a wider coherent strategy. In the first part of this chapter (A: Improving care) we consider what elements might be important to develop in a national strategy for improving quality of care in general practice. In the second part (B: Choice and voice) we discuss, to a limited extent, what would be needed for the strategy to improve choice and voice for the public.

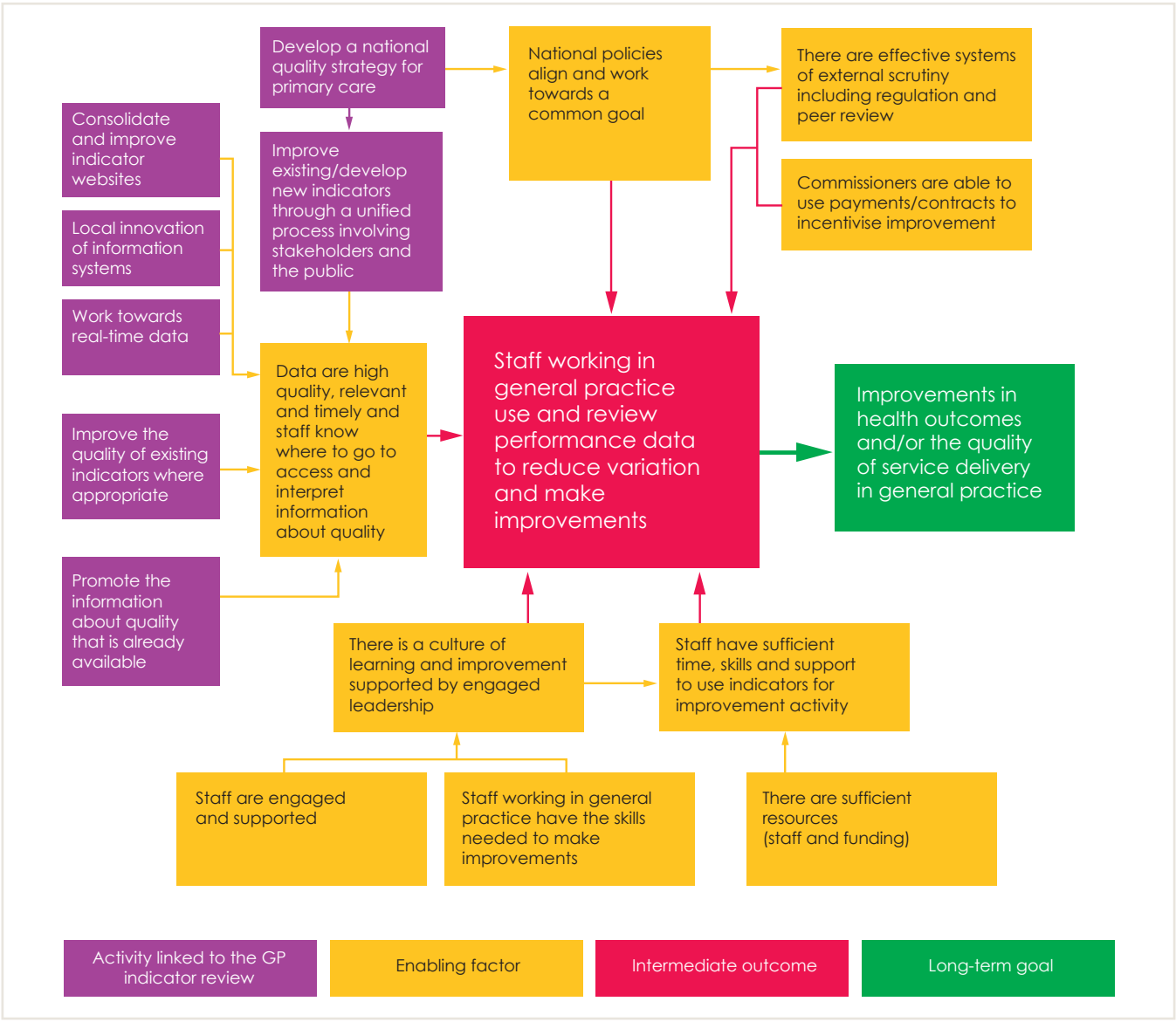
A: Improving care

In our report, *Constructive comfort: accelerating change in the NHS,* the Health Foundation identified seven success factors for improvement to take place in NHS providers:

- Committed and respected leadership engaging the staff.
- A culture which is hospitable and supportive of change.
- Data and analytics that measure and communicate impact.
- Management practices that ensure execution and implementation.
- An enabling environment which supports and drives change.
- Resource and support to do the work of change.
- Capabilities and skills to identify and solve problems.[70]

Based on this, Figure 3 (overleaf) suggests some activities that would be needed to accelerate improvement in general practice. On this basis, the activities covered by this review (shown in purple) are just a part.

Figure 3: Basic change model for improvement



As discussed in *Constructive comfort*, there are a range of approaches or interventions (levers) that national policy makers adopt to incentivise or encourage change, summarised in the box below.

Policy levers of change

- Type 1: 'prodding' or 'stimulating' – initiatives to change provider behaviour such as setting targets, issuing guidance, performance management, competition, regulation, contracting, commissioning and setting payment incentives, such as QOF.
- Type 2: 'proactive support' – initiatives that directly or indirectly support providers and commissioners from within to improve performance. These approaches are focused on developing internal capacity and are reliant upon the intrinsic motivation of staff to make the right changes.
- Type 3: 'people-focused' – these approaches involve both prods and proactive support, targeting individual NHS staff rather than organisations, as well as actions to inspire, engage and involve staff. Approaches include using policy mechanisms such as: education and training, national contracts, professional regulation and clinical standards.[70]

If the overall aim is to help general practices improve care it will be important to consider all three types of lever and how they interact. National policy-making has tended to focus on 'prod' interventions aimed at influencing behaviour at the organisational level through controls such as setting targets, payment incentives or regulation. However, the new deal for general practice, announced by the Secretary of State in June 2015, set out a number of commitments (both new and existing), including:

- workforce reform
- support for infrastructure development
- reduction in bureaucracy
- support for new models of care
- assessing quality of care
- help to support struggling practices.[2]

These commitments include interventions which are 'people-focused' and begin to consider 'proactive support'. This is a positive step towards a needed comprehensive strategy for quality in general practice.

Broadly speaking, improvement activity in general practice can be divided into interventions targeting patients, those targeting professionals and practice-level interventions. Table 9 highlights examples of these interventions that research has shown to be effective.

Table 9: Three levels of quality improvement intervention in general practice

Intervention level	Effective interventions
Interventions targeting patients	Improving access, increasing the duration of consultations, seeing the same clinician over time, patient education, patient access to records, gaining patient feedback and using technology and other support tools.
Interventions targeting professionals	Training in quality improvement methods, inter-professional learning, audit and feedback, educational outreach visits, improvement collaboratives, decision-support tools, nurse-led services and increased staffing levels.
Practice-level interventions	Providing a wider range of services, quality improvement projects, telehealth, clinical audit, payment incentives, significant event analysis, electronic tools, and improving data collection and error reporting.
Source: Based on evidence compiled from the Health Foundation's evidence scan on improving quality in general practice.[71]	

As Figure 3 suggests, if the objective of improved and published indicators is to enable staff working in general practice to use and review performance data to reduce variation and to make improvements, there are a number of enabling factors that must be in place. These include the following:

- Data are high quality, relevant and timely and staff know where to go to access and interpret information about quality.
- There is a culture of learning and improvement[72] supported by engaged leadership.
- Staff have sufficient time, skills and support to use indicators for improvement activity.
- National policies align and work towards a common goal.

Data are high quality, relevant and timely and staff know where to go to access and interpret information about quality

Chapter 3 outlines that many of the national websites examined appear to be underused and may not contain sufficiently timely data to be useful. The roots of the concerns expressed by stakeholders we spoke to and those responding to the online consultation exercise included:

- the nature of general practice is heterogeneous and much of 'quality' was not thought to be measureable using existing quantitative indicators
- the quality of existing data on which nationally available indicators are constructed was not thought to be high enough
- national indicators did not sufficiently reflect context
- there was a fear that nationally published indicators would be used inappropriately for performance management and that undue weight on a small group of indicators could skew activity inappropriately. There was an obvious concern about any extra burden of either additional scrutiny or regulation which would reduce the space for activity to improve care.

These arguments were also expressed but more intensely regarding the use of indicators to assess the quality of care provided by an individual GP. By focusing on the individual GP, the contribution of practice nurses, community pharmacists and other staff was thought to be minimised at a time when there were numerous initiatives to expand their roles.

A common theme during our engagement discussions was whether general practice was the right unit of analysis. In time, it would be appropriate to analyse data based on a practice and federation level. In addition, it was suggested that it would be important to view the whole primary care landscape and that focusing predominately on general practice rather than primary care as a whole might be counter-productive and lead to further silos.

In considering how to improve the information available about the quality of general practice performance, it is important to bear in mind the overall objectives of what the system would like general practice to deliver and how data could be developed to support those objectives. The 'quality paradox', as proposed by Swinglehurst and colleagues, suggests that the pursuit and measurement of quality in health care often fails to deliver the predicted benefits, and may undermine the characteristics it seeks to assure.[73] For example, McShane and colleagues have suggested that the Quality and Outcomes Framework (QOF) has resulted in quality becoming equated with the recording of disease-specific biomedical markers, and has failed to assist the health and care economy to deliver person-centred, coordinated care.[74]

There is a culture of learning and improvement supported by engaged leadership

The challenges facing general practice have been well publicised in recent months: high workload and stress with implications for the quality of care that can be provided.[75,76,77] Stakeholders contributing to this review echoed these findings and the online consultation exercise highlighted the low morale and lack of trust felt by staff working in general practice. The general feeling was that, overwhelmingly, general practices wanted to improve care for patients, but were under significant pressure and needed support to do so. In particular, there were widespread concerns that published indicators might be summarised in a 'judgement' that would be too simplistic and unfair and would de-motivate staff and generate fear rather than be used as a tool for learning or improvement. For example, one respondent commented:

> *'It seems you can access and engage a few keen GPs in the world of quality improvement but with GP morale at an all-time low it is difficult to attempt to add anything to their workload even if the change is evidenced to deliver quality improvement.'*

The ten-point action plan to address workforce issues by focusing on improving recruitment, retaining doctors and supporting those who wish to return to general practice[78] will help to tackle some of the structural issues linked to shortages of GPs. However, the current climate makes it harder to achieve the objective of intelligent transparency.

The conclusions of the National Advisory Group on the Safety of Patients in England, chaired by Don Berwick, are relevant here:

- Recognise that transparency is essential and expect and insist on it.
- Ensure that responsibility for functions related to safety and improvement are vested clearly and simply.
- Give the people of the NHS career-long help to learn, master and apply modern methods for quality control, quality improvement and quality planning.
- Make sure pride and joy in work, not fear, infuse the NHS.

Don Berwick said:

> *'I hope that you will invest even more than ever before in learning, growth, development, ambition, and pride. This is the route that can make the NHS a "learning organisation" in every sense of the term, and it can unleash momentum for improvement that no simple, top-down, control-oriented, requirement-driven culture ever can.'*[79]

Throughout this review, we heard that there was more trust in locally-developed dashboards and efforts to improve quality. It was reported that CCGs or federations were able to interpret data taking account of local context and were in a better position to offer support to help practices improve (see box about Wandsworth CCG). Many of the general practice stakeholders involved in the review were positive about the need to develop effective local peer review or local accreditation of quality within the CCG, which they thought would be very impactful.

Wandsworth CCG's role in supporting continuous improvement in general practice

Wandsworth CCG has taken an active role in supporting continuous improvement in quality. All practices within the CCG are signed up to support a members' development programme and, as part of the programme, practices are required to facilitate and participate in a visit from the practice support team at the CCG. In addition, each practice is funded for a monthly session to focus on key areas within the practice to develop and improve quality.[80]

To support the programme, the CCG developed a local quality tracker. The tracker pulls together information and data from a variety of sources with the aim of providing an overview of how practices are delivering services and their engagement with quality improvement schemes. The tracker will be updated and reviewed on a regular basis to identify practices that may need support.[81]

The data included in the quality tracker includes national data (taken from NHS Choices, QOF, GPOS, the friends and family test and CQC standards), local data taken from contract information, as well as information relating to participation in the members' development programme.

The Clinical Service Accreditation Alliance (CSAA) was created following an agreement on 17 October 2013 for a core group of professional bodies to work with the CQC, commissioners, the third sector, patient representatives and other key stakeholders to develop an overarching strategy for clinical service accreditation. The intention of the alliance is first to develop an assessment process (accreditation of clinical services) that fills the information gap the regulators and commissioners currently face and, second, to develop a process that is truly patient-centric by assessing pathways and services, rather than care provided by individual providers.[*,82] The focus is not as yet on general practice, but this could be developed in future alongside additional evidence on the potential impact of accreditation.

* The Health Foundation is supporting this work via a grant of £200,000.

Peer review activity in the NHS ranges from NHS England's national peer review programme (covering cancer, trauma, paediatric diabetes and stroke (as a pilot) services)[83] to local activity organised by CCGs or federations. Royal colleges have also been active in this area. For example, the Royal College of General Practitioners (RCGP) developed two quality initiatives: practice accreditation and the quality practice award, which aim to help practices improve their quality of care.[84]

Feedback from our engagement process highlighted that there would be benefit to collecting national data on the views of staff working in general practice in a similar fashion to the NHS Staff Survey.[85] There is a mandatory annual survey for all trainee GPs organised by the General Medical Council,[86] which includes questions on satisfaction with role and workload. A survey for GP trainers (clinical and academic supervisors of GP trainees) is due to be introduced from 2016 onwards.[87] Currently workforce information is collected as part of NHS Workforce Minimum Data Set (wMDS)[88] but the purpose and scope of the wMDS is to support future workforce planning and education commissioning.[89] It is not a source that reflects staff satisfaction. In 2006, the Health and Social Care Information Centre collected data on workload from GPs and practice staff from a sample of general practices across the UK and published the results in the UK GP workload survey report in 2007. A previous survey was conducted in 1992/3.[90]

The General Practitioners Committee of the BMA has conducted a number of surveys on specific issues such as appraisal and revalidation[91] and GP premises.[92] The RCGP also carries out surveys of its membership.[93] In addition, there is a repeated cross sectional survey (as opposed to a practice-by-practice census) of GPs' working conditions and attitudes to primary care reforms (previously undertaken in 1998, 2001, 2004, 2005, 2008 and 2010). Manchester University undertook the seventh survey in this series in 2012. Each survey has a nationally representative cross-sectional element (n=1,189 respondents in 2012) and a longitudinal element (n=2,015 respondents in 2012).[94] These surveys offer valuable insight into various issues facing general practice more broadly, but do not give information that may support benchmarking across each practice in England or peer review.

There may be scope to explore a more regular staff survey of each practice. One of the challenges of this approach would be how to deal with the presentation of results for practices with small numbers of staff, and implementation would not be straightforward. However, progress in these areas would require additional consultation with professional stakeholders and technical experts to assess the feasibility, burden and potential benefit.

More broadly, the Primary Care Faculty of NHS Improving Quality's Transforming Care Team highlighted to us some questions that would be important to consider in future indicator development:

- Can organisations demonstrate the effective leadership required to drive improvement at all levels, from clinicians to administrative staff?
- Is the workforce satisfied with the care they are delivering?
- Do they feel supported in their roles and able to speak out when they have concerns?
- Are they empowered to make improvements in the services they deliver?
- Is there a culture of innovation and continuous quality improvement?[95]

Staff have sufficient time, skills and support to use indicators for improvement activity

As we identified above, there has been less focus at a national level on policy levers and interventions which offer proactive and targeted support to professionals. Evidence suggests that skills, capacity and knowledge of improvement methodologies in general practice (with

the exception of clinical and significant event audit) are low[96,97,98] (although this is not unique to general practice). To improve the quality of general practice effectively, continuous improvement approaches may be needed, supported by specific quality improvement training for general practice teams.[71]

For example, researchers explored the enablers and constraints to implementing a large-scale quality improvement programme to improve care for people with chronic obstructive pulmonary disease (COPD) across 189 general practices. While practice staff were eager to take part in collaborative improvement projects, challenges included a lack of skill in systematic improvement, issues accessing data, poor quality of data and tensions between the way that many primary care clinicians work and the more quantitative, disease-based orientation of some quality improvement processes. The authors concluded that for improvement efforts to operate effectively within primary care, greater resource needed to be allocated to support and engage practices in the principles of system-based improvement.[98]

The Health Foundation has significant experience in supporting interventions of this type. For example, as part of our *Closing the Gap through Clinical Communities* programme we supported teams by providing learning and development in areas of quality improvement, including knowledge of systems, measurement, understanding of variation, and spreading learning.[99] In addition, the Health Foundation's *Engaging with Quality in Primary Care* programme sought to engage primary care clinicians in clinical quality measurement and to increase the capacity for clinical quality improvement in primary care.[100] In one of the programme's projects, the University of Bristol led a randomised controlled trial of a training and support programme called Identification and Referral to Improve Safety (IRIS) which aimed to improve the general practice response to domestic violence. The study demonstrated a substantial increase in identification of victims and their referral to specialist domestic violence services, resulting in a subsequent reduction in recurrent abuse and improved quality of life.[101,102] The programme has now been commissioned by CCGs and local authorities in 12 English localities and the training has been delivered to 122 general practices. The current annual rate of referral of victims of domestic violence from IRIS practices in England to specialist domestic violence agencies is 683 per year, with trial data indicating that at least 600 of these referrals would not have taken place without the IRIS programme. The programme started implementation in Scotland in June 2013.[103]

Health Foundation-funded project: improving quality and safety in primary care

As part of the *Closing the Gap through Clinical Communities* programme, Dr Neil Houston led a project though which 43 general practices in Scotland worked to reduce harm and ill-health caused by heart failure and adverse reactions to prescription drugs.[99]

Teams used the Institute for Healthcare Improvement's breakthrough collaborative methodology[104] (a short-term learning system that brings together a large number of teams to seek improvement in a focused topic area). They aimed to address the lack of experience and practical skills in implementing quality and safety improvement at the practice level. As part of the programme, participating practices were taught skills in the use of general improvement methodologies, including: small tests of change, care bundles, trigger tools, patient safety climate surveys and patient involvement.[105]

By the end of the project, many practices demonstrated significant improvements in the two clinical areas (albeit with variation) and practices reported that care of patients had become safer and more reliable, with practices improving their safety culture and becoming more efficient.

From 2013, the national Scottish Patient Safety Programme in Primary Care was rolled out to general practices across Scotland and was in part based on the work of Dr Houston's project.[106] This project has also influenced the emerging World Health Organization (WHO) patient safety in primary care agenda.

Nationally, the *Productive General Practice* programme, developed by the NHS Institute for Innovation and Improvement, was designed to help support staff to improve work processes with the objective of releasing time to invest in improving patient outcomes and staff wellbeing.[107] Locally there are initiatives at CCG level: for example, Tower Hamlets CCG has a *Quality in General Practice* programme.[108] As part of this programme, staff working in practices within the CCG were surveyed in 2013. Participants were asked to select the key challenges for their practice in delivering an excellent service from a list of 16 options, and asked to provide an opinion on what would help address these challenges.[109]

Clearly there is an agenda here to develop CCGs to support local improvement activity by general practices, in addition to developing indicators. CCGs have some local flexibilities to help, for example in using local payment incentives to encourage practices. In June 2015, NHS England gave permission to GPs in Somerset to opt out of QOF in return for a new local contract with equivalent funding. The scheme allowed practices to stop reporting in all but a small set of core clinical QOF indicators and, instead, required them to present regular reports to the regional team, outlining how the released funding has been used to improve local services. The pilot scheme had three focus areas – improving care, integration projects and sustainability projects – alongside encouragement to be creative and innovative in designing new models of care. Their first quarterly report described their latest initiatives, including enhanced provision of end-of-life care through practice collaboration in very rural communities, efforts to support patients with multiple long-term conditions to better manage their own care and the development of a shared nursing team model between practices.[110]

A common question during our engagement discussions was: whose role is it to steer improvement activity? Should it be a CCG, a federation, a national body? Attention needs to be given to providing practical and technical support for improvement at multiple levels of the system, as well as addressing the underlying problems that make improvement more challenging. Such support should seek to build internal capacity within organisations rather than relying on external interventions. The merger of Monitor and the NHS Trust Development Authority into NHS Improvement represents an opportunity for improvement to have a greater voice in the system. However, there are risks in embedding system-wide improvement functions into an organisation that will develop out of two organisations whose main focus has been the acute sector rather than primary care.

National policies align and work towards a common goal

Clearly, how national policies align is critical to supporting the improvement of quality in general practice. Through the engagement process, two national initiatives were thought to have a large influence over the activity carried out by practices: the QOF, and the inspection and subsequent rating by the CQC.

Quality and Outcomes Framework (QOF)

In April 2004, the government introduced the QOF as part of the new general medical services (GMS) contract. It is a voluntary, points-based incentive programme for general practices, which financially rewards achievement against a set of clinical quality indicators and provides core resources for practices to use for employment of staff. Each QOF point for 2015/16 is worth approximately £160.[48] For 2015/16, 40% of QOF points were removed, in an attempt to reduce bureaucracy, recognise an increase in workload in specific disease areas and allow GPs and practice staff more time to focus on the needs of individual patients, with the released funding reallocated through the global sum.[111]

The impact of QOF has been a controversial topic, with mixed opinion about its benefits. Evidence suggests that the improvements gained from QOF have been modest[112] and that the evidence base is inconclusive.[113]

One of the criticisms levelled at QOF is that it has led to GPs pursuing specific targets rather than considering a broader picture or supporting improvement more generally. For example, Carolyn Chew-Graham and colleagues found that routine review consultations in primary care focused on the biomedical agenda set by QOF and 'socialised patients into the role of passive subjects of surveillance'.[114] However, QOF has been used to incentivise the use of audit in general practice to identify where improvements might be made in care. For example, QOF indicator CS004 measures whether a contractor has a policy for auditing its cervical screening service and performs an audit of inadequate cervical screening tests in relation to individual sample-takers at least every two years.[111]

Scotland offers an example of how QOF could be used to incentivise broader quality improvement activity. In 2014/15, QOF was used to support the Scottish Patient Safety Programme through incentivising the development of a safety culture. Through QOF, practices were asked to conduct two structured case note reviews each year, using a validated tool, to detect patient safety incidents.[115] Critically, the practice team was required to share a reflective report on actions and themes that arose from the review with the NHS board. Practices have implemented a number of improvements including educational sessions, protocol development and significant adverse event reviews. Aggregation of the case note reviews has helped some NHS boards to theme areas for improvement.[116] In addition, a further indicator has been developed relating to the practice conducting a safety climate survey with all staff (clinical and non-clinical) using a validated tool, meeting to discuss the results and sharing a reflective report on actions with the NHS board.[115]

National level QOF payments are a powerful incentive for activity, and there is scope to consider further how they might be used to support improvement in England. However, the local payment flexibilities that CCGs now have through co-commissioning may in time become more powerful than national payment incentives as they are more likely to be based on locally-agreed priorities, and be nuanced to address local context.

Care Quality Commission (CQC)

The CQC's major role is in assessment, rather than actively supporting improvement, and it has powers to enforce action if services are shown to be lacking. By providing a detailed assessment of quality through inspection and ratings, it prompts action by practices to address issues identified.

As much priority must be given to the alignment of actions within the strategy as designing the individual components. In Chapter 5, we have suggested a potential roadmap as a basis for designing a more comprehensive strategy. In particular, peer review could be exploited more effectively as a lever for improvement, but also as a vehicle for incentivising better use, and development of, data. Throughout the engagement exercise, we heard concerns about a perceived lack of alignment at a national level. Evidence shows that clear, challenging goals are important for high level care but that often there can be *'priority thickets'* – dense patches of overlapping or disjointed goals that command attention and resources but do not necessarily provide clear direction.[117]

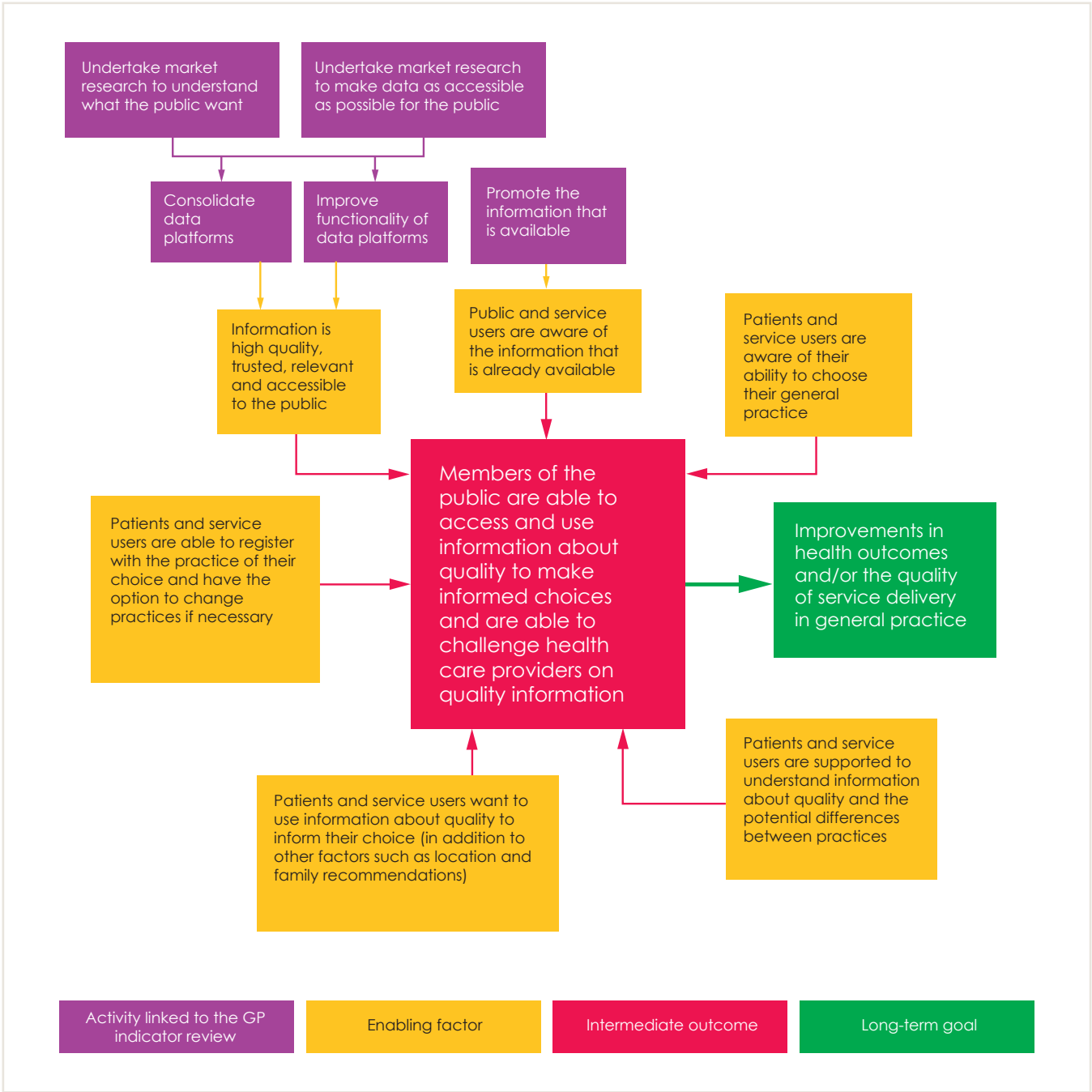
B: Choice and voice

In parallel with the previous section on improving care, we suggest that information is an important component of facilitating choice and voice, but that publishing better indicators alone is unlikely to lead to improved use of information by the public – or indeed the exercise of choice and voice.

If the main purpose of publishing indicators is for the public to access and use information about quality to make informed choices and challenge providers, Figure 4 overleaf outlines a basic model describing the factors that need to be in place to achieve that purpose. We suggest that the following are critical enablers:

- Information is high quality, trusted, relevant and accessible to the public.
- The public, patients and service users are aware of the information that is already available.
- Patients and service users are aware of their ability to choose their general practice.
- Patients and service users are supported to understand information about quality and the potential differences between practices.
- Patients and service users are able to register with the practice of their choice and have the option to change practices if necessary.
- Patients and service users want to use information about quality to inform their choice (in addition to other factors such as location and family recommendations).

Figure 4: Basic change model for choice and voice



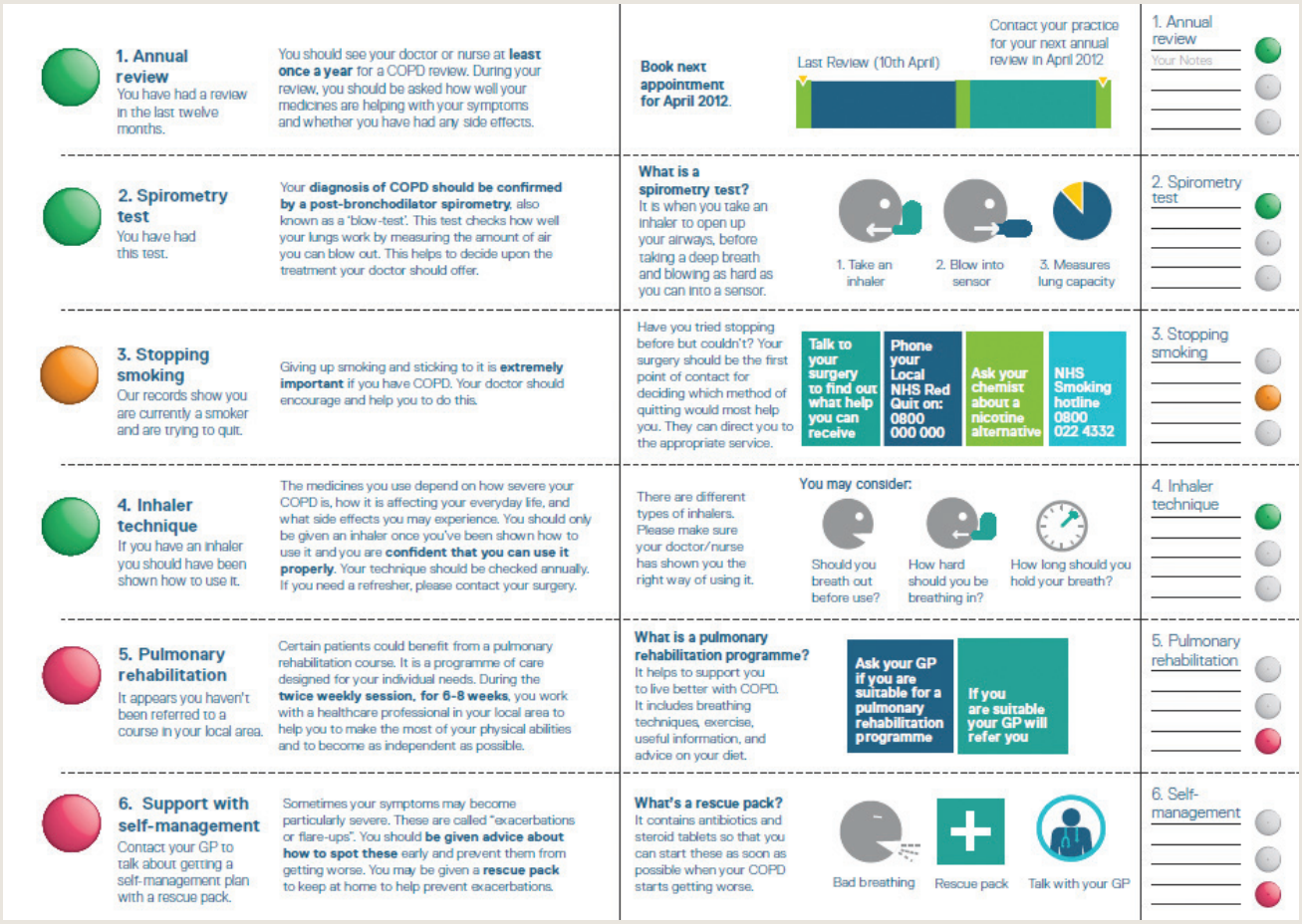
The Health Foundation has funded a number of projects that have sought to improve the way health services improve access to information for patients. For example, in 2011 NHS Redbridge produced a quality scorecard for people with chronic obstructive pulmonary disease (COPD) that could be used by them to negotiate better care and to reduce hospital admissions by improving standards of COPD management (see box below).

NHS Redbridge - COPD information for the public

The NHS Redbridge project aimed to make information about a specific disease (COPD), and its associated treatment, more accessible to people with that condition. The aim of the project was to produce a quality scorecard for people with COPD that could be used by them to negotiate better care and to reduce hospital admissions by improving standards of COPD management.

The NHS Redbridge team developed an IT system which provides personalised information to COPD patients and their GPs. The IT system extracted information from primary care databases to create personalised patient scorecards. The scorecards were co-produced by patients, GPs, practice nurses and practice managers and focused on six evidence-based interventions based on NICE guidelines. The scorecards were sent to patients along with a letter advising them to see their GP to discuss further interventions, as well as information about community-based services that could enable exacerbations to be managed at home. The system was also used to generate reports for GPs and patients that compared quality with primary and secondary care costs for each patient.

Feedback from patients suggested that it helped them to understand their condition and how they could better self-manage. They added that the checklist enabled them to be more confident in asking their GP questions.[118,119]



As a further example, South Yorkshire Housing Association, Gentoo Group and St Vincent's Housing Association are working together on the Over2You project, funded by the Department of Health. Over2You aims to raise the aspirations of what people expect from health and social care providers and to give people a voice in improving quality.[120] Over2You has two key strands:

- Health and social care users, their family and friends co-design and co-deliver information sessions for other users, family and friends on quality standards and customer rights. This aims to raise expectations and self and peer advocacy skills to increase the number of voices speaking about quality in health and care and to increase the emphasis on the importance of customer, family and friends' voices across the sector.
- Over2You recruits users, family and friends as volunteers who carry out person-centred quality audits of health and social care services, where quality measures are defined by those with personal experience. Volunteers receive accredited training and are supported by health care professionals who act as mentors, enabling volunteers to navigate the system and challenge poor quality care where they find it.[121]

During the consultation process for this review, Over2You project leads carried out some focused work with their volunteers and customers to explore perceptions of quality measures in general practice.

The project offers an example of genuine engagement with the public to define quality, but also to support people in having a voice who may not normally be involved in consultations or engagement. The project's client group includes people with mental health needs, learning disabilities, physical disabilities, older people, people with substance addictions and people experiencing homelessness. See the box overleaf for more information about the project.

The examples from NHS Redbridge and the Over2You projects show that there is scope to work more proactively to identify how different organisations can contribute to empowering patients and communities through better communication and use of information about quality. Further thought should be given to a range of complementary methods for displaying information as well as online resources. For example, from 1 April 2015, practices are required to display their CQC rating,[122] but its effects are not yet known. Detailed consideration of alternative options was outside the scope of this review but the question of 'how' to engage is as important as how to present information. As part of the consultation exercise, we received a helpful submission from Monitor outlining the organisation's wish to support other organisations to raise patient awareness about choosing their general practice and the potential benefits of doing so.

Over2You – insight into how traditionally under-represented groups might define and measure quality across general practice

As part of the Health Foundation consultation into GP quality indicators, Over2You carried out a series of events and activities to engage people whose voices are seldom heard, but who access health services more often than most.

Over2You designed a range of creative, co-design activities to engage traditionally under-represented groups in conversations about how they would define and measure quality across general practices, with the aim of encouraging higher levels of participation, attracting individuals who were not 'usual suspects' and facilitating peer-led events. Through their novel approach, Over2You hoped to generate a different type of conversation from the traditional customer-professional discussion.

As an example, 12 children, aged between 4 and 11 were asked to describe what their ideal GP looked like and to consider this question from the point of view of the fictional character 'Bob' from the film *Minions*. This helped the children consider the experiences of others as well as themselves.

The factors which contributed most to a positive visit to the GP surgery among these children were:

- having a colourful, comfortable and welcoming waiting room containing toys
- having a waiting room with a comfortable level of noise; many children noted the that quietness of waiting rooms can make their experience intimidating or scary
- staff wearing normal ('not scary') clothes and being called by their names instead of 'doctor'
- GPs opening their doors before patients enter, or even welcoming patients into their room from the corridor, since the process of knocking on the door of the doctor was raised as a scary experience.

The team noted that there appeared to be very few opportunities for children to provide feedback on their experience. As part of the exercise, a subgroup of the children were asked about how they would like to give feedback and the following themes emerged:

- Children thought they should be able to say whether they liked their doctor or not and whether or not they felt scared.
- They suggested they would like to give feedback using a simple process, like star stickers or smiley face scales, to indicate the quality of their experience.[121]

For more details of Over2You's engagement work, visit their website: www.over2you.org.uk

We would like to thank Ruby Smith and the team at Over2You for approaching the Health Foundation review team and for conducting their engagement events quickly to allow us to feature their work in this report.

Summary and conclusions

Publishing better indicators by themselves will not be the most effective way to achieve most of the three purposes – improvement, choice and voice and accountability – but only one element of what should be a wider coherent strategy to support progress.

To achieve the purpose of improvement, of all the elements that might make up a strategy, the key one is to create an environment for learning not fear. This means indicators should be used less as a blunt overall 'judgement' and more as a device to learn and measure progress. This could be supported by a range of mechanisms, for example local peer review, as well as local and national payment incentives to encourage change. Indicators that are seen as clinically valid are likely to be more powerful in encouraging improvement activity.

To achieve the purpose of strengthening public choice and voice, there is much more scope to engage with the public on what matters most to them about the quality of care.

7. Conclusions and recommendations

This review initially appeared to be a relatively discrete and fairly technical task but was in fact a complex and largely strategic one. This is why we touch on so many different issues in this report. In the time available we could not do justice to all the issues raised. However, we believe our recommendations are a solid place to start and would be supported by stakeholders.

Throughout the course of our review, we have linked with colleagues from The King's Fund who have been undertaking a parallel review for the Department of Health on measuring the performance of local health systems.[3] Several conclusions are common to both of these reviews, including the recommendations to select a small set of headline indicators to present key performance information to the public, avoid the use of aggregate scores based on performance indicators alone, consolidate the disparate array of websites presenting information about local health system performance and have NICE and others continue to play a leading role in indicator assurance and development.

In our review, there was almost unanimous support among stakeholders for the concept of transparency and developing information on quality of care. The amount of work done to date in this area and the obvious goodwill is ample testimony of this. Relative to other countries we examined, the NHS in England is very advanced in its development of information, particularly in general practice. But as people regularly told us during the review, what is needed is intelligent transparency, not *any* transparency. If transparency is undertaken in a collaborative and intelligent way, it has the potential to support improvements to health care services for the population of England.

We believe the following practical recommendations will help achieve intelligent transparency faster.

Consolidation

The number of national websites with indicators on the quality of care in general practices, and all underpinning activity, should be consolidated. Key national bodies (possibly through the National Quality Board) would need to collaborate to achieve this, in particular the Department of Health, NHS England, Public Health England and the Care Quality Commission (CQC).

As this review recognises, the direction of government policy is towards establishing MyNHS as the primary portal for information about the quality of health and care services. If the current websites were to be consolidated, and this content were hosted by the MyNHS site, it will be important to consider carefully this review's findings, conduct further market research and fully appraise a range of options. This is particularly important given some of the limitations of the MyNHS website as it currently stands. An alternative option to developing public and professional channels on MyNHS would be to re-focus MyNHS as a professional-

facing website and use NHS Choices as the public-facing channel, given the website's higher usage figures (driven by other content such as information about health and illness). Intelligent consolidation would take time to do well as the functionality of some of the existing website is currently superior to that of MyNHS.

The website consolidation we are recommending would be for the purposes of publishing general practice indicators. Following consolidation, there may still be a need for additional websites to provide other valuable information or services.

Clarity of purpose and audience and market research

The purposes of, and main audiences for, publication of indicators should be made explicit. Further market research should be done to identify who the different audiences are, what they would value most with respect to indicators and their presentation, as well as other factors that could increase usage.

Indicators for the public

Much of the information likely to be of interest to the public is already available, including indicators of access to care, patient experience of care and the CQC's rating, where available. This rating provides a better assessment of overall quality than currently available quantitative indicators alone. There is considerable scope to raise awareness among the public of the information that is already available and further thought should be given to a range of complementary methods for displaying information, as well as online resources. Such activity may be more effective around a 'trigger point', such as someone moving house. For members of the public interested in more detailed information, there could be clear links to a professional-facing channel.

Indicators for professionals

The term 'scorecard' is divisive - we recommend avoiding this terminology if a key purpose is for improvement. There appears to be low awareness, among GPs in particular, of the main websites currently containing quality indicators for general practices. We recommend consolidation of the existing websites and additional market research and engagement to understand how those working in general practice make use of online information. In the short term, quick wins would include raising awareness of existing sites and making some currently restricted indicators from the Primary Care Web Tool available in the public domain (although this tool is already available to large numbers of people working in the NHS, so potential benefits here would relate to transparency). In the longer term, as noted above, we recommend careful consolidation of websites such as Public Health England's National General Practice Profiles, the General Practice Patient Survey and the Primary Care Web Tool into one website or channel aimed specifically at professionals.

Composite scores and population grouping

We strongly advise against composite measures for a public or professional audience. We suggest users should be able to select from a full menu of indicators by various groupings. Such an approach could readily be seen as responsive to the needs and aspirations of patients themselves, and thus offer additional credibility with the public. Such groupings could include age groups or other population groupings, or groupings by clinical condition or service. Selection could also include comparison with similar practices, allowing in part for context. If population groups are to be pre-defined by the Department of Health, we recommend that there should be alignment between the population groups used for MyNHS or other websites and those used by the CQC to avoid confusion and additional burden.

Future process

For the future, a more efficient process is needed to select priorities and design and develop indicators for general practice. This should involve all key stakeholders – the public, professionals and organisations accountable for the quality of care. The process that NICE uses to develop indicators is useful and we suggest this could be developed further, for example by:

- testing the development of indicators in areas where CCGs have access to a wider range of data
- advising on how data may best be presented statistically (including adjustment for local context and 'value added' measures to estimate the impact of a general practice)
- developing meaningful groupings of indicators or a small set of 'sentinel' indicators
- developing a strategic roadmap with milestones for the next five years.

A key task would be to decide which existing or new indicators are the most valuable and which can be retired. Such a process might also serve other system priorities better. For example: reducing the burden of regulation through effective surveillance of risk; encouraging the development of new models of care by developing better measures of integrated and digital care; improving safety in general practice care; developing shared decision making or self-management support; improving productivity or value for money; and developing indicators that reflect a practice's engagement with quality improvement.

Sentinel indicators

To develop intelligent simplicity, we suggest that an indicator development process might consider the development of a small number of 'vital signs' or 'sentinel' indicators to assess progress on what matters most to the public, front-line professionals and those bodies accountable for the quality of care in general practices in England. It is important that these collectively would not pretend to give a summary picture of the overall quality of care in general practice or be ranked in any way. Nor could they (to be credible) be selected outside a process involving all key stakeholders to decide what is important. But they could help identify *'the signal from the noise'*, at a national level, and be particularly useful for purposes of making improvements and for accountability.

We recommend a follow-up to this review which would involve comprehensive engagement with front-line professionals, stakeholder organisations and the public focused on developing sentinel indicators.

Strategy to support improvement

Publishing data on a website by itself is unlikely to result in progress towards the key purposes (improvement, choice and voice for patients, and greater accountability) without other mechanisms to prompt change. We recommend the development of a national quality strategy for general practice, and for primary care more broadly, to give focus to improvement activity and indicator development to serve intelligent transparency.

We recommend that attention is given to improving the capacity of the system to analyse and respond to data and information on quality of care. This would include organising practical and technical support for general practices, federations and CCGs in improvement and in addressing the underlying problems that make improvement more challenging. Such support should seek to build internal capacity within organisations rather than relying on external interventions. The role of the CCGs in interpreting data and supporting practices locally is vital – we recommend that local innovation should be supported.

More broadly, the Secretary of State for Health's annual report could be used more effectively to produce a comprehensive and transparent assessment of progress in improving quality of care in general practices (as well as across the NHS) and reducing inequalities.

Appendices and references

Appendix A: Technical Advisory Group

We were very grateful to have been supported by a Technical Advisory Group whose terms of reference were to give advice on:

- principles by which indicators should be published publicly and to discuss the most appropriate purposes for certain types of indicator, taking into account the current pressures on general practice and the political environment
- existing work that has been done to date relating to indicator development in primary care and, more specifically, general practice
- the context within which indictors are currently being developed and used
- the process by which priorities for future metric development might be identified, and what the priorities might be
- drafts of the final report and to test key recommendations and conclusions for their feasibility, given the current pressures on general practice and the political environment.

In total, the Technical Advisory Group met twice during the review process. The group was advisory in nature. The overall shape, quality and conclusions of the work are the responsibility of the Health Foundation. Any errors are the authors' and the authors' alone. We gratefully acknowledge the support of the Technical Advisory Group in the work of this review.

The external members of the group were:

Paul Aylin: Professor of Epidemiology and Public Health, Imperial College London

Nick Black: Professor of Health Services Research, London School of Hygiene and Tropical Medicine

John Campbell: Professor of General Practice and Primary Care, University of Exeter Medical School

Henry Clay: Co-Founder, Primary Care Foundation

Julian Flowers: Consultant in Public Health and Head of Public Health Data Science, National Knowledge and Intelligence Service, Public Health England

Paul Foggitt: Operations and Delivery, Primary Medical Services, NHS England

Andrew Green: Chair of the British Medical Association's General Practice Committee Clinical and Prescribing Committee

Martin Marshall: Professor of Healthcare Improvement, University College London, and leads Improvement Science London

Veena Raleigh: Senior Fellow, Health Policy, The King's Fund

Peter Smith: Emeritus Professor of Health Policy, Imperial College London

Dave Roberts: Head of Primary Care Information, Health and Social Care Information Centre

Martin Roland: Professor of Health Services Research, University of Cambridge

Adam Steventon: Director of Data Analytics, The Health Foundation

Rob Stones: Head of Analytical Services, North Region Team, NHS England

Hamish Young: Acting Head of Provider Analytics for Adult Social Care and Primary Medical Services, Care Quality Commission

Appendix B: Engagement process

In considering the role of general practice quality indicators, the review team has tried to engage a wide group of local and national stakeholders in a dialogue, to try as far as possible to reflect the current context facing general practice. We have had many productive and constructive conversations and we hope that the content of this report adequately reflects the concerns and opportunities identified by the sector.

Engagement approach

The review was announced by the Secretary of State in June 2015 with a report required to be completed by the end of September 2015. Given the short timescales for the review, the period available for consultation was limited. However, we undertook the following activity:

- An online consultation exercise.
- Engagement with stakeholders via informal discussions and roundtable events.
- Public focus groups.
- Discussion with US health systems.

Online consultation exercise

The Health Foundation worked with Citizen Space to create an online platform to gather the views of interested parties regarding how the existing information available on the quality of general practice in England could be best used and developed in the future.

The Health Foundation created a survey for interested parties to complete, which included both qualitative and quantitative questions. The online consultation was open for responses from 20 July to 24 August 2015. We received over 600 responses to the online consultation, which was an excellent response given the short timeframe for the consultation exercise and the timing during the summer holiday period.

The survey itself was divided into six sections:

- Tell us more about your role
- Your organisation
- Tell us about the healthcare websites you use
- Information sources
- Time to have your say
- About you

Respondents were directed through different pathways in the survey, depending on whether they answered yes or no to the question '*Do you work in general practice or represent general practice?*'. Respondents who answered yes were then asked about their role in general practice. Those who selected '*A practising GP?*' or '*A person who works in a general practice but not as a GP?*' were directed through a different pathway from those who selected '*Working in an organisation representing general practice?*', '*Working in an organisation that uses general practice data?*' or '*Other?*'.

All respondents had the opportunity to answer a series of quantitative questions regarding the information available on a number of websites (NHS Choices, MyNHS, CQC, Health and Social Care Information Centre (HSCIC), Public Health England National General Practice Profiles (PHE's NGPP) and NHSE GP patient survey). Respondents who identified themselves as a practising GP or as someone who worked in general practice (but not as a GP) were also asked to consider the Primary Care Web Tool website.

The 'Information sources' section of the consultation asked all respondents questions about the sources they used to find out information on the quality of care in their own practice, or in general practices more widely. The 'Time to have your say' section of the consultation asked for opinions on developing quality indicators and the advantages and disadvantages associated with publishing indicators in the public domain. This section also sought respondent opinion on the usefulness of providing better information on the quality of care provided in general practice for a number of population groups.

All consultation respondents were asked to provide personal details, including their name, email address and job role; however, these responses were not mandatory and were not published on the consultation website. 546 respondents gave permission for their answers to be published anonymously on the consultation website.

Given the short timescales, the survey did not go through extensive piloting or testing, which limits the potential validity of the survey results.

In addition, we received 18 submissions that covered a broader set of issues than the online consultation.

Engagement with stakeholders

As part of the wider engagement process we spoke to a large number of organisations and individuals. We are particularly grateful to those organisations who arranged 'roundtable' events or visits on our behalf, enabling us to reach a wider range of individuals and organisations than we could have achieved alone. We would like to thank in particular the following national organisations:

- Academy of Medical Royal Colleges
- British Medical Association
- The Family Doctors Association
- National Association of Primary Care
- NHS Alliance
- NHS Clinical Commissioners
- NHS Partners
- Royal College of General Practitioners
- Royal College of Nursing
- Royal Pharmaceutical Society

Engagement with the public

We commissioned insight agency BritainThinks to conduct research with the public to:

- explore if and how the general public use existing data to choose their general practice
- explore whether there is unmet demand for additional or different data
- explore whether the general public would want and/or use specific prompted forms of additional or different data
- explore preferences for accessing the data (and attitudes to portals currently showing information about different practices).

Methodology

Focus groups: BritainThinks conducted eight focus groups in four locations across England. Field work was conducted between 11 and 17 August 2015. The sample composition was structured to ensure findings could be analysed by gender, age, health and environment (urban, suburban, rural) as per Table B1 below.

Quantitative survey: BritainThinks conducted an online survey, run on an omnibus of 1,723 participants with data weighted to be representative of the adult English population. Fieldwork was conducted between 19 and 21 August 2015.

The results of the research can be found in full on the BritainThinks website: http://britainthinks.com/Health-Foundation-GP-data

Table B1: Focus group composition

Location	Group composition	Group composition
Southampton (Urban south)	**Group 1:** female, young families, no long-term health conditions	**Group 2**: male, young families, no long-term health conditions
Manchester (Urban north)	**Group 3:** female, aged 18-44, no long-term health condition	**Group 4:** male, aged 18-44, long-term health condition
Diss (Rural)	**Group 5:** female, aged 45-64, long-term health condition	**Group 6:** male, aged 45-64, no long-term health condition
Egham (Suburban)	**Group 7**: female, aged 65+, long-term health condition	**Group 8,** male, aged 65+, long-term health condition

Appendix C: Online consultation results

Our online consultation invited NHS professionals from across England including, but not restricted to, general practitioners, practice managers, general practice nurses and pharmacists, and their representative organisations, as well as patient and carer groups and the Department of Health's arm's-length bodies, to share their views on how we could use data better to improve the quality of general practice.

Who responded?

Respondent categories were first split into those who do and those who don't work in – or represent – general practice. Those who said they do were split further into: a practising GP, someone who works in general practice but not as a GP, working in an organisation representing general practice, and working in an organisation that uses general practice or other – the latter three were grouped together as 'Others who work in or represent general practice'. These groups are summarised in Table C1 below:

Table C1: Respondents to the Health Foundation's consultation exercise

Works in or represents general practice?	Stated sub-type	Respondents	Percentage
Yes	GP	361	60%
Yes	Works in a general practice but not as a GP	167	28%
Yes	Others who work in or represent general practice	25	4%
No	Does not work in or represent general practice	47	8%
Total		**600**	**100%**

The majority of those who said they worked in a general practice but not as a GP described themselves as in a management position (see Table C2). Those who worked in or represented general practice described themselves mostly as working in clinical commissioning groups (CCGs), with a small number of GP trainees, individuals from the Royal College of General Practitioners (RCGP), the Care Quality Commission (CQC) and some private enterprises. Those describing themselves as 'not working in or representing general practice' included individuals who worked for NHS England, various CCGs, universities and a wider range of other organisations.

Table C2: Respondents to the Health Foundation's consultation exercise. Breakdown of those who said they worked in a general practice but not as a GP

Inferred sub-type	Frequency
Management	113
Did not say	47
Nurse	6
Admin	1
Total	167

Consultation results* **

Usage frequency of websites

Respondents were asked '*How often do you look at the information available on the quality of care in general practices on the following websites?*', and were given a choice of answer:

- Never
- About once a year
- About once every 6 months
- About once every quarter
- About once a month
- About once a week
- About once a day
- N/A (excluded from analysis)

The websites that participants were asked to consider were those of:

- NHS Choices
- Care Quality Commission (CQC)
- Health and Social Care Information Centre (HSCIC)
- Public Health England's National General Practice Profiles (PHE's NGPP)
- The General Practice Patient Survey (GPPS)
- MyNHS
- NHS England's Primary Care Web Tool (PCWT)

The distributions that comprise these averages are shown below, in order of most to least used (by website). Respondents were able to select 'N/A' or 'Don't know' for a number of questions and the response rate excludes these responses. The overall response rate varied by website from 100% for NHS Choices to 91% for the PCWT.

* Note: Any presentation of an average is from the whole respondent sample, and not aggregated from the values of the four categories. This by default provides a weighted average, representing each respondent equally. Since the GPs formed 60% of the respondents, the overall average (grey bar) response from all respondents often closely follows the GP group (red diamond).

** Note: The response rate to a number of multiple choice questions is included.

Key for Charts C2–C7

Overall	
GP	
Works in a general practice but not as a GP	
Others who work in or represent general practice	
Does not work in or represent general practice	

Chart C1: Usage frequency of websites (NHS Choices)

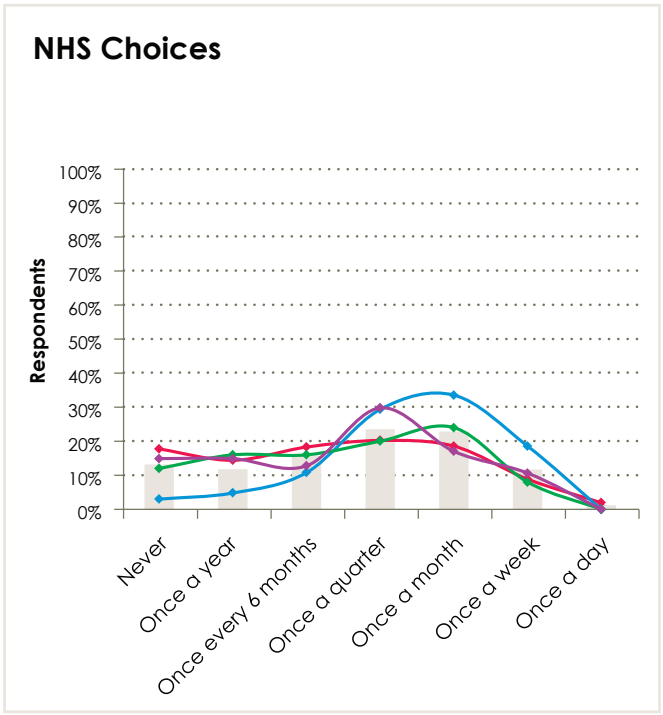


Chart C2: Usage frequency of websites (CQC)

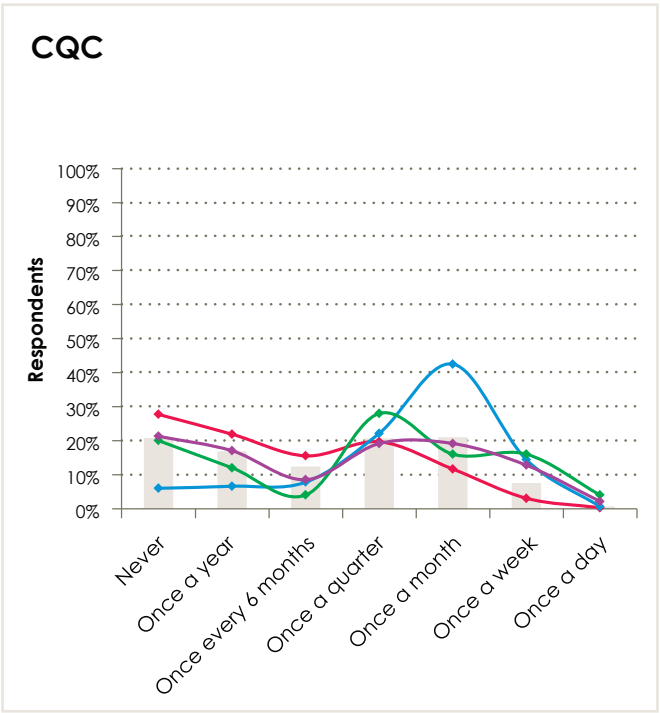


Chart C3: Usage frequency of websites (PCWT)

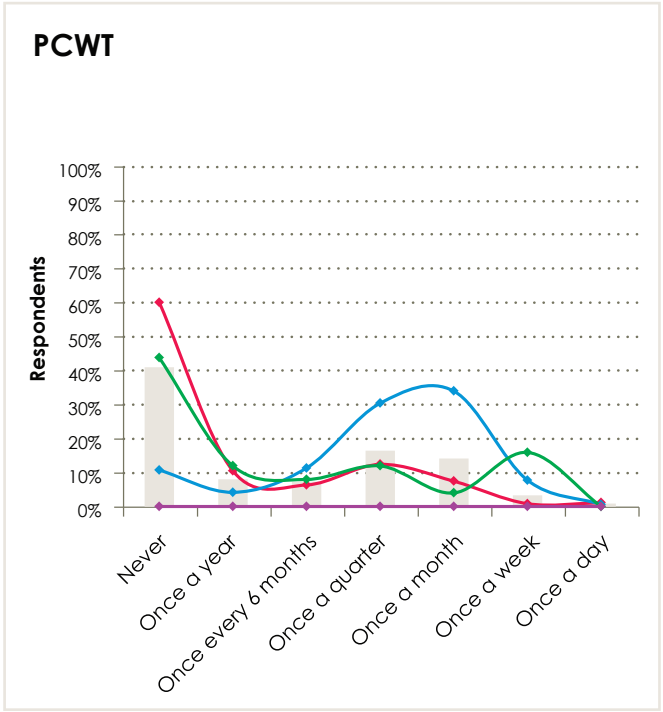


Chart C4: Usage frequency of websites (HSCIC)

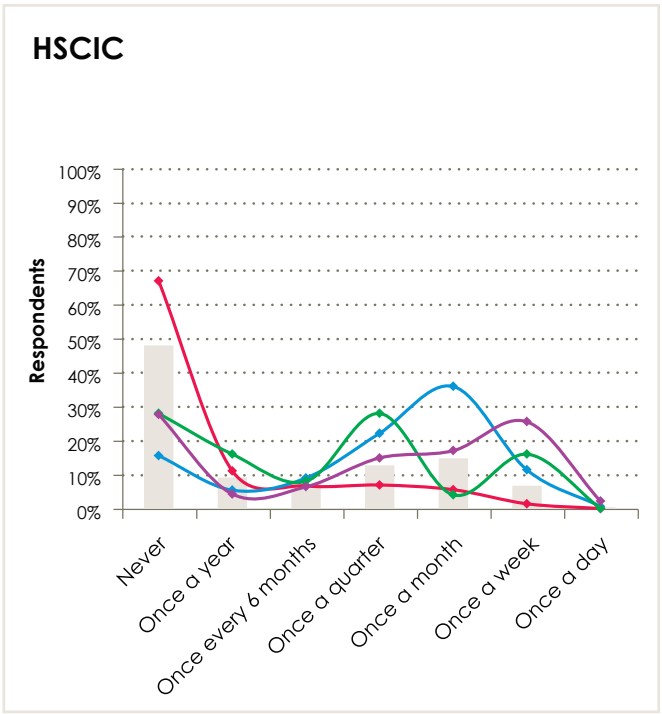


Chart C5: Usage frequency of websites (PHE's NGPP)

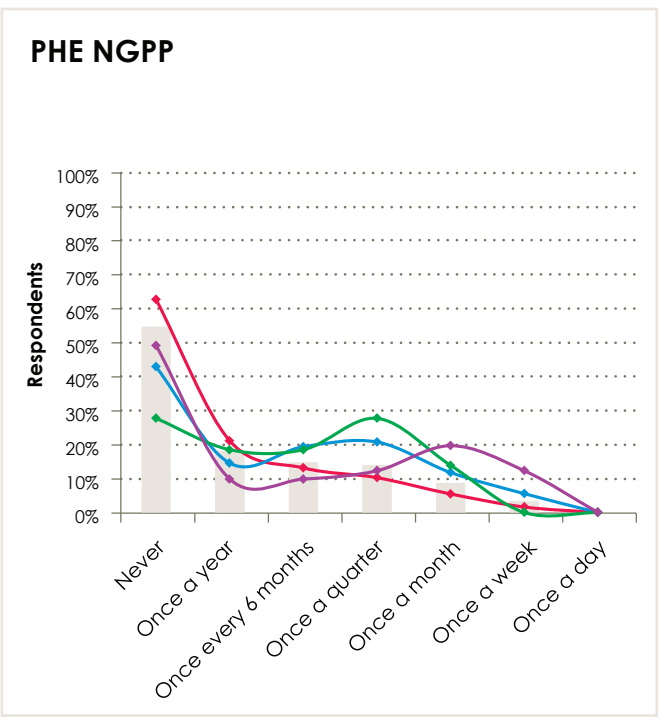


Chart C6: Usage frequency of websites (GPPS)

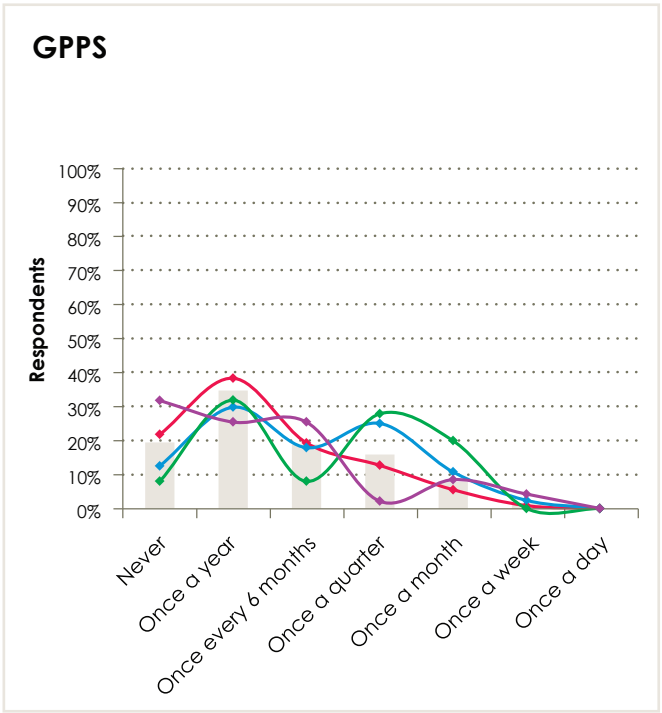
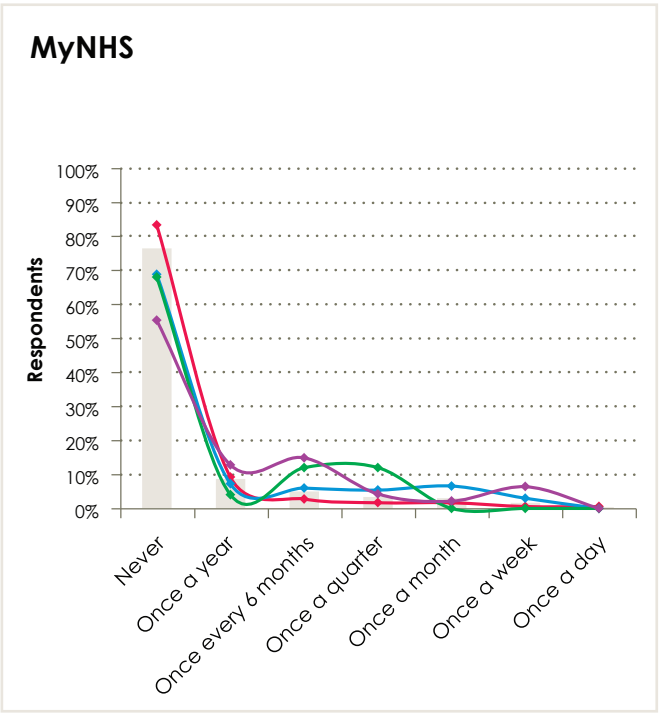


Chart C7: Usage frequency of websites (MyNHS)



Usefulness

Respondents were asked: '*On a scale of 1 to 5 (1 being the least and 5 being the most), how useful do you find the information available on the quality of care in general practices on the following websites?*' They were given a choice of answer:

- 1
- 2
- 3
- 4
- 5
- Don't know
- N/A

The overall response rate (excluding those who responded Don't know and N/A) varied considerably. NHS Choices, CQC and GPPS all had response rates over 80%, whilst the other websites all had response rates below 60% (see Chart C8), potentially reflecting a lack of awareness of those websites as a resource for GP performance data. The response rate was consistently higher amongst those who worked in general practices than for GPs themselves, perhaps reflecting their greater interaction with such websites. They also found them consistently more useful than GPs did (see Chart C9), possibly reflecting their performance management role.

Among those who responded, the overall usefulness scores were consistently low, ranging between 1.8 and 2.8, indicating that there may be room to improve how useful the indicators are on informing users about the quality of general practice. Those who did not work in or represent general practice responded most positively, followed by those who worked in general practices but were not GPs. GPs themselves consistently gave the lowest scores for each website.

Chart C8: Response rates for each website on the extent to which different websites were thought useful.

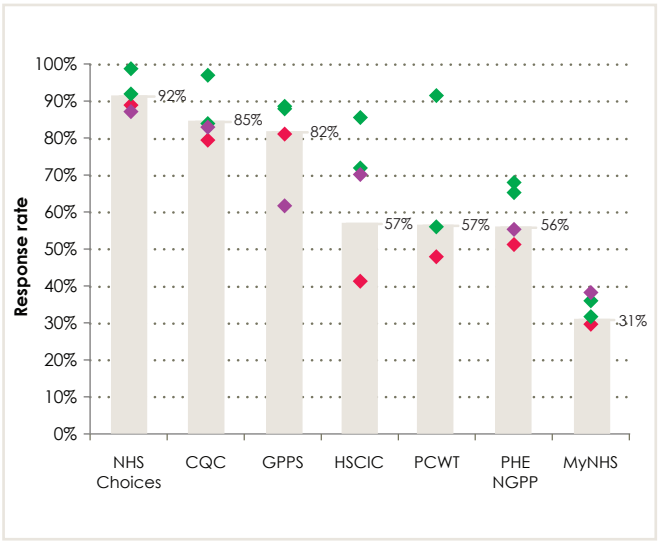
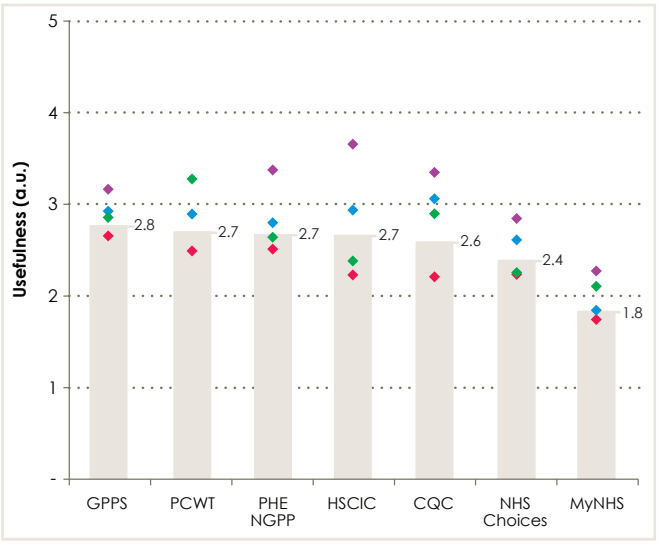


Chart C9: The extent to which different websites were thought useful.



Key

Overall	
GP	
Works in a general practice but not as a GP	
Others who work in or represent general practice	
Does not work in or represent general practice	

Accuracy and comprehensiveness

Respondents were asked: '*On a scale of 1 to 5 (1 being the least and 5 being the most), how far do you agree that the information available on the quality of care in general practices on the following websites gives an accurate and comprehensive picture of the quality of care for patients?*' They were given a choice of answer:

- 1
- 2
- 3
- 4
- 5
- Don't know
- N/A

Again, the response rates varied considerably by website, with fewer respondents answering the question for the MyNHS website. For PCWT and HSCIC, there was a large discrepancy in response rate between GPs and people who worked in general practices (see Chart C10).

For those who provided numerical answers, the scores were fairly consistent amongst all websites, ranging from 1.7 to 2.4 (see Chart C11).

Chart C10: Response rates for each website on the extent to which different websites were thought accurate and comprehensive.

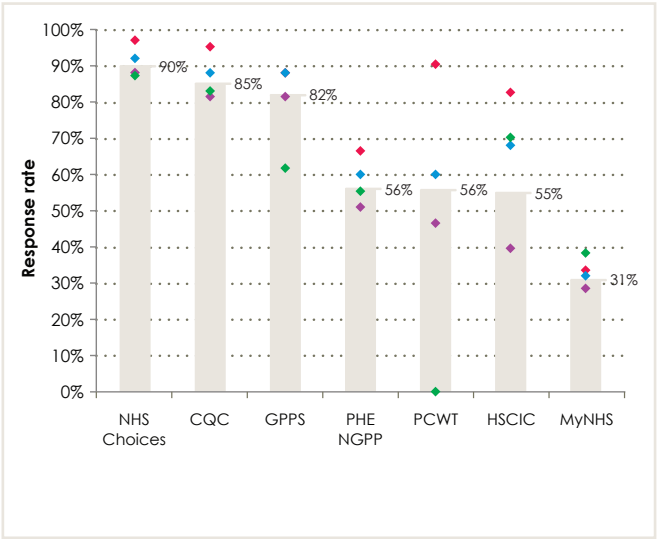
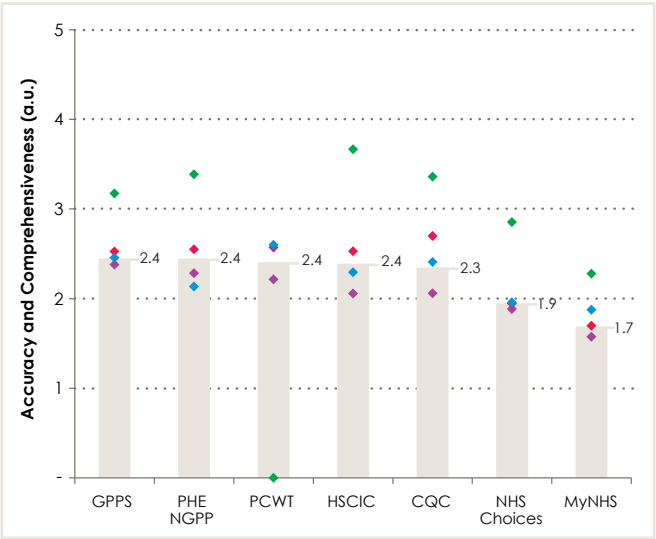


Chart C11: The extent to which different websites were thought accurate and comprehensive.



Key

Overall	
GP	
Works in a general practice but not as a GP	
Others who work in or represent general practice	
Does not work in or represent general practice	

Are there gaps in the data?

Respondents were asked: *'Overall, do you think there are gaps in the information available on the different aspects of quality in general practice on the websites named above?'* 65% suggested that there were gaps in the data, with 24% saying no there were not; 11% responded 'don't know'.

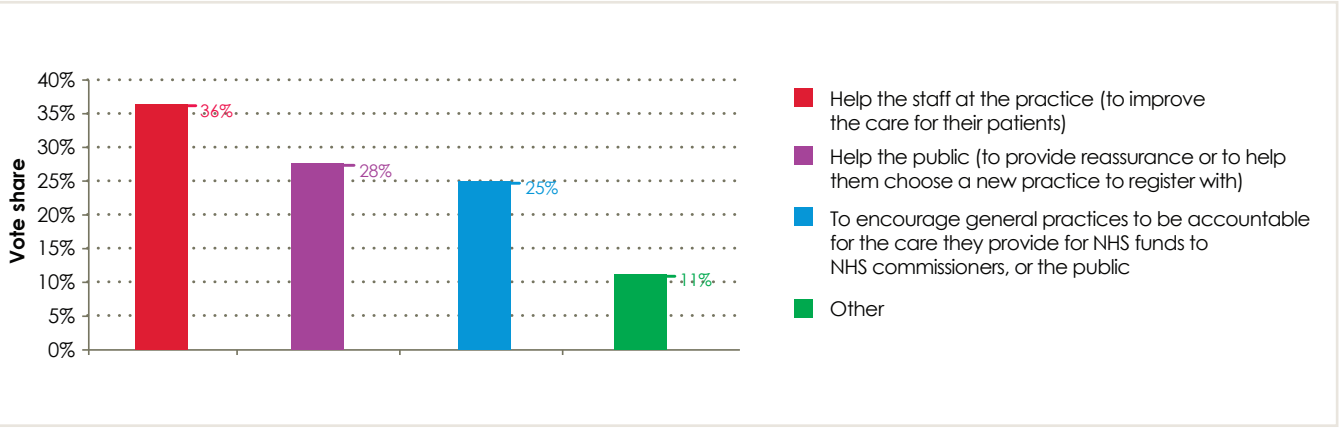
What should the indicators be designed to do?

Participants were asked: '*Should efforts to further develop existing indicators on the quality of care provided by general practices be mainly to…? (Please tick as many as applicable)'*. Available responses included:

- Help the staff at the practice (to improve the care for their patients)
- Help the public (to provide reassurance or to help them choose a new practice to register with)
- To encourage general practices to be accountable for the care they provide for NHS funds to NHS commissioners, or the public
- All of the above or other
- Other

Chart C12 shows that the distribution of preference was fairly even across the three broad types of purpose, with a small preference for improvement. If '*All of the above*' was selected, a score was given for each of the three purposes provided.

Chart C12: The distribution of preferences for the different purposes of data development



If respondents answered 'Other', they were asked to specify their reason for selecting this option. Respondents were divided in opinion between those who thought that existing indicators should be developed and those who thought that they should not. Reasons given for developing existing indicators included the benefit to patients, to help healthcare providers improve, and to improve the quality of existing indicators. For the second group, respondents suggested that developing indicators would increase the burden on general practice staff and that the existing indicators did not adequately reflect quality and, therefore, should not be developed further.

Appendix D: Overview of websites containing information about quality and sources of information

Websites

NHS Choices

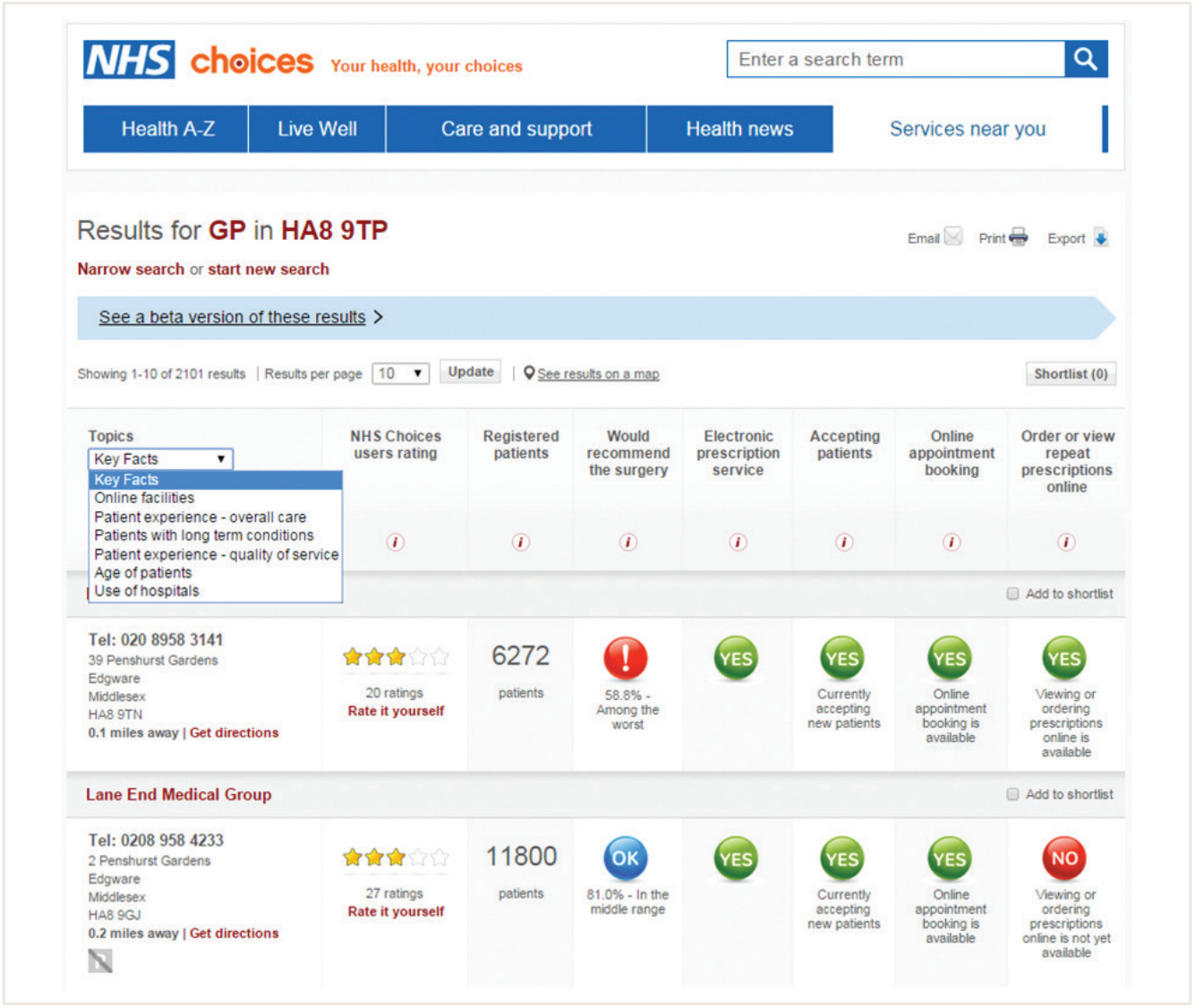
NHS Choices was launched in June 2007. Its aim was to support the public to become active consumers of healthcare, rather than passive recipients, and to help individuals, their families or carers to make more informed choices.[123] Users are able to search for GPs based on proximity to a given postcode, and view their performance against a set of indicators, grouped by topic. The full list of topics and descriptions is given in the table below.

Table D1: Information domains included in NHS Choices

Information domain	Information or indicators included as part of this section
Key facts	NHS Choices user rating (trip-advisor style rating), practical information about list status and the proportion of people who would recommend the practice.
Online facilities	Availability of online access to medical records and test results
Patient experience – overall care	Patient experience data including information on ease of making appointments and ability to see a preferred GP (from the GP patient survey)
Patient experience – quality of service	Patient experience data including satisfaction with the length of consultation and the extent people feel listened to by their GP (from the GP patient survey)
Patients with long term conditions	Practice population prevalence of diseases such as asthma, chronic heart disease, depression etc. (from QOF)
Age of patients	Percentage of patients in the registered list in different age groups
Use of hospitals	Use of choose and book and emergency admissions for long-term conditions

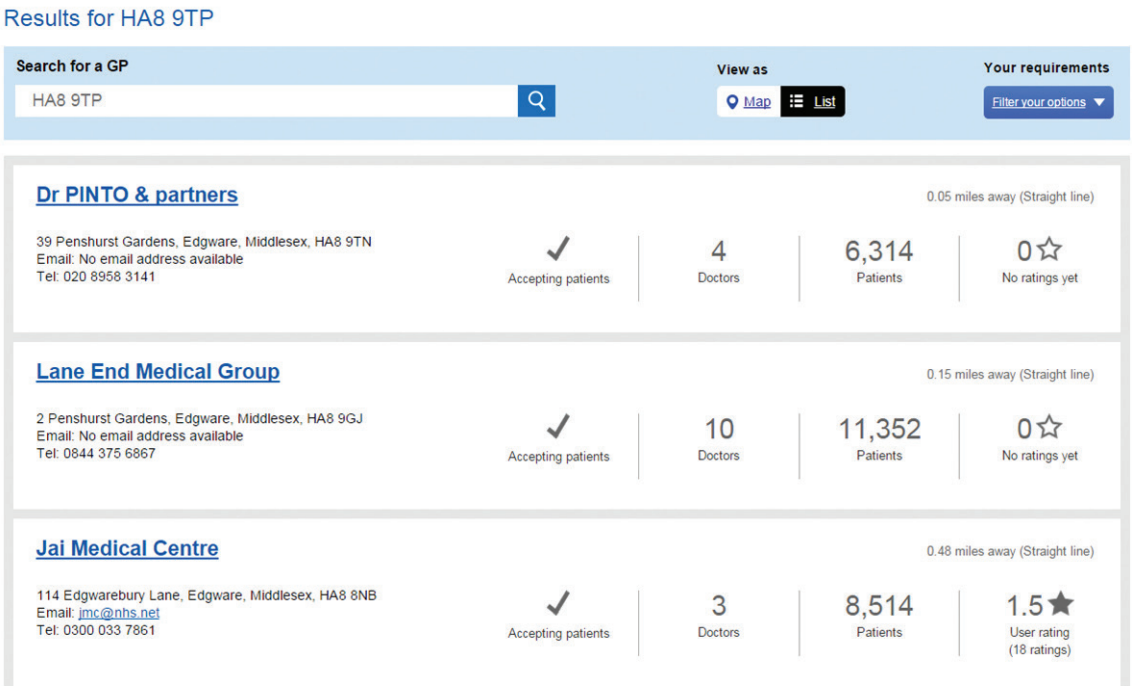
The interface is simple, user-friendly and has a range of functionality, including the ability to view results on a map, sort the listed GPs by the metric results and to create a shortlist of practices for comparison (Figure D1). Some of the results are also presented relative to the rest of the sample data set, ie, whether 75% for a particular metric is amongst the best, worst or in the middle range of a data set.

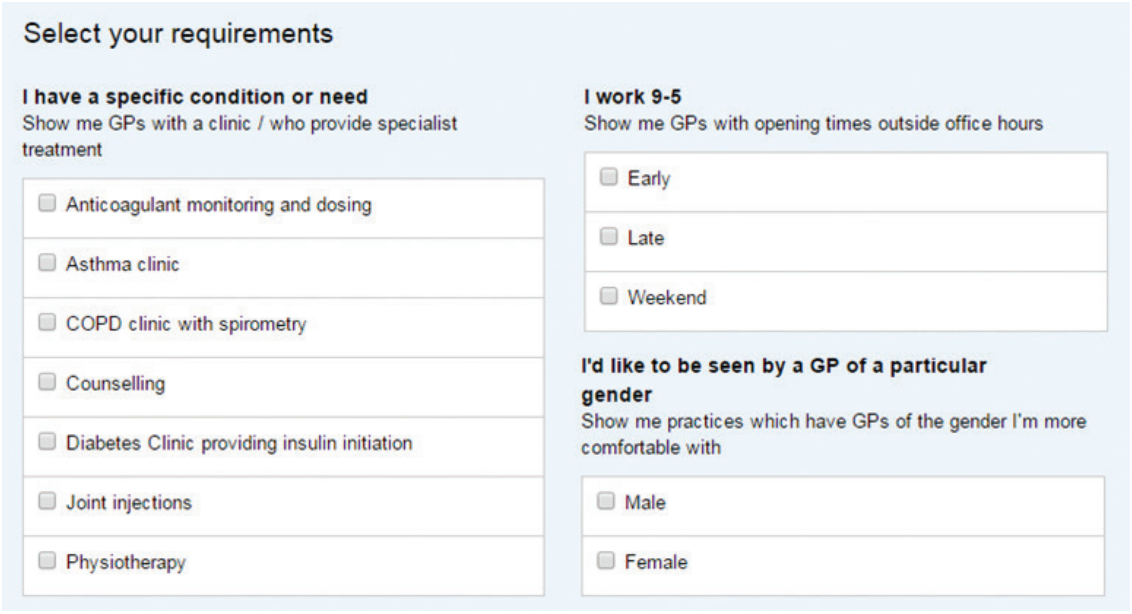
Figure D1: Screen shot from the NHS Choices website www.nhs.uk accessed via http://tinyurl.com/NHS-Choices-GP-Search on 4 September 2015. Contains public sector information licensed under the Open Government Licence v3.0. This shows the default search results upon entering a postcode in the GP search function on the NHS Choices website. Practices are listed down the left hand side, with the corresponding indicators along the top. Users are able to change which indicators are displayed using the topics filter.



Users are also given the option to view the same results in the Beta version (Figure D2), which states clearly that it is a test product in development.[124] This version only currently provides basic information on each surgery, but no performance data. However, it does allow the user to filter the results based on the surgery's provision of specialist services, out-of-hours services or the ability to offer a choice of a male or female GP.

Figure D2: Screen shot from NHS Choices Beta website (http://beta.nhs.uk/) accessed via the 'See a beta version of these results' link on NHS Choices search results page (http://tinyurl.com/NHS-Choices-GP-Search) on 4 September 2015. Contains public sector information licensed under the Open Government Licence v3.0 . NHS Choices Beta has a similar layout to the established website, with practices listed down the side and indicators along the top. As a beta version of NHS Choices, it understandably lacks functionality; however, it does have the unique ability to filter the practices shown by their opening hours, available services and GP gender.





MyNHS

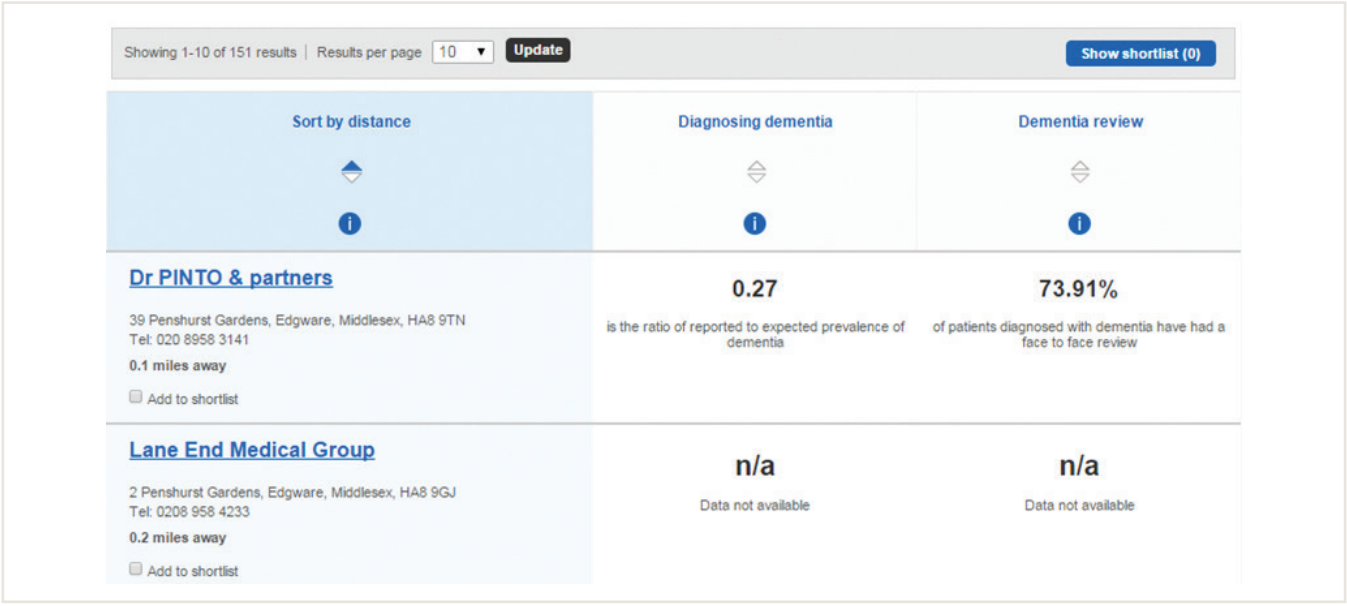
Launched in the autumn of 2014,[125] MyNHS is managed under the NHS Choices banner and currently exists as a Beta version. It recognises that the large amount of data already available on various websites can make comparison of general practices difficult for the public and the profession alike, and therefore has the stated purpose of providing performance information, readily and publicly available in one place, to support transparency, increase accountability and drive quality.[126]

The MyNHS website displays results in a similar ways to NHS Choices (Figure D3) but has a different selection of topics for the user to filter results (see Table D2).

Table D2: Information domains included in MyNHS

Information domain	Overlap with NHS Choices	Information or indicators included as part of this section
CQC Ratings	None	The CQC inspection rating
Practice workforce	None	Number of GPs, Nurses, patients as well as their relative levels per 1,000
Safe & Effective Part 1	None	Indicators on vaccination and level of certain drugs prescribed (antibiotics, anti-inflammatories, hypnotics)
Safe & Effective Part 2	Some	Emergency admission as well as various QOF indicators around learning disabilities, blood pressure management and diabetes
Safe & Effective Part 3	None	QOF indicators around atrial fibrillation, diabetes and cervical cancer screening
Caring	Total	Overall patient experience, as well as the extent to which individuals are treated with care and concern, and involved in decision making by the nurse or GP
Responsive	Total	Satisfaction with opening hours, seeing a preferred GP and ease of phone contact
Care of over 75's	None	Palliative care or those with dementia or osteoporosis
Chronic Disease Management	None	Support for mental health, stopping smoking, management of diabetes and identification of COPD and CHD
Dementia	None	The dementia indicators covered in 'Care of over 75's' domain
Diabetes	None	QOF indicators around management of blood sugar levels, vaccination and cholesterol in patients with diabetes
Cardiovascular disease	None	QOF indicator on blood pressure management
Cancer	Some	Cervical cancer screening and emergency cancer admissions (covered in other domains above)
Mental Health	None	QOF indicators on mental health (covered in other domains above)

Figure D3: Screen shot from the MyNHS website (www.nhs.uk/service-search/performance/search) accessed via http://tinyurl.com/MyNHS-Improvement-GP-Search on 4 September 2015. Contains public sector information licensed under the Open Government Licence v3.0. This website is also similar to NHS choices in its layout; however, it contains a wider variety of clinical indicators such as those regarding dementia, diabetes and mental health, as well as patient experience indicators.



As shown in Table D2, there is very little overlap in the indicators used in MyNHS and NHS Choices. MyNHS provides a more clinical and operational focus, although it does share indicators relating to patient experience with NHS Choices. Nevertheless, it is not as clear for the average user whether the results displayed represent strong, weak or average performance. There is no colour coding; however, for some indicators, hovering over the 'i' symbol provides some information on the context – eg, 'higher values are better' – but this still doesn't indicate how good a value is relative to the data set.

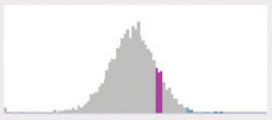
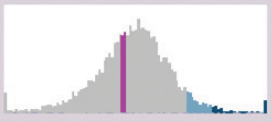
CQC inspections and intelligent monitoring reports

The CQC's intelligent monitoring system (CQC IM), launched in November 2014,[127] collects and analyses data about various services across primary and secondary care. The stated purpose of IM for general practices is to help inspectors plan inspection activities and to provide a prompt to ask questions about the quality of care. The data is then published in order to allow anyone who is interested to understand how the CQC make decisions that affect their inspection. Intelligent monitoring is not a rating or judgement on the quality of care.[128]

The CQC IM report is composed of a set of indicators that cover three of the five core areas covered during an inspection (whether services are effective, responsive and caring). The indicators that focus on effectiveness are taken from the GP High Level Indicators (GPHLI) and GP Outcome Standards (GPOS). The indicators that focus on responsiveness and care are taken from the GP patient survey.

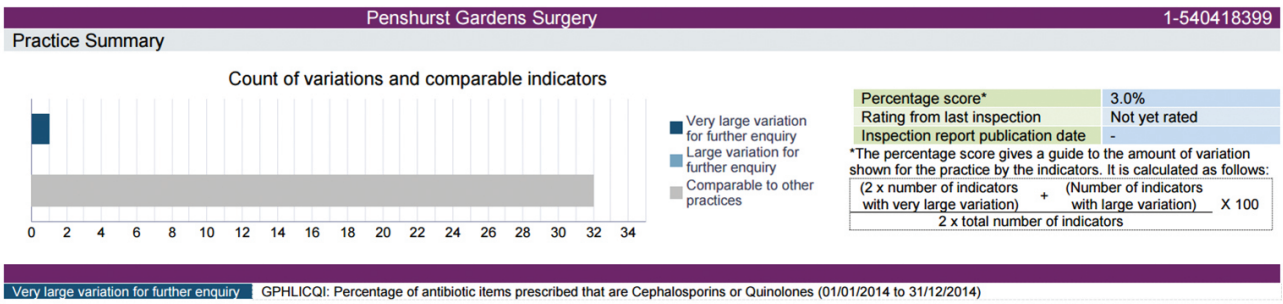
The CQC publishes an updated IM report twice a year for every practice in the country, which contains the latest available data as well as any changes as a result of consultations with various bodies, including the RCGP, the BMA, GPs and the public.[129] The most recent version* is composed of 33 indicators and includes a distribution plot for each, showing the performance of the selected practice compared to all other practices. Any deviation from the average is categorised as either 'comparable to other practices', 'large variation' or 'very large variation', which is used to guide further enquiry (Figure D4). The summary page then provides an overall variation score, as well as the details of any indicators with a 'large' or 'very large' variation (Figure D5).

Figure D4: CQC Intelligent monitoring report extract from the CQC website (www.cqc.org.uk) accessed via http://tinyurl.com/CQC-IM-Report on 4 September 2015. Contains public sector information licensed under the Open Government Licence v3.0 . Individual indicator distribution plots (report structure as per August 2015). The CQC IM reports are designed to identify and highlight variation, as shown in the distribution plots, to help guide practice inspections. The purple lines represent the score for the practice. If the practice's score sits within either of the blue shaded areas, it is highlighted as a variation and reported in the practice summary.

ID: Indicator description (time period)	Observed	Average	Numerator	Denominator	Z-score	Z-score range
GPHLIAC01: The number of Emergency Admissions for 19 Ambulatory Care Sensitive Conditions per 1,000 population. (01/01/14 to 31/12/14)	20.05	14.40	206	10.27	0.94	
GPHLIAP: Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU). (01/01/14 to 31/12/14)	0.26	0.28	5753	22032	-0.39	

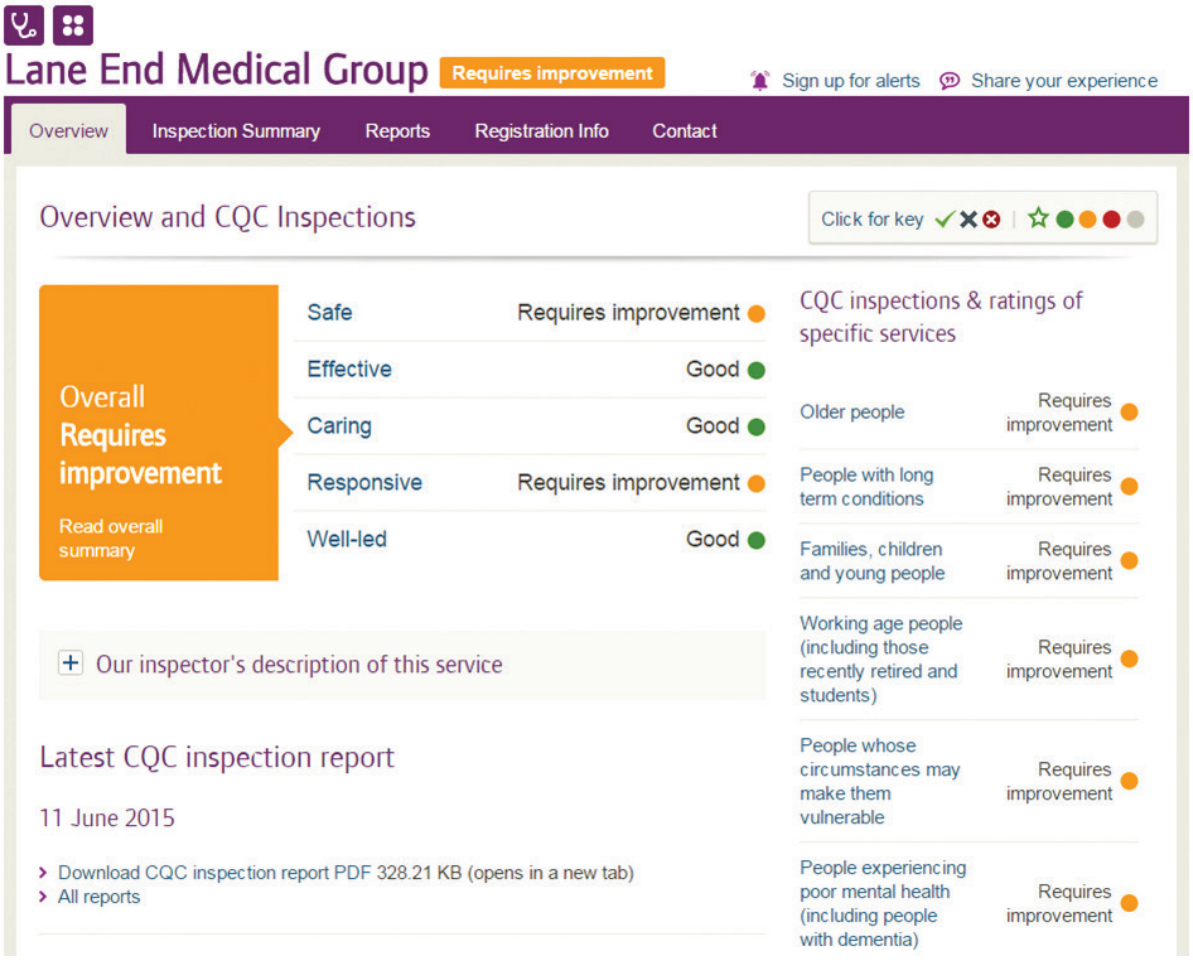
* The version prior to this contained 37 indicators and was slightly less intuitive, listing the observed and expected values for each, in order to identify discrepancies and guide any inspection

Figure D5: CQC Intelligent monitoring report extract from the CQC website (www.cqc.org.uk) accessed via http://tinyurl.com/CQC-IM-Report on 4 September 2015 – practice summary. Contains public sector information licensed under the Open Government Licence v3.0 . The practice summary page provides a bar graph showing the number of indicators that either fell within the normal range of values (grey) or those with notable variation (light or dark blue), as well as a percentage score, which acts as a guide for the overall level of variation across all the measured indicators.



In addition to its intelligent monitoring reports, the CQC provides information on practices it has inspected, allowing users to see their local practice's overall rating, but also the ratings split by the five key question areas or by population groups (Figure D6). Users are able to read the inspector's summary and full report.

Figure D6: Screen shot of a CQC inspection page for a practice from the CQC website (www.cqc.org.uk) accessed via http://tinyurl.com/CQC-Inspection-Overview on 4 September 2015. Contains public sector information licensed under the Open Government Licence v3.0 . The practice overview page contains the Overall practice ratings are on the left, with the individual ratings for key question areas in the middle, and individual ratings for population groups on the right.



Primary Care Web Tool (restricted)

The NHS Primary Care Web Tool (PCWT) is an online resource, accessible to general practice staff, CCG area and regional teams of NHS England and other approved stakeholder organisations, but not to the general public. Managed by NHS England, its aim is to support transparent measurement across practices. The PCWT is formed of two modules, each with a different set of indicators: the General Practice High Level Indicators (GPHLI) and General Practice Outcome Standards (GPOS).[17]

The GPOS were initially developed in the London region in 2010 for use on the MyHealthLondon website, which was launched in December 2011.[130] The development of GPOS data indicators was led by clinicians in collaboration with commissioners as an agreed approach to improve quality, access and patient experience, through an identification and reduction of variation. The standards were initially developed in London and were then extended, covering all practices in England by June 2013.[131] The GPHLI are a pre-analysed set of indicators that were developed for assurance management and monitoring purposes during the formation of NHS England. They were published on the PCWT for the first time in April 2013.[132] As the PCWT evolves, the aim is for the two sets of indicators to be consolidated into one, with only the most relevant indicators remaining.

There are approximately 42 GPHLI and 28 GPOS (comprising 30 general practice indicators within). In GPOS, five indicators are composite measures and six indicators are provided for supportive information. Both sets of indicators are grouped into domains to reflect the five domains of the NHS Outcomes Framework:[133]

- Preventing people from dying prematurely
- Enhancing quality of life for people with long-term conditions
- Helping people to recover from episodes of illness or following injury
- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

The indicators that comprise both GPHLI and GPOS draw on several sources, including QOF, HSCIC, NHS Business Services Authority, GPPS and PHE.

Public Health England – National General Practice Profiles

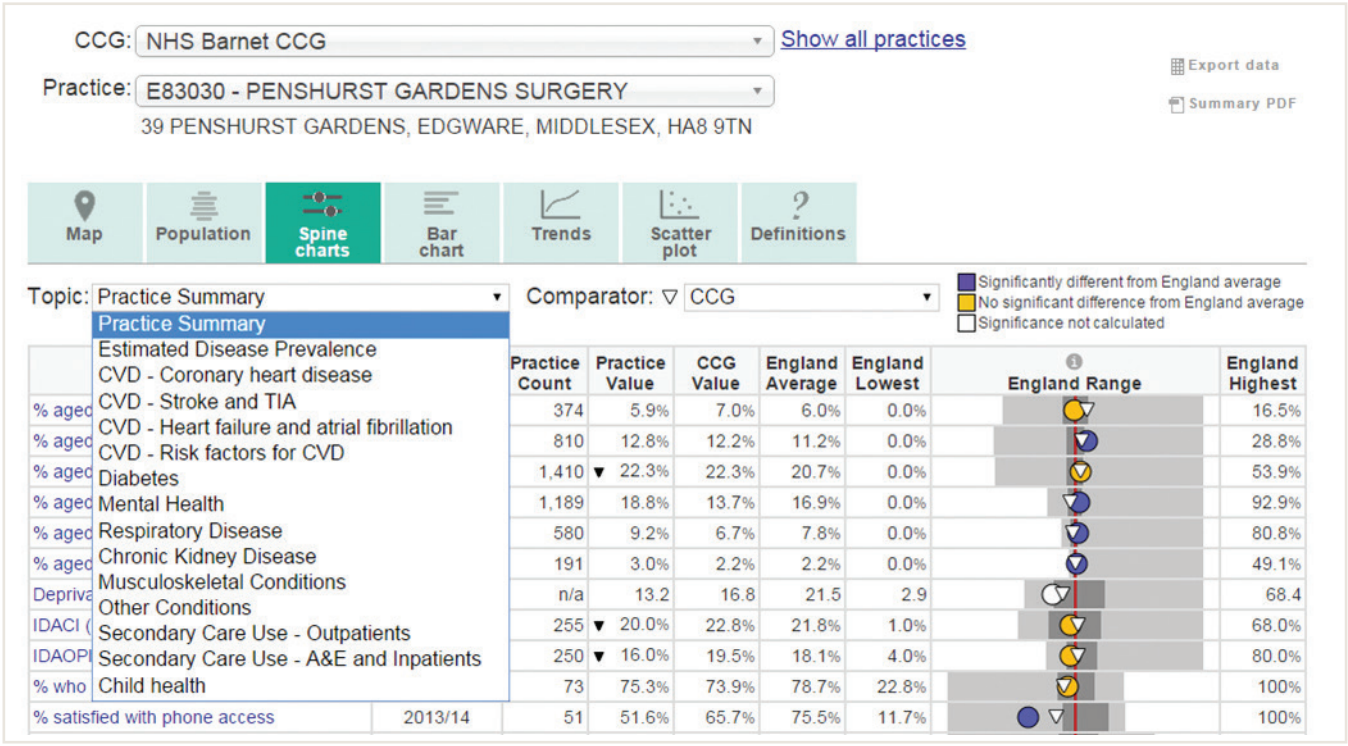
The National General Practice Profiles (NGPP) form just one of several modules available through Public Health England's (PHE) Fingertips tool. Its stated purpose is to support general practice staff, CCGs and local authorities to ensure that they are providing and commissioning effective and appropriate healthcare services for their local population.[134] The website is clear that the profiles were not designed to encourage public choice and voice, and a great deal of care needs to be taken with the interpretation of the profiles.[135]

The profile includes a large number of indicators (over 250) and is broken into several modules, broadly covering:

- local demography
- Quality and Outcomes Framework domains
- disease prevalence estimates
- admission rates
- patient satisfaction.

The functionality of the tool is extensive: users can view the data as a spine chart, a bar chart, a line graph over time (for trend analysis), a scatter plot (to assess the relationship between two indicators) and as a population pyramid (Figure D7). Statistical information is simplified with a colour scheme, to indicate where significant differences exist, and the user is able to contextualise the data by choosing to compare the selected practice to its CCG or deprivation decile average. Users are also able to download a neatly formatted PDF report or export the raw data.

Figure D7: Screen shot of the National GP Profiles from the Public Health England website (www.gov.uk/government/organisations/public-health-england) accessed via http://tinyurl.com/PHE-NGPP-GP-Search on 4 September 2015. Contains public sector information licensed under the Open Government Licence v3.0 . The NGPP allows users to view practice scores across a wide range of indicators, as shown by the long list within the topics filter, and do so in both tabular and graphical formats. The graph type displayed can be changed by selecting the pale green boxes along the top.



Websites for accessing general practice patient survey data and QOF

While the general practice patient survey (GPPS) is the source for most of the '*patient experience*' indicators used in the websites above, there is also a publicly available website where users can compare their general practice survey results to others in the local area, or a custom shortlist.[136] When a practice is selected, the user is first provided with a high -level, easy to understand practice summary, with CCG and national averages for comparison purposes (Figure D8), before having the option to delve deeper into each question (Figure D9). A function unique to the GPPS is that users can filter results by the respondents' profile – eg, by gender, age groups, ethnicities and disease groups – thereby increasing the relevance of the answers.

Figure D8: Screen shot of practice overview results from the GP Patient Survey website (www.gp-patient.co.uk) accessed via http://tinyurl.com/GPPS-GP-Search on 4 September 2015. Contains public sector information licensed under the Open Government Licence v3.0 . The GP Patient Survey page. This page highlights what the practice does best and areas it could improve upon, judged by what it scored highest and lowest for. To give additional context, the CCG and national average are provided as well.

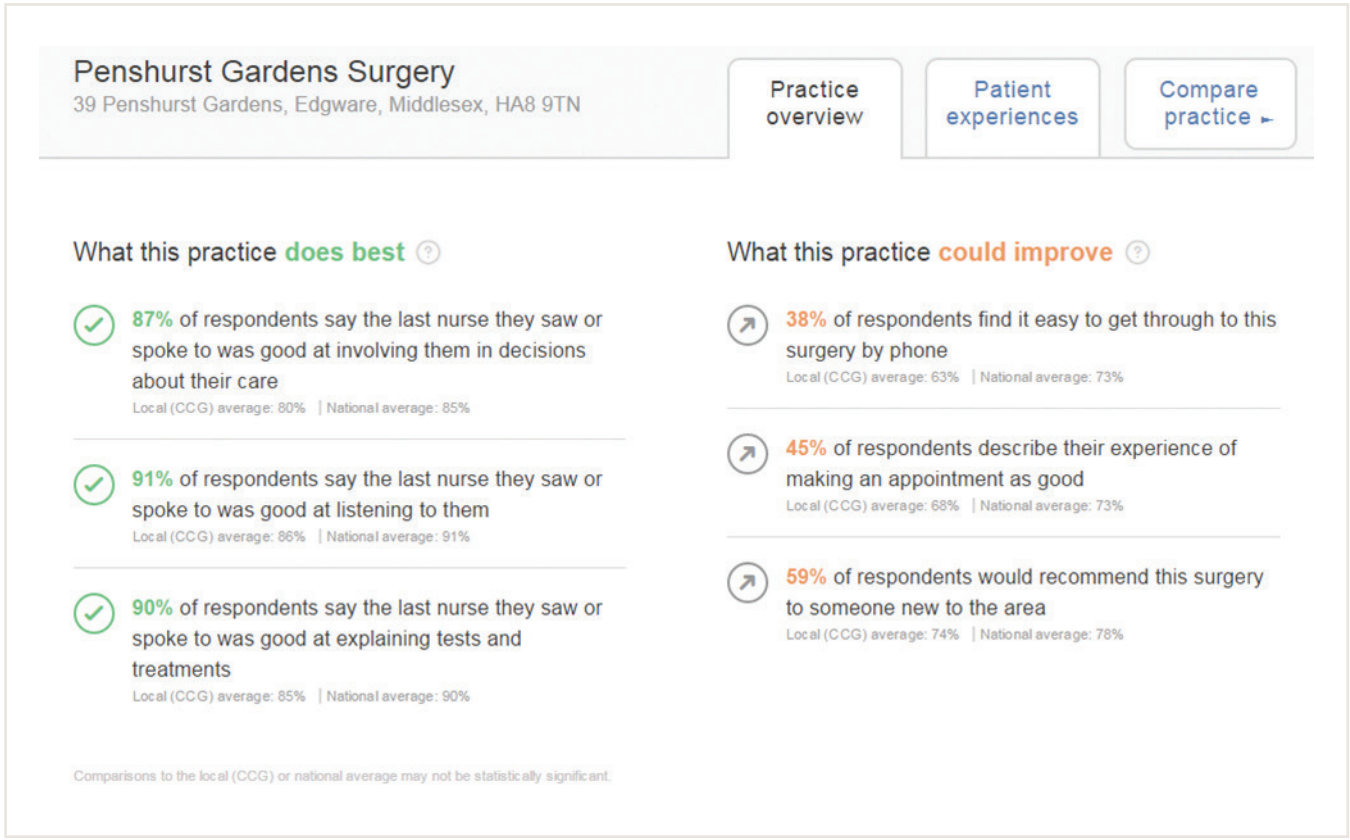
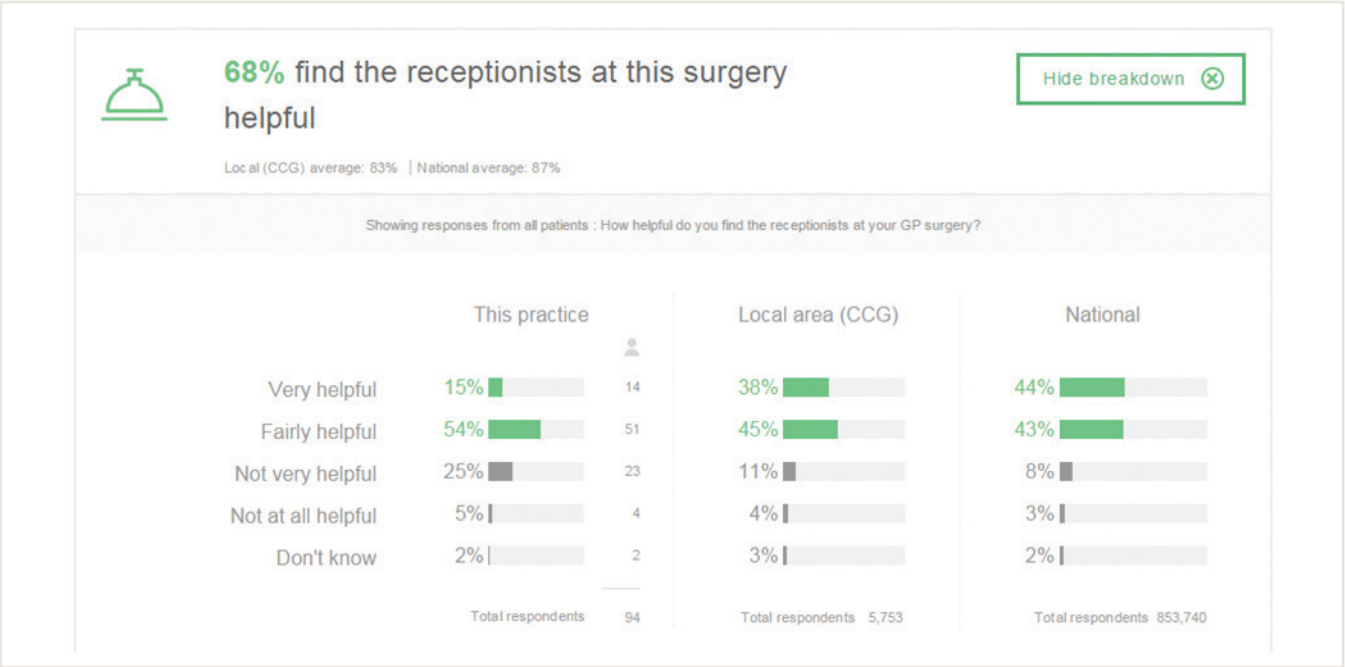
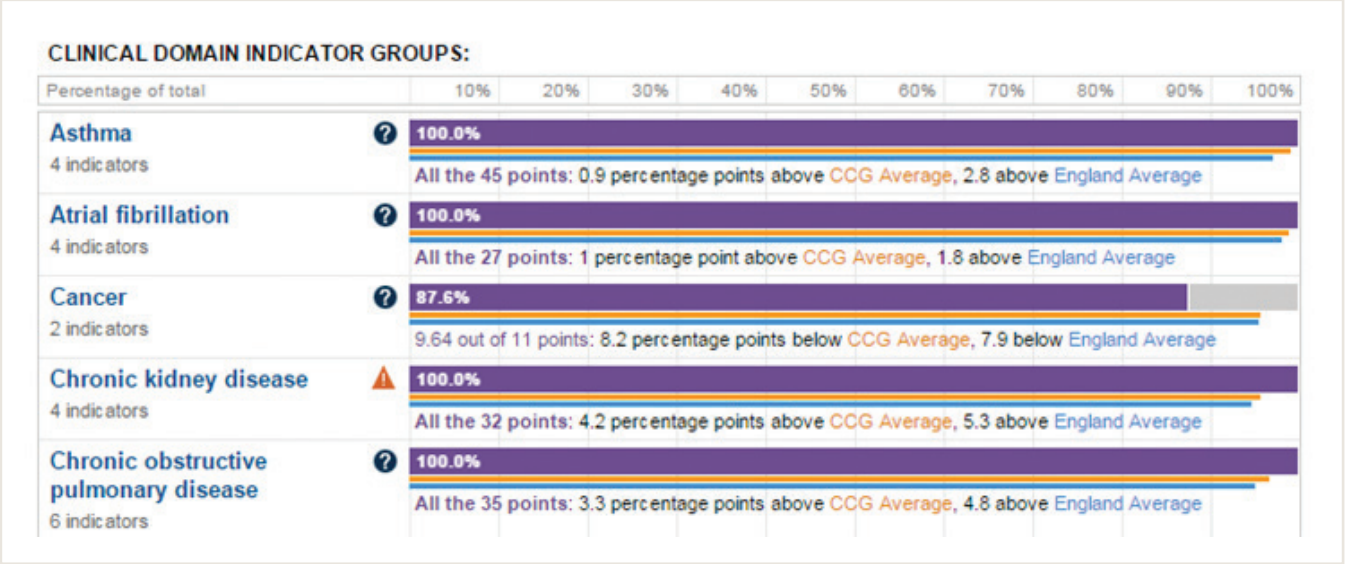


Figure D9: Screen shot of practice results for specific questions from the GP Patient Survey website (www.gp-patient.co.uk) accessed via http://tinyurl.com/GPPS-GP-Search-Questions on 4 September 2015. Contains public sector information licensed under the Open Government Licence v3.0 . Individual questions from the GP survey can be inspected in more detail, providing the distribution of answers and the total number of respondents.



Similarly, QOF data is used as a source for the other websites, and it can be analysed via a dedicated, standalone website that allows comparison of QOF data between general practices, practices within a CCG and the national average. Aggregated percentage points are provided for the QOF achievement within each group, with the option of drilling down to see the achievement percentage of each indicator (Figure D10).

Figure D10: Screen shot of QOF General Practice Results from the HSCIC website (www.hscic.gov.uk) accessed via http://tinyurl.com/QOF-GP-Search on 4 September 2015. Copyright © 2015, re-used with the permission of the Health and Social Care Information Centre. All rights reserved. The website allows users to see how an individual general practice scored for each QOF indicator (purple bars), with CCG and national averages available for comparison. The left hand side shows an aggregate score for each of the groups of indicators within the clinical domain, which links to a more detailed page, showing the scores for each indicator within that group



National Cancer Intelligence Network (NCIN) – General Practice Profiles

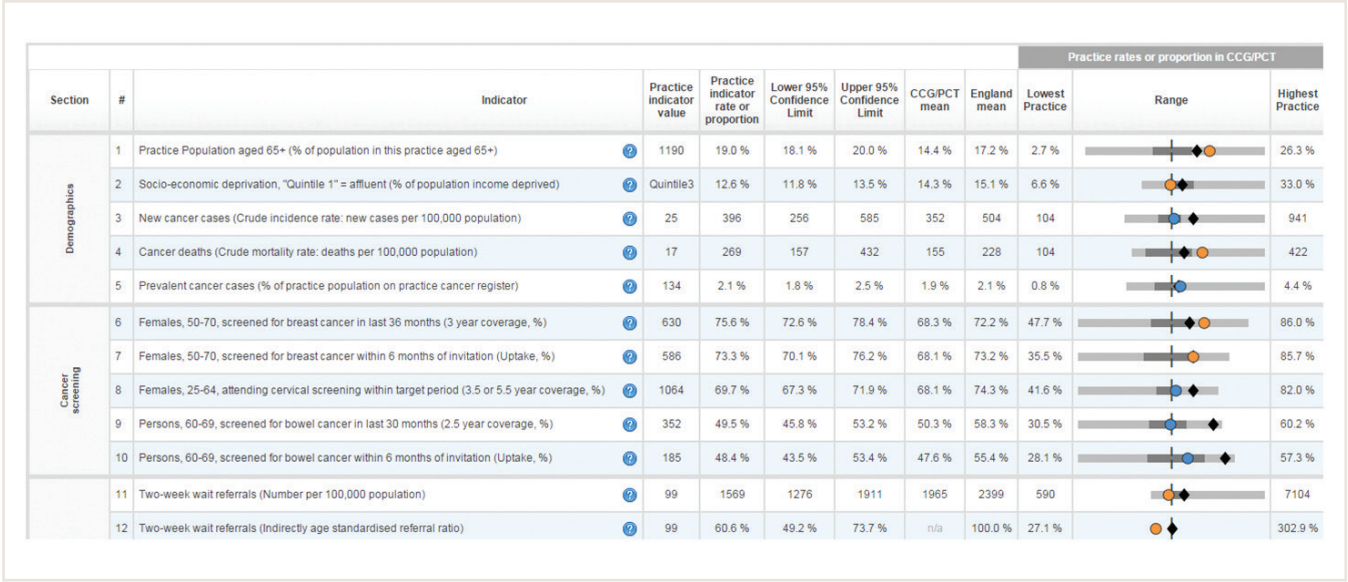
The NCIN General Practice Profiles, managed by Public Health England, is a website for viewing cancer -related indicators by individual practices. It was designed to be used by GPs, commissioners and other health professionals working in the National Awareness and Early Diagnosis Initiative (NAEDI) as a benchmarking tool to help identify variation, but not as a performance management tool.[137] The four domains under which the indicators are classified, along with example indicators, are given in the table below:

Table D3: Indicator domains included in NCIN GP Profiles

Indicator domain	Examples of indicators included as part of this section
Demographics	Practice Population aged 65+ (% of population in this practice aged 65+) Cancer deaths (Crude mortality rate: deaths per 100,000 population)
Cancer screening	Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %)
Cancer waiting times	Two-week wait referrals (Number per 100,000 population)
Presentation and diagnostics	In-patient or day-case colonoscopy procedures (Number per 100,000 population)

In the profile, users are able to select their general practice of interest and then view the results for each indicator in a spine chart, with CCG and national values presented as a benchmark (Figure D11).

Figure D11 Screenshot of the National Cancer Intelligence Network – General Practice Profile, accessed via https://www.cancertoolkit.co.uk/Profiles/PracticePublic/Filters on 7 September 2015. Contains public sector information licensed under the Open Government Licence v3.0 . The NCIN GPP is similar in layout to the NGPP fingertips tool, whereby the indicators are listed on the left, individual practice and benchmarking data is tabulated in the middle, with the representative graphs on the right.



										Practice rates or proportion in CCG/PCT		
Section	#	Indicator	Practice indicator value	Practice indicator rate or proportion	Lower 95% Confidence Limit	Upper 95% Confidence Limit	CCG/PCT mean	England mean	Lowest Practice	Range	Highest Practice
Demographics	1	Practice Population aged 65+ (% of population in this practice aged 65+)	1190	19.0 %	18.1 %	20.0 %	14.4 %	17.2 %	2.7 %		26.3 %
	2	Socio-economic deprivation, "Quintile 1" = affluent (% of population income deprived)	Quintile3	12.6 %	11.8 %	13.5 %	14.3 %	15.1 %	6.6 %		33.0 %
	3	New cancer cases (Crude incidence rate: new cases per 100,000 population)	25	396	256	585	352	504	104		941
	4	Cancer deaths (Crude mortality rate: deaths per 100,000 population)	17	269	157	432	155	228	104		422
	5	Prevalent cancer cases (% of practice population on practice cancer register)	134	2.1 %	1.8 %	2.5 %	1.9 %	2.1 %	0.8 %		4.4 %
Cancer screening	6	Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %)	630	75.6 %	72.6 %	78.4 %	68.3 %	72.2 %	47.7 %		86.0 %
	7	Females, 50-70, screened for breast cancer within 6 months of invitation (Uptake, %)	586	73.3 %	70.1 %	76.2 %	68.1 %	73.2 %	35.5 %		85.7 %
	8	Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	1064	69.7 %	67.3 %	71.9 %	68.1 %	74.3 %	41.6 %		82.0 %
	9	Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)	352	49.5 %	45.8 %	53.2 %	50.3 %	58.3 %	30.5 %		60.2 %
	10	Persons, 60-69, screened for bowel cancer within 6 months of invitation (Uptake, %)	185	48.4 %	43.5 %	53.4 %	47.6 %	55.4 %	28.1 %		57.3 %
	11	Two-week wait referrals (Number per 100,000 population)	99	1569	1276	1911	1965	2399	590		7104
	12	Two-week wait referrals (Indirectly age standardised referral ratio)	99	60.6 %	49.2 %	73.7 %	n/a	100.0 %	27.1 %		302.9 %

Sources

QOF

Indicators included in the QOF, as stated above, are used in almost every website for presenting GP performance indicators. Individual practice results for QOF achievements can be downloaded from the HSCIC website. HSCIC collects this data from general practices using a combination of two systems: the CQRS (Calculating Quality Reporting Service) and GPES (General Practice Extraction Service). To report on QOF, GPs record activities about the services they provide into their clinical systems. This data is then extracted automatically by GPES and reported to the CQRS. Where automatic extraction is not available, QOF achievement is reported manually by GPs on CQRS through a web-based server.[138]

GPPS

Many of the indicators relating to 'patient experience' in the websites above use the GPPS as their primary source. The GPPS is carried out twice a year by the independent survey agency Ipsos MORI and commissioned by NHS England. For each survey, adult registered patients are selected at random from across England. Approximately 1.3 million adults were selected for the most recent survey. Results are published in January and July and include data from the two latest waves. The results are weighted according to the practice population age groups, as well as to local factors such as deprivation, crime levels, ethnicity, marital status, overcrowding in households, household tenure and employment status.[139]

Hospital Episodes Statistics (HES)

Hospital Episode Statistics (HES) is a data warehouse containing details of all admissions, outpatient appointments and accident and emergency attendances at NHS hospitals in England.[140] The statistics are used in GP indicators regarding emergency admissions data, outpatient attendances, new to follow-up ratios and did not attend rates.

GP Workforce Census

The general practice census is collected each year and records numbers and details of general practice staff and practice information. The results are publicly available and can be viewed at commissioning region level down to individual practices.[141]

Prescription Data – ePACT

Data on the prescription of certain types of drugs, including hypnotics, anti-inflammatories and antibiotics are derived from ePACT. Users can analyse the previous 60 months of prescribing data contained within the NHS Prescription Services' Prescribing Database. Some of the data available includes costs and volumes of prescribing and average daily quantities. Access to ePACT is restricted to certain organisation including (but not limited to) NHS trusts and foundation trusts, CCGs, NHS England Area Teams (now incorporated into NHS England Regional Teams), Department of Health, CQC, NICE and HSCIC.[142]

Eastern Region Public Health Observatories (ERPHO)

ERPHO is the primary source used to for disease prevalence estimates. The estimates are provided down to the level of individual practices and are based on population factors such as age, sex, smoking status and deprivation score. The models themselves use data from the Office for National Statistics, DH and the Department for Communities and Local Government.[143]

English Indices of Deprivation

The English Indices of Deprivation measures relative levels of deprivation in Lower Layer Super Output Areas (LSOAs) in England, released by the DCLG.[144] The current figures were published in 2010 – however, an update version is due for release in September 2015. It is used as a peer selector in PHE's NGPP, whereby the user can choose to compare the practice of interest to others within the same national deprivation decile. But it is also a standalone metric within the same website.

NHS Comparators

NHS Comparators was a tool used by commissioners and providers, enabling them to investigate aspects of local activity, costs and outcomes. It has since been decommissioned but is still used in several PHE NGPP and PCWT indicators.

NHS Choose and Book

NHS Choose and Book was replaced with the NHS e-Referral Service in June 2015. It allows patients who have been referred onwards by their GP to have a choice as to who provides their care at a time and location that suits them.[145] The number of referrals made using this system is recorded for each practice, which can then be calculated as a percentage of total referrals.

Appendix E: Population groups suggested as part of the consultation exercise

As part of the online consultation exercise, participants were shown the list of five proposed population groups as below:

- People over 75
- People under 75 with long-term conditions
- Maternity, children and young people
- Mental health
- The generally well

They were then asked '*are there other population groups for which you think better indicators of quality of care provided by general practice should be developed as a priority?*' More than 30 population groups were suggested by online consultation participants:

- Patients requiring palliative care
- Older patients
- Frail and elderly patients
- Housebound patients
- Nursing or care home residents
- Patients with long -term conditions
- Patients with comorbidity
- Carers
- Black and minority ethnic people
- Immigrants
- Homeless patients
- Traveller and gypsy communities
- Deprived population groups
- Patients with alcohol & drugs misuse
- Maternity patients
- Families
- Men

- Women
- Young children and teenagers
- Patients in child protection services
- Patients with learning difficulties
- Patients with physical disabilities
- Vulnerable adults
- Patients with mental illness
- Patients living in rural areas
- Lesbian, gay, bisexual, and transgender people
- Patients with respiratory conditions
- Patients with sensory impairments
- Staff in general practice
- Practice populations
- Patients with specific illnesses/diseases:
- Dementia
- Cancer
- Diabetes
- Asperger's syndrome
- HIV
- Stroke
- Multiple sclerosis.

Appendix F: Quality and Outcomes Framework indicators plotted against population groups

The following table show Quality and Outcome Framework (QOF) indicators plotted against the five population groups examined in this review. The dark red shows the indicator fits with the population group; light red shows a potential fit.

Table F1: 2015/16 QOF indicators in England plotted against population groups

Indicator code	Indicator description	Mental health	People over 75	People under 75 with long-term conditions	Maternity, children and young people	The generally well
AST001	The contractor establishes and maintains a register of patients with asthma, excluding patients with asthma who have been prescribed no asthma-related drugs in the preceding 12 months					
AST002	The percentage of patients aged 8 or over with asthma (diagnosed on or after 1 April 2006), on the register, with measures of variability or reversibility recorded between 3 months before or any time after diagnosis					
AST003	The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23					
AST004	The percentage of patients with asthma aged 14 or over and who have not attained the age of 20, on the register, in whom there is a record of smoking status in the preceding 12 months					
AF001	The contractor establishes and maintains a register of patients with atrial fibrillation					
AF006	The percentage of patients with atrial fibrillation in whom stroke risk has been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more), NICE 2014: NM81					
AF007	In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anticoagulation drug therapy, NICE 2014: NM82					
CAN001	The contractor establishes and maintains a register of all cancer patients defined as a 'register of patients with a diagnosis of cancer excluding non-melanotic skin cancers diagnosed on or after 1 April 2003'					
CAN003	The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis, NICE 2012 menu ID: NM62					

CKD005	The contractor establishes and maintains a register of patients aged 18 or over with CKD with classification of categories G3a to G5 (previously stage 3 to 5)					
COPD001	The contractor establishes and maintains a register of patients with COPD					
COPD002	The percentage of patients with COPD (diagnosed on or after 1 April 2011) in whom the diagnosis has been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register					
COPD003	The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months					
COPD004	The percentage of patients with COPD with a record of FEV1 in the preceding 12 months					
COPD005	The percentage of patients with COPD and Medical Research Council dyspnoea grade ≥3 at any time in the preceding 12 months, with a record of oxygen saturation value within the preceding 12 months, NICE 2012 menu ID: NM63					
COPD007	The percentage of patients with COPD who have had influenza immunisation in the preceding 1 August to 31 March					
DEM001	The contractor establishes and maintains a register of patients diagnosed with dementia					
DEM004	The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months					
DEM005	The percentage of patients with a new diagnosis of dementia recorded in the preceding 1 April to 31 March with a record of FBC, calcium, glucose, renal and liver function, thyroid function tests, serum vitamin B12 and folate levels recorded between 12 months before or 6 months after entering on to the register, NICE 2010 menu ID: NM09					
DEP003	The percentage of patients aged 18 or over with a new diagnosis of depression in the preceding 1 April to 31 March, who have been reviewed not earlier than 10 days after and not later than 56 days after the date of diagnosis, NICE 2012 menu ID: NM50					
DM017	The contractor establishes and maintains a register of all patients aged 17 or over with diabetes mellitus, which specifies the type of diabetes where a diagnosis has been confirmed, NICE 2011 menu ID: NM41					
DM002	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, NICE 2010 menu ID: NM01					
DM003	The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less, NICE 2010 menu ID: NM02					
DM004	The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less					
DM006	The percentage of patients with diabetes, on the register, with a diagnosis of nephropathy (clinical proteinuria) or micro-albuminuria who are currently treated with an ACE-I (or ARBs)					
DM007	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 59 mmol/mol or less in the preceding 12 months, NICE 2010 menu ID: NM14					
DM008	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months					

DM009	The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 75 mmol/mol or less in the preceding 12 months					
DM018	The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March					
DM012	The percentage of patients with diabetes, on the register, with a record of a foot examination and risk classification: 1) low risk (normal sensation, palpable pulses), 2) increased risk (neuropathy or absent pulses), 3) high risk (neuropathy or absent pulses plus deformity or skin changes in previous ulcer) or 4) ulcerated foot within the preceding 12 months, NICE 2010 menu ID: NM13					
DM014	The percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register, NICE 2011 menu ID: NM27					
EP001	The contractor establishes and maintains a register of patients aged 18 or over receiving drug treatment for epilepsy					
HF001	The contractor establishes and maintains a register of patients with heart failure					
HF002	The percentage of patients with a diagnosis of heart failure (diagnosed on or after 1 April 2006) which has been confirmed by an echocardiogram or by specialist assessment 3 months before or 12 months after entering on to the register					
HF003	In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction, the percentage of patients who are currently treated with an ACE-I or ARB					
HF004	In those patients with a current diagnosis of heart failure due to left ventricular systolic dysfunction who are currently treated with an ACE-I or ARB, the percentage of patients who are additionally currently treated with a beta-blocker licensed for heart failure					
HYP001	The contractor establishes and maintains a register of patients with established hypertension					
HYP006	The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less					
LD003	The contractor establishes and maintains a register of patients with learning disabilities					
MH001	The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy					
MH002	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate					
MH003	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months, NICE 2010 menu ID: NM17					
MH007	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12 months, NICE 2010 menu ID: NM15					
MH008	The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years, NICE 2010 menu ID: NM20					
MH009	The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months, NICE 2010 menu ID: NM21					

MH010	The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range in the preceding 4 months, NICE 2010 menu ID: NM22					
OST004	The contractor establishes and maintains a register of patients: 1. Aged 50 or over and who have not attained the age of 75 with a record of a fragility fracture on or after 1 April 2012 and a diagnosis of osteoporosis confirmed on DXA scan, and 2. Aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis Although the register indicator OST001 defines two separate registers, the disease register for the purpose of calculating the APDF is defined as the sum of the number of patients on both registers. NICE 2011 menu ID: NM29					
OST002	The percentage of patients aged 50 or over and who have not attained the age of 75, with a fragility fracture on or after 1 April 2012, in whom osteoporosis is confirmed on DXA scan, who are currently treated with an appropriate bone-sparing agent, NICE 2011 menu ID: NM30					
OST005	The percentage of patients aged 75 or over with a record of a fragility fracture on or after 1 April 2014 and a diagnosis of osteoporosis, who are currently treated with an appropriate bone-sparing agent, NICE 2011 menu ID: NM31					
PC001	The contractor establishes and maintains a register of all patients in need of palliative care/support irrespective of age					
PC002	The contractor has regular (at least 3 monthly) multi-disciplinary case review meetings where all patients on the palliative care register are discussed					
PAD001	The contractor establishes and maintains a register of patients with peripheral arterial disease, NICE 2011 menu ID: NM32					
PAD002	The percentage of patients with peripheral arterial disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less, NICE 2011 menu ID: NM34					
PAD004	The percentage of patients with peripheral arterial disease with a record in the preceding 12 months that aspirin or an alternative anti-platelet is being taken, NICE 2011 menu ID: NM33					
RA001	The contractor establishes and maintains a register of patients aged 16 or over with rheumatoid arthritis, NICE 2012 menu ID: NM55					
RA002	The percentage of patients with rheumatoid arthritis, on the register, who have had a face-to-face review in the preceding 12 months, NICE 2012 menu ID: NM58					
CHD001	The contractor establishes and maintains a register of patients with coronary heart disease					
CHD002	The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less					
CHD007	The percentage of patients with coronary heart disease who have had influenza immunisation in the preceding 1 August to 31 March					
CHD005	The percentage of patients with coronary heart disease with a record in the preceding 12 months that aspirin, an alternative anti-platelet therapy, or an anti-coagulant is being taken					
STIA001	The contractor establishes and maintains a register of patients with stroke or TIA					
STIA008	The percentage of patients with a stroke or TIA (diagnosed on or after 1 April 2014) who have a record of a referral for further investigation between 3 months before or 1 month after the date of the latest recorded stroke or the first TIA					
STIA003	The percentage of patients with a history of stroke or TIA in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less					

STIA009	The percentage of patients with stroke or TIA who have had influenza immunisation in the preceding 1 August to 31 March					
STIA007	The percentage of patients with a stroke shown to be non-haemorrhagic, or a history of TIA, who have a record in the preceding 12 months that an anti-platelet agent, or an anti-coagulant is being taken					
BP002	The percentage of patients aged 45 or over who have a record of blood pressure in the preceding 5 years, NICE 2012 menu ID: NM61					
CVD-PP001	In those patients with a new diagnosis of hypertension aged 30 or over and who have not attained the age of 75, recorded between the preceding 1 April to 31 March (excluding those with pre-existing CHD, diabetes, stroke and/or TIA), who have a recorded CVD risk assessment score (using an assessment tool agreed with the NHS CB) of ≥20% in the preceding 12 months: the percentage who are currently treated with statins, NICE 2011 menu ID: NM26					
OB002	The contractor establishes and maintains a register of patients aged 18 years or over with a BMI ≥30 in the preceding 12 months, NICE 2014 menu ID NM85					
SMOK002	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months, NICE 2011 menu ID: NM38					
SMOK003	The contractor supports patients who smoke in stopping smoking by a strategy which includes providing literature and offering appropriate therapy					
SMOK004	The percentage of patients aged 15 or over who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 24 months, NICE 2011 menu ID: NM40					
SMOK005	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months, NICE 2011 menu ID: NM39					
CS001	The contractor has a protocol that is in line with national guidance agreed with the NHS CB for the management of cervical screening, which includes staff training, management of patient call/recall, exception reporting and the regular monitoring of inadequate sample rates					
CS002	The percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding 5 years					
CS004	The contractor has a policy for auditing its cervical screening service and performs an audit of inadequate cervical screening tests in relation to individual sample-takers at least every 2 years					
CON001	The contractor establishes and maintains a register of women aged 54 or under who have been prescribed any method of contraception at least once in the last year, or other clinically appropriate interval e.g. last 5 years for an IUS					
CON003	The percentage of women, on the register, prescribed emergency hormonal contraception one or more times in the preceding 12 months by the contractor who have received information from the contractor about long acting reversible methods of contraception at the time of or within 1 month of the prescription					

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About the authors

Dr Jennifer Dixon

Dr Jennifer Dixon joined the Health Foundation as Chief Executive in October 2013. Jennifer was Chief Executive of the Nuffield Trust from 2008 to 2013. Prior to this, she was director of policy at The King's Fund and was the policy advisor to the Chief Executive of the National Health Service between 1998 and 2000. Jennifer has undertaken research and written widely on health care reform both in the UK and internationally. Originally trained in medicine, Jennifer practised mainly paediatric medicine, prior to a career in policy analysis. She has a Master's in public health and a PhD in health services research from the London School of Hygiene and Tropical Medicine. In 1990, Jennifer was a Harkness Fellow in New York. She is currently a trustee of the Care Quality Commission (CQC) having joined in July 2013. In addition, Jennifer is a visiting professor at The London School of Economics and Political Sciences, Imperial College and the London School of Hygiene and Tropical Medicine. In 2009, Jennifer was elected a fellow of the Royal College of Physicians. She was awarded a CBE for services to public health in 2013.

Emma Spencelayh

Emma Spencelayh joined the Health Foundation in October 2013 as Senior Policy Advisor. Prior to joining the Health Foundation, Emma supported Dr Jennifer Dixon on a range of strategic projects at the Nuffield Trust and transferred with Jennifer when she moved to the Health Foundation. While at the Nuffield Trust, Emma led the secretariat for the Ratings Review commissioned by the Secretary of State for Health. She joined the Trust from the Department of Health where she was a Senior Policy Advisor in the NHS Policy and Strategy Unit. Prior to this, she worked on a variety of high-profile policy areas as part of the Civil Service Fast Stream Programme including integrated care. Emma also worked on the development of the new public health system including responsibility for the public health provisions in the Health and Social Care Act 2012. Emma started her career on the NHS Management Graduate scheme with placements at Poole Hospital NHS Foundation Trust and NHS Bournemouth and Poole.

Anna Howells

Anna graduated from Durham University in 2014 with a BSc (Hons) degree in Biological Sciences with Study Abroad, and was the first biology student from Durham to be selected for the international exchange programme through which she spent a year studying at the University of Calgary in Canada. Anna also completed an international summer programme at the Dalian University of Technology in China, where she studied Chinese environmental policy and its impact on public health.

After gaining experience on the frontline of health care services as a domiciliary care worker, Anna joined The Health Foundation as a Policy Intern in January 2015 and has since taken up a role with the new models of care team at NHS England.

Abraham Mandel

Abraham joined the Policy team at the Health Foundation in July 2015 as a secondee from PwC. Abraham has spent the last two years working on consulting engagements in the health sector including working with several different NHS Trusts to benchmark their operating theatre performance both nationally and internationally in order to identify areas for improvement. He has also worked with a Middle Eastern nation's Ministry of Health to conduct a detailed review of the country's hospital build programme, forecasting bed supply and demand from now until 2025. Prior to this, he performed financial modelling for two London CCGs to develop a decision-making business case for a shift towards community-based care.

Abraham has an MSc in Nanotechnology & Regenerative Medicine and a BSc in Human Genetics.

Felix Gille

Felix Gille joined the Health Foundation in July 2015 as a Policy Intern. Felix has since returned to his PhD studies on 'public trust' in the NHS at the London School of Hygiene and Tropical Medicine. His PhD research is exploring three NHS case studies (Care. Data, Biobank and 100,000 Genomes Project) to conceptualise 'public trust' in health systems and to develop further the underlying theory.

Felix has a master's degree in health economics, policy and management from Karolinska Institutet, Sweden and a bachelor's degree in European public health from Maastricht University, the Netherlands.

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