The Health Foundation

Summary

Indicators of quality of care in general practices in England

An independent review for the Secretary of State for Health

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This document provides a summary of the independent review, *Indicators of quality of care in general practices in England*. The full report is available from www.health.org.uk/publication/indicators-quality-care-general-practices-england

About the review

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.

Acknowledgements

We were struck by the generous contributions made by many and extend our thanks to those who took to time to contribute to the review process. We are grateful also to have been supported by a Technical Advisory Group, the membership and terms of reference of which are shown in Appendix A of the full report.

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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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 (see the full report for more details):

- Engagement with key stakeholders, 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.
- 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.

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