NHS Nottingham North and East Clinical Commissioning Group
NHS Nottingham West Clinical Commissioning Group
NHS Rushcliffe Clinical Commissioning Group

Primary Care Quality Assurance Framework (Medical Services)

1.0 Introduction:

From the 1 April 2015 the responsibility for monitoring quality and responding to concerns arising from General Practices has been delegated to the Clinical Commissioning Groups. The CCGs already had a statutory duty to assist and support NHS England with quality but now has delegated authority for contracting Primary Care Medical Services.

It is proposed that a Primary Care Quality Group is established for each of the South Nottinghamshire CCGs as a sub-group of their individual CCG Primary Care Commissioning Committees to provide a governance framework for monitoring Primary Care quality and responding to any concerns.

Whilst Practices as providers are accountable for the quality of services and are required to have their own quality monitoring processes in place, NHS England and CCGs as commissioners have a shared responsibility for quality assurance. Through the duty of candour and the contractual relationship with commissioners, practices are required to provide information and assurance to commissioners and engage in system wide approaches to improving quality.

The three domains of quality: patient safety, clinical effectiveness and patient experience will be monitored through routine internal contractual processes and clinical governance structures in parallel with external sources such as CQC, peer reviews, national surveys etc.

The quality assurance framework describes our proposed approach to monitoring and assuring quality in all Primary Care commissioned medical services.

2.0 Quality Assurance Framework:

A single definition of quality for the NHS was first set out in High Quality Care for All in 2008, following the NHS Next Stage Review led by Lord Darzi, and has since been embraced by staff throughout the NHS and by successive governments. This definition sets out the three dimensions to quality that must be present to provide a high quality service.

1. Clinical effectiveness - quality care is delivered according to the best evidence available that demonstrates the most clinically effective options available that are likely to improve a patient's health outcomes.

2. Safety – quality care is delivered in a way that reduces the risk of any avoidable harm and risks to a patient's safety.

.

3. Patient experience – quality care provides the patient (and their carers) with a positive experience of receiving and recovering from the care provided, including being treated according to what the patient (or their representatives) wants or needs, and with compassion, dignity and respect.

.

Quality assurance is the systematic and transparent process of checking to see whether a product or service being developed is meeting specified requirements.

The mechanisms through which the CCG will assure itself of primary care (medical services) quality are described in the following sections.

2.1 Primary Care Quality Sub-Groups

The purpose of the Primary Care Quality Sub-Groups is to jointly review quality performance. The groups will use the Primary Care Quality Dashboard and Risk Matrix and other information sharing in order to identify potential or actual risks to quality, agree a response and to ensure that concerns about quality and risks are escalated appropriately to the Primary Care Commissioning Committees (see Appendix 1 for Draft Terms of Reference).

2.2 Primary Care Quality Dashboard and Risk Matrix

The dashboard will consist of a range of metrics across the three domains of quality incorporating information from the following sources:

- GP Web Tool High Level Indicators (HLIs)
- GP Web Tool Outcome Standards (GPOS)
- Care Quality Commission (CQC)- inspection outcomes
- Patient Experience- including Friends and Family Test (FFT) results, Patient Satisfaction Surveys and complaints data.
- Patient Safety – including Serious Incident (SI) data.
- CCG Indicators- to be determined (e.g. workforce indicators/ imms and vacs/ screening etc)

The information within the dashboard will be used to determine a Red/ Amber/ Green (RAG) rating for the different components of quality.

The methodology used to rate the practices will be as follows:

- GP Web Tool GPOS- practices will be risk stratified based on the number of adverse outlying indicators. Practices classed as an outlier: 6 level 2 triggers or more turn Red, Any Level 2 and/or 6 or more Level 1 triggers turn Amber, No level 2 triggers and less than 6 level 1 triggers turn Green.
- GP Web Tool HLIs- practices will be risk stratified based on the number of adverse outlying indicators. Practices classed as an outlier: 6 outliers or more turn Red, Any outliers turn Amber, No outliers turn Green.
- CQC- practices will be risk stratified based on their latest CQC inspection outcome. Practices classed as Inadequate turn Red, Requires Improvement turn Amber, Good turn Green, Outstanding turn Blue, No visit turn grey.
- Patient Experience- practices will be risk stratified based on the number of adverse outlying indicators. Practices classed as an outlier (3 adverse indicators or more from Friends and Family Test/ Healthwatch/ Patient Participation Groups) turn Red, any adverse outlying indicators turn amber, No adverse outliers turn green. Complaint information will be recorded on the dashboard and trends/ themes will be identified but this will not attract a rating.
- CCG Indicators- to be determined.
- Patient Safety- Serious Iincident information will be recorded on the dashboard and trends/ themes will be identified but this will not attract a rating.

Derived scores will be attributed dependent on the RAG rating as follows, Red will attract 3 points, Amber will attract 2 points and Green will attract 1 point, Blue will attract no points.

The information from the different components of the dashboard will be aggregated to stratify practices into different levels of risk using a RAG risk matrix which in turn will identify the level of surveillance appropriate for each practice (see Appendix 2 for a draft of the Primary Care Quality Dashboard and Risk Matrix).

The methodology used to stratify the practices will be as follows:

The sum of all five derived scores (four if the practice has not yet had a CQC inspection) will result in an overall aggregated score and RAG rating with an associated surveillance level being applied as follows:

Overall RAG rating	Aggregated Score (no CQC score)	Aggregated Score (with CQC score)	Surveillance Level
Red	12	15	Stage 4 Formal Action
Amber/Red	10-11	12-14	Stage 3 Investigation
Amber	8-9	10-11	Stage 2 Enhanced Surveillance
Amber/Green	6-7	7-9	Stage 2 Enhanced Surveillance
Green	4-5	4-6	Stage 1 Routine

The Primary Care Quality Sub-Group may determine following triangulation of the dashboard data with other sources of information/ intelligence that the surveillance rating needs to be amended. If this is the case the rationale will be clearly recorded on the risk matrix.

2.3 Surveillance and Escalation

The following describes the process and escalation in relation to Primary Care Quality Assurance:

Stage 1 Routine Quality Surveillance (Green)

Routine Monitoring undertaken by the Primary Care Quality Group includes the following:

- Routine Quality Metric Monitoring using the Primary Care Dashboard (GP Web Tool, CQC, Patient Experience, CCG Indicators and Safety Indicators)

- Other Patient Safety Indicators including: monitoring of Health Care Associated Infections (HCAI), safeguarding vulnerable children and adults, reporting of patient safety incidents, workforce numbers, skills and training, uptake of vaccinations and Immunisations

- Other Patient Experience Indicators including: the complaints managed by NHSE and Healthwatch feedback

- Scheduled practice visits. Practice visits are intended to be an informal way for practices to have an open discussion about areas of their practice. This is intended to be a supportive process and part of the on-going dialogue with practices and the CCG.

Potential concerns / risks identified through the regular reviews at Stage 1 will be assessed for importance and urgency to inform the short and medium term response. It is important to note that an outlying score does not necessarily mean there is a concern but it does indicate that performance in the area identified needs further examination. The Primary Care Quality

Group will use the dashboard and risk matrix and any other relevant intelligence to identify those practices that require escalation to Stage 2 and report to the Primary Care Commissioning Committee.

Stage 2 (Amber/ Green or Amber) Enhanced Surveillance

This is the reactive element of the quality assurance framework. The provider is escalated to this level where there are a number of potential concerns / risks, or a concern / risk is considered significant. Actions should focus on supportive measures to bring about improvements to practice quality performance.

Actions will include a supportive meeting with the practice to discuss the concerns and agree any required actions. There will be a report produced which is shared with the provider as to areas of good practice as well as areas for improvement. The provider will be required to produce an action plan. This plan will be monitored through the Primary Care Quality Group and the Primary Care Commissioning Committee will be kept informed of progress. There will be a number of options available following this visit: Support should be put in place or signposted to enable the provider to deliver their action plan. Where the concerns are not addressed in a timely manner the Primary Care Quality Group will invoke Stage 3 and report to the Primary Care Commissioning Committee.

In significant, exceptional circumstances, the breach may be so severe that the Primary Care Commissioning Committee may escalate the practice to Stage 3.

Stage 3 (Amber/Red) Investigation

In most cases this will include formal investigation including an initial conversation with the practice to share the intelligence, understand the situation, substantiate the concerns / issues and where necessary to formally agree improvement actions and any support required. Should the identified risk remain or increase a Risk Summit will be considered. This would involve the Primary Care Team; Quality Team; Contracting colleagues, NHS England and the provider. Action will be monitored via the Primary Care Quality Group and escalated to the Primary Care Commissioning Committee.

Stage 4 (Red) Formal Action

Formal contractual actions may be considered when all other avenues to support improvement have been exhausted, where it is considered necessary, or where it is already an established lever to drive and support improvement.

For practices in formal action, or where risks/issues are considered significant, individual case reports will be provided by the Primary Care Quality Review Group to the Primary Care Commissioning Committee (see Appendix 3 for a flowchart of the surveillance and escalation process).

At all stages there will need to be effective management of actual, potential or perceived conflicts of interest.

The **Quality Scrutiny Group (NHSE)** should be made aware of altered surveillance levels via submission templates.

3.0 Recommendation

The Primary Care Commissioning Committee is asked to approve The Primary Care Quality Assurance Framework (Medical Services) including the:

- Terms of Reference for the Primary Care Quality Sub-Group
- Primary Care Quality Dashboard and Risk Matrix
- Surveillance and Escalation Flowchart

Appendix 1 Terms of Reference for the Primary Care Quality Sub-Group

1. Introduction	The Primary Care Commissioning Committee resolves to establish a sub-group to be known as the Primary Care Quality Sub-Group to ensure robust assurance processes are in place with regard to the quality of primary care delivered to patients by registered GP Practices of the CCG. These terms of reference set out the membership, responsibilities, and reporting arrangements of the Primary Care Quality Sub-Group.
2. Membership	The membership of the Primary Care Quality Sub-Group is as follows: • Head of Quality, Patient Safety and Experience, South CCGs • Patient Experience Manager, South CCGs • Head of Primary Care Operations, NNE CCG (*amend for each CCG) • Strategy and Development Manager, NW CCG • Service Improvement Coordinator, Rushcliffe CCG • Quality Lead, Primary Care Hub, Area Team • Lay representative • Clinician representative • Quality Support Officer, South CCGs Each member will nominate a deputy to attend in their absence.
3. Chair and Deputy	The Chair of the Primary Care Quality Sub-Group will be the Head of Quality, Patient Safety and Experience, South CCGs. The Vice-Chair will be the Patient Experience Manager. In the event of the Chair being unable to attend all or part of the meeting, the Vice-Chair will deputise.
4. Quorum	A quorum will be two members which must include the chair or deputy chair.
5. Attendees	Minimum attendance of 75% of meetings is required annually. Apologies should be sent to the South CCGs Quality Monitoring Officer prior to meetings.

	Attendance will be monitored by the Primary Care Commissioning Committee.
6. Frequency and conduct of business	The Primary Care Quality Sub-Group will meet monthly. Secretarial support will be provided by the Quality Support Officer, South CCGs. Agenda and supporting papers will be circulated to members not less than five working days prior to any meeting using a forward planner approach.
7. Authority	The Primary Care Quality sub-group is authorised by the Primary Care Commissioning Committee to consider any matter in its terms of reference. It is authorised to seek any information it requires from any source, and all employees are directed to co-operate with any request made by it.
8. Responsibilities	The principal duties of the Primary Care Quality sub-group are to: • Act as a central information sharing point for concerns about the quality of care identified by stakeholders, areas of good practice and review of quality intelligence including: ➢ Data sources including GP web tool (High Level Indictor set (HLIs) and GP Outcome Standards (GPOS)) ➢ Patient experience data including GP patient survey analysis/ feedback from Healthwatch ➢ Outcome of CQC inspections ➢ Outcome of CCG / NHS England practice visits ➢ Contractual compliance / intelligence ➢ Incidents ➢ Complaints ➢ Whistleblowing • Develop systems, processes and working relationships to ensure quality monitoring is robust and consistent • Monitor action plans, review progress on key actions and identify any on-going concerns using exception reporting • Escalate concerns about processes and resources related to monitoring quality in primary care to the Primary Care Commissioning Committee • Make recommendations regarding monitoring processes and operational requirements which will be approved by the Primary Care Commissioning Committee
9. Reporting	The Primary Care Quality Sub-Group will report to the Primary Care Commissioning Committee at the next available meeting providing a brief written update to the Committee and highlighting any areas of concern. A summary report of the work of the committee will be submitted annually to the Primary Care Commissioning Committee.
10. Declaration of Interest	At the beginning of each meeting Members will be required to declare a personal interest if it relates to a particular issue under consideration. Any such declaration will be formally recorded in the minutes of the meeting. The Chair's decision regarding a Member's participation, or that of any attendee, in any meeting will be final.

11. Conduct	The members and attendees will act in accordance with any applicable laws and guidance, and observe the CCGs' Conflict of Interest Policy.
12. Review of the Terms of Reference	The Primary Care Quality Sub-Group Terms of Reference will be reviewed on an annual basis from the date that they were approved by the Primary Care Commissioning Committee. Any resulting changes to these terms of reference or membership of the Primary Care Quality Sub-Group must be approved by the Primary Care Commissioning Committee before they shall be deemed to take effect.

Appendix 2: Draft Primary Care Quality Dashboard and Risk Matrix

Version 2 DRAFT
Primary Care Quality D

Appendix 3: Draft Surveillance and Escalation Process Flowchart

PRIMARY CARE
QUALITY SURVEILLAN