FOCUS ON QUALITY AND PERFORMANCE MANAGEMENT STANDARDS

Introduction

LMCs have raised concerns with regard to the way that some PCOs are currently trying to impose a range of quality and performance standards on contractors. This paper will look at the two documents which are currently circulating and being adopted by PCOs to assess primary care quality standards, in particular:

- Standards for Better Health
- Modernising Primary Care through a Balanced Scorecard approach

It will give a brief overview of what the documents propose and then look at the key issues these raise. In particular we offer a legal opinion that should help LMCs clarify what is and is not acceptable under the nGMS contract in relation to these quality and performance standards.

Standards for Better Health

This document was produced by the Department of Health to aid the process of 'moving away from a system that is mainly driven by national targets to one in which standards are the main driver for continuous improvements in quality'. The standards within it are aimed at all health care organisations including Trusts and private and voluntary providers of NHS care. With the introduction of a range of alternative providers this is the DH's attempt to ensure that whoever the healthcare provider is they satisfy immediately a set of core standards and they continue to work towards a set of developmental standards. 'The framework ensures that the extra resources being directed to the NHS are used to help raise the level of performance measurably, year on year'. The standards cover:

- Safety
- Clinical and Cost Effectiveness (including NSFs and NICE)
- Governance
- Patient Focus
- Accessible and Responsive Care
- Care Environment and Amenities
- Pubic Health

Standards for Better Health will form a key part of the Healthcare Commission's performance assessment of health care organisations and it will assess progress towards achieving the developmental standards.

The standards themselves, as they are aimed at all healthcare organisations, are broad in nature rather than specific in how they should be achieved, or proven, within any particular environment. For instance one of the developmental standards under Clinical and Cost Effectiveness reads:

D2 Patients receive effective treatment and care that:

a) conform to nationally agreed best practice, particularly as defined in National Service Frameworks, NICE guidance, national plans and agreed national guidance on service delivery;

b) take into account their individual requirements and meet their physical, cultural, spiritual and psychological needs and preferences;

c) are well co-ordinated to provide a seamless service across all organisations that need to be involved, especially social care organisations; and
d) is delivered by health care professionals who make clinical decisions based on evidence-based practice.

The NSFs have never been fully funded, nor is compliance with them a duty on GMS practices. NICE guidance is good practice but is only guidance and has no legal force. National plans and "agreed national guidance" are non-statutory and are visited on PCOs not practices.

We are aware that some PCTs wish to incorporate Standards for Better Health into the QOF or clinical governance visits.

In other PCT areas the introduction of the 'Balanced Scorecard' is probably, in part, an attempt by some managers to incorporate the wide ranging, broad standards within Standards for Better Health into a PCT-specific document for practices to fulfil.

Modernising Primary Care – a Balanced Scorecard approach

The balanced scorecard approach first emerged in Tower Hamlets and more recently West Midlands Regional LMC alerted the GPC office that there was a desire in its SHA/PCT areas to introduce this package of standards which grades practices on a banded system. In this way all primary care providers will be judged either Band A – high achieving practices reaching 80% of the assessment requirements, Band B practices reaching 65%-79% achievement and Band C practices achieving less than 65% of the assessment requirements.

Assessment will be in relation to:
1) Compliance with Health Care Commission Core and Developmental Standards; contribution to existing and new NHS targets.
2) Statutory contractual requirements as set out in the nGMS and PMS regulations as amended.
3) Environment i.e. premises and infection control.
4) Access to and availability of medical services performed under these regulations.
5) The range of services available – i.e. essential, additional and enhanced.
6) The quality of services provided, including public health targets.
7) The clinical and cost effectiveness of prescribing.
8) Patient views.

Band C practices will be considered practices that are not meeting core standards and remedial action will be taken.

While some of the standards against which the practices will be assessed are indeed statutory requirements, i.e.: based on the new GMS contract, or acceptable professional or public health targets, many are not. There is a desire to establish a benchmark for the number of direct patient contact sessions and appointments practices provide per 1000 of the population (and practices will be banded against that). Practices will be assessed on access against their PCAS survey, despite the fact that they may not be participating in the Access DES. Practices will be banded in relation to their opening hours and OOH cover arrangements. Band A is 'open for core hours and offers some extended hours'. This is completely outwith the new contract. Furthermore, the intention is to make the 'league table' publicly available.

We are aware that this kind of 'balanced scorecard' is being considered in other areas.

Key issues

Do practices have to comply with these standards?

GPs have a duty to meet their contractual requirements and to fulfil the quality markers in the enhanced services should they wish to participate in them. PCOs have a duty to ensure that the contract is being complied with and to ensure that there is no fraudulent activity taking place. Most GPs accept that involvement in clinical governance and audit is part of professional life. However, the "balanced scorecard" goes above and beyond that, grading some activities that are completely outside the new contract (such as extended opening hours) and threatening those practices who might fall into the Band C category with remedial action.

The legal position

Where a PCO is ensuring and auditing compliance with the nGMS contract, then practices are under an obligation within the GMS regulations (Schedule 6, Part 5, Paragraph 77) to provide information to PCOs that enables them to ensure compliance with the contract. This is a 'reasonable request' that the PCO can make in fulfilling its duties as a commissioner.

The setting up of league tables that threaten the lowest scoring practices with remedial action is not acceptable. This falls outside what was agreed under nGMS and in any event the nGMS contract has particular processes written within it for dealing with breaches of contract and poorly performing doctors, which may lead to a remedial notice or termination of contract. GP contractors are working within these contractual regulations, as are PCOs in relation to how they must deal with practices who are considered to be in breach of contract or an individual doctor failing in performance.

It would not be correct for a PCT to issue a remedial notice to a practice because it was not providing extended opening hours over and above what is set out in the GMS contract regulations. Any performance procedures invoked by a PCT *must* be in accordance with the appropriate set of regulations - the GMS Contract regulations in the case of opening hours.

Furthermore, as working extended hours is not part of contracted essential services, it should not be assessed for such a league table. Practices who are not involved in certain enhanced services cannot be penalised through a contractual route for not being involved in them. So again, this should not be assessed for league table purposes. The benchmarking of the number of GPs per practice population is again, outwith the new contract where there is no stated doctor/patient ratio.

PCOs are not entitled to demand that practices provide information that is not part of their contractual obligations. Arbitrary demands for non-contractual information or where that information is going to be used inappropriately to manage a practice's performance in an unregulated context, should not be complied with as this was never envisaged or agreed.

How can Standards for Better Health be reasonably implemented at practice level?

When considering Standards for Better Health it will probably prove most useful to see it within the context of clinical governance. It does not form part of the QOF although some of the indicators in the QOF do match across to the standards.

In Liverpool, Standards for Better Health has been incorporated into a clinical governance document that has been accepted by the LMC. Both the PCO and the LMC are viewing work in this area as being able to confirm that the contract is being fulfilled and it is also in part developmental. It is understood that extra resources may be needed by some practices in relation to the standards and where a practice is seen to be struggling this will be dealt with in a supportive manner. The Standards receive a straight yes or no answer, there is no league table or grading, and there is no intention to publish this information, thereby potentially naming and shaming. Where there are serious concerns about performance, this is dealt with through the performance management procedures that are in line with professional standards and the new contract regulations.