Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

Meeting of Primary Care Commissioning Committee

Date: 25th May 2021
Time: 9:30am-12pm
Location: Microsoft Teams

Agenda Number :	9	
Title:	Quality in General Practice	
Confidential Papers	**Commercially Sensitive**	No
	Legally Sensitive	No
	Contains Patient Identifiable data	No
	Financially Sensitive	No
	Time Sensitive – not for public release at this time	No
	Other (Please state)	No

Purpose: Discussion

Key Points for Discussion:

Following recent presentations at PCCC on Health Inequalities work as part of the BNSSG Primary Care Strategy (PCS) update and the Quality and Resilience update on the development of quality assurance processes, the question was asked: what does quality look like in Primary Care?

In particularly, there are some specific areas of inconsistency and unwarranted variation that have been highlighted during Covid that need addressing.

This papers provides an overview of the vision, the problems we are trying to solve, what we are already doing and a proposed roadmap in regard to creating an infrastructure to monitor and improve quality in general practice. This will inform how we link this with wider primary care as we move to ICPs/ICS.

Primary Care Commissioning Committee is asked to review feedback to date and to agree the next steps.

Recommendations:	To discuss the current approach to quality in general practice and to agree next steps.
Previously Considered By and feedback :	Clinical Leads Forum April 2021 Clinical Executive Committee May 2021

Management of Declared Interest:	None declared
Risk and Assurance:	Quality assurance and clinical governance reporting processes are currently in place which report through PQRC, PCOG and PCCC. Any further requirements following discussions will be taken through this route.
Financial / Resource Implications:	Financial and resource implications will need to be reviewed following the outcome of discussions.
Legal, Policy and Regulatory Requirements:	There are no known specific legal requirements.
How does this reduce Health Inequalities:	Having a systematic approach will reduce health inequalities by ensuring high quality care.
How does this impact on Equality & diversity	Quality assurance, monitoring and audit will highlight any areas of relating to equality and diversity or variation to service which will then be addressed accordingly.
Patient and Public Involvement:	There will be continued involvement of patients and the public as part of the ongoing PCS communication and engagement plan to ensure that we are capturing the elements of quality which matter to them.
Communications and Engagement:	A co-designed approach to improve quality in general practice will require engagement with general practice colleagues and will need to form part of the ongoing PCS communications and engagement plan.
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Please keep these front pages to a maximum of two

Agenda item: 9

Report title: Quality in General Practice

1. Background

"The definition of quality in health care, enshrined in law, includes three key aspects: patient safety, clinical effectiveness and patient experience. A high-quality health service exhibits all three. However, achieving all three ultimately happens when a caring culture, professional commitment and strong leadership are combined to serve patients…" NHS 5yr Forward View October 2014.

The WHO defines quality as 'the extent to which health care services provided to individuals and patient populations improve desired outcomes'.

Our BNSSG Primary Care Strategy describes how primary care providers working together collaboratively keep people healthy and independent, ensuring that those who require treatment or care are treated in the most appropriate place by the appropriate healthcare professional.
Primary Care has the power to deliver population wide health benefits; in order to continue to do this it must clearly identify its key beneficial features, understand its core functions and support them.

Key features:

Research (Starfield et al 2005) has identified 5 key features of Primary Care necessary to deliver maximal benefit:

1. Greater accessibility
2. Better person focused prevention
3. Better person focussed quality of clinical care
4. Earlier management of problems (avoiding hospitalisation)
5. The accumulated benefits of the above four features of Primary Care

Evidence demonstrates that better person focussed prevention and clinical care are enhanced by relationship continuity (seeing a clinician that you know and trust – who knows and cares about you) which leads to:

Better health outcomes, more satisfied patients, better cost control, more personalised decisions on appropriate care, more effective care outside hospital, earlier diagnosis, better targeting of expensive interventions to those most likely to benefit, limited use of interventions that have a significant harm rate, better acceptance of self-limiting illness, better medicines usage and adherence, better uptake of screening programmes and immunisations, cost savings in investigations, prescribing, hospital referral, admissions, use of accident and emergency departments and the overall cost of health care.

(RCGP 2020 vision for General Practice)

Enhancing access and relationship continuity of care across all Practices would deliver significant benefits to our patients and the wider system.

The BNSSG Primary Care Strategy sets out the 5 year approach to quality in general practice and wider primary care which:

- meet the needs of our population
- is data driven
- establishes a network of quality leads in practices and wider primary care
- provides a menu of support for practices to develop quality improvement (QI)
- needs to set outcomes to measure quality and agree who will monitor these
- aligns with the resilience programme
- works with our citizens to design services with outcomes that are important for to our population

The Primary Care Strategy delivery plan outlines the outcomes we want to achieve and what success will look like for our patients and practices. These build on the NHS Outcomes Framework domains:

- Preventing people from dying prematurely
- Enhancing quality of life for those living with long-term conditions
- Helping people to recover from episodes of illness or injury
- Ensuring people have positive experiences of their care
- Treating people in safe environments and protecting them from avoidable harm

BNSSG PCS
2019-2024 Delivery P

The BNSSG Primary Care Strategy Quality Ambition

The vision of the BNSSG system is to offer highly quality and consistent care to the population, driving up improvements in population health, reducing health inequalities and developing the personalisation approach working with people to achieve their health goals. The system will ensure that services are safe and effective, making the best use of combined resources. A learning culture that supports continuous quality improvement will be championed which enables excellence in patient care and experience. In order to achieve this vision general practice needs to be resilient, effectively managing current demands and being able to plan and redesign for the future.

Over the next 5 years our ambition is to:

- Develop a continuous quality improvement and learning culture in primary care to support the achievement of our vision

- Reduce health inequalities and develop our personalisation approach by working with people to achieve their health goals

- Drive forward our population health management approach to enable us to plan and deliver care to people that will lead to improvements in health outcomes

- Proactively listen to how people experience primary care and work with them to design better care, including access to services and the pro-active planning and co-ordination of their care

- Support every practice to maintain safe and effective services as evidenced by all practices receiving Good or Outstanding CQC ratings

- Proactively support Primary Care to be resilient through tailored improvement support

- To have in place regular opportunities for the sharing of good practice in quality and resilience improvement, supporting the spread of learning across the whole system

- Develop our Primary Care Networks and our ICPs to become responsible for the resilience of the care provided for their population

Patient Safety

July 2019 saw the publication of **The NHS Patient Safety Strategy - Safer culture, safer systems, safer patients.** The emphasis is on creating safer systems providing care in the right place at the right time and learning as much from what works well as from what hasn't gone well.

There are three strategic aims:

- to improve understanding of safety by drawing intelligence from multiple sources of patient safety information (**Insight**) – including a new safety learning system and introducing the Patient Safety Incident Response Framework to improve the response to an investigation of incidents
- to equip patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system (**Involvement**) – including the development and roll-out of a system-wide patient safety syllabus
- to design and support programmes that deliver effective and sustainable change in the most important areas (**Improvement**) – targeting a number of different groups in our population to improve their care

In line with these national recommendations, BNSSG will:

- Work together to further foster a culture of openness and transparency that focuses on continuous learning and improvement

- Learn from and share the outcomes of looking at patients' compliments, concerns and complaints, safeguarding, Significant Event reviews and feedback from patients about their experience of care to ensure that we actively listen to our patients, public, carers and other key stakeholders.

- All stakeholders continue to understand their responsibilities to safeguard and promote the welfare of people using national policy and guidance to support this work

- Approaches and actions are put in place to reduce the risk of avoidable harm

Patient Experience

We will broaden out the traditional ways in which we have considered this by including aspects that encompass personalised care. This means that we will:

- Focus on how care is planned and delivered in a way that is based on people's preferences, their and their community's strengths and also their individual needs

- Include the use of both meaningful public and patient engagement to gain insight and co-production to design services as part of our quality improvement efforts

Clinical Effectiveness

We will work together to:

- Establish meaningful clinical and social outcomes on both a population and individual level that can be measured to track and inform quality improvement.

- Share benchmarking information without judgement such that organisations are encouraged to jointly explore the information and take action where there is unwarranted variation. This unwarranted variation means that there may be some people who could be benefiting from care but currently aren't. It may also mean that some people are getting care that might not be effective for them.

- Systematically adopt and spread evidence-informed interventions that improve population health and help to use resources to best effect. We trialled this in the area of some primary care pathology testing and will use what we have learnt from the quality improvement approach we took and the impact we made.

The achievement of these goals will be supported by a **Primary Care Quality Forum** made up of quality leads from primary care providers. Quality Leads are being identified within practices and Primary Care Networks and in other providers across the healthcare community. The leads will be brought together to discuss quality improvement and adopt and spread learning and good practice; foster a culture where incidents, significant events and complaints can be discussed without judgement and used to make improvements. There is also the opportunity to equip Quality Leads with quality improvement skills to support the development and delivery of improvement projects and a culture of continuous improvement in their practice/Primary Care Network/organisation. We are not just focusing on GPs for these leads; there is currently funding available from HEE to develop General Practice Nurses as health improvement and safeguarding champions, for example; they would be valuable members of a Quality Forum.

2. Our Current Approach to Quality in General Practice in BNSSG

2.1 Standard Operating Procedure

A standard operating procedure has been developed with a proposed approach and process for the delivery of targeted support for practices in greatest need of support to improve quality and resilience. Current identification is through the Primary Care Quality and Resilience Dashboard and the practices rated red and amber within it or another source i.e. practices themselves, incident reports, complaints or external agencies in order to provide assurance to Primary Care Commissioning Committee. This dashboard collates information at a practice level such as workforce, CQC rating, QOF achievement, Friends and Family Test information, and complaints. This dashboard is reviewed on a monthly basis at the Quality, Resilience and Contracting subgroup of the Primary Care Operational Group and practices which are red or amber are contacted for support. Practices can also self-refer to the CCG if they feel they require support. The CCG Quality team have developed a Quality stocktake tool which aligns with the Resilience support tool and this is currently being trialled with practices. The results of the tool will form the basis of an improvement plan and memorandum of understanding with the practice so the practice clearly understands who is to support them in this work and what the outcomes are.

These tools are solely for the red and amber practices, not for those rated green or blue on the dashboard.

10.1 - Appendix 1 - Primary Care Quality

2.2 Datix

Across BNSSG we have invested in Datix, which is a central point of reporting concerns between primary care and secondary care. An incident reporting guide was sent out to practices around use of Datix in March 2020. Incidents reported onto the CCG Datix are reviewed by the Quality and Medicines Optimisation Teams and where necessary providers are asked to investigate further and share learning. The quality team communicate with GP practices when incidents are challenging to resolve and speak to system providers to resolve more complex problems. Escalations are reported to GP Quality Lead for review and support to take forward concerns into the system. There is work ongoing to collate Datix themes which can then be reported back to practices in order to promote learning; there is proposed development of a newsletter to be sent to practices with this information. The Medicines Optimisation team are also supporting with communication to practices to increase the use of Datix; there is also work within the Quality team to improve the usability of the tool.

2.3 Remedy and The Referral Service

All of BNSSG has access to Remedy, our clinical resource site. This is promoted regularly and has had excellent feedback from clinicians who use it. It holds the latest clinical guidelines to support patient management and also contains the latest information about referral processes, both routine and urgent. There is a monthly newsletter produced which highlights key information. As we develop this quality approach, it would make sense for Remedy to be the platform which holds details of this as well as having a vital part to play in it.

The BNSSG Referral Support Service provides peer review of referrals and supports clinicians in practices with signposting to alternative services or management plans for patients. Whilst

feedback to practices is provided in order to aid learning and improve awareness of BNSSG referral pathways, it would be helpful to make this process more robust and understand how practices disseminate the information, and what the impact is on the referrals, there is no collation of themes to promote learning in practices. The rapid rollout of Advice and Guidance during Covid has been welcomed by general practice and enables patients to access more specialist advice and support rather than waiting for an outpatient appointment. This service needs to be evaluated to ensure that general practice clinicians are using it appropriately and that both secondary care and general practice clinicians account for the change in workload that this brings.

3. Quality Outcomes – staff and patient engagement

During the engagement process for the BNSSG Primary Care Strategy, we asked our health and care staff and our citizens what was important to them:

Patient outcomes:

Access

- I can get an appointment when I need one
- I know who I can see for a particular problem
- I usually get my care delivered where I want it
- I am sure all the people involved in my care talk to each other and me

The people who look after me

- The health and care professionals looking after me have access to regular training to keep their skills up-to-date
- The team looking after me has people in it who can help me with the different problems I may have and they work well together
- I can be sure that the team looking after me is looking to the future by continually training and developing new staff, so I can be sure of a consistent service

Organisation

- The services offered are helpful to me and my family
- If I can't get what I need locally, I don't have far to travel
- I can access services in different ways
- My care is delivered from a place where I feel safe and comfortable

Quality and resilience

- The care I receive is: up to date; trustworthy; delivered safely; tailored to my situation; high quality; aiming to improve something I care about

Staff outcomes:

- I have enough time to give the person in front of me
- I can manage my workload effectively and go home on time
- I have all the information I need in front of me

- I can ask easily for help when I need it and get it in a timely fashion – whether from the primary care team or the wider system

The response to Covid has highlighted areas in general practice and the wider system with inconsistencies and unwarranted variation that need addressing. Some of these areas can be highlighted with the following examples; these are also reflective of the staff and citizen insights gained during the Strategy engagement, which shows it is still just as relevant today.

- **A new way of working - the shift to remote consulting in general practice**

The quick switch to remote consulting and telephone triage was a necessary one, but we now need to understand how to mitigate for the risks and inequalities this introduces. No one practice signposts in the same way as the next one, no one practice triages in the same way, there is no standardisation of healthcare navigation protocols, and every clinician has different thresholds for reviewing patients face to face.

- **Advice and Guidance**

Secondary care Advice and Guidance services are currently becoming overwhelmed and there are reports of quality issues with referrals. We need to understand these issues in more detail in order to ensure this is a sustainable service to offer. We need to standardise the process and feed back to clinicians where there are issues with referrals.

- **Referrals to ED**

There are anecdotes of patients being sent inappropriately to ED by practices; records on Connecting Care are now easily reviewed and there may have been more appropriate ways for that patient to have a review e.g. hot clinic, referral direct to specialty, a change in pathways etc. There needs to be an easy way to feed back to practices in circumstances where improvements can be made quickly.

- **Communication between secondary care and primary care**

Increasing waiting times in secondary care for example in 2ww referrals or routine gynaecology appointments which have been frozen which are communicated via patients rather than between primary and secondary care.

4. Next steps

In order to deliver the ambitions of the Primary Care Strategy, the quality outcomes of Clinical Leads' workstreams and Outcomes and Activity group need to be aligned with the work of the Quality team and Medicines Optimisation team, as appropriate. This will ensure joining up of the work and that a quality infrastructure around general practice is further developed.

In order to take the next steps in forming the Quality Forum in general practice, we propose

- To undertake a survey to practices to baseline quality activity in practice with aim of supporting development

- To hold a workshop to define quality in primary care with practices, design the approach with practices and PCNs and agree/prioritise patient related outcome measures
- To hold a wider discussion at Clinical Cabinet, Primary Care Strategy Board, and Quaity Surveillance Group
- Ensure this is part of ICP development and aligns with ICS/ICP outcomes framework

5. Recommendations

The committee is asked to comment and feed back on the proposed next steps as outlined above.

6. Risk implications

Quality assurance and clinical governance reporting processes are currently in place which report through QSG, PQRC, PCOG and PCCC. Any further requirements following discussions will be taken through this route.

7. How does this reduce health inequalities

Having a systematic approach will reduce health inequalities by ensuring high quality care. We are working closely with Public Health and their profiling, PHM and BHCDG for a joined up approach.

8. How does this impact on Equality and Diversity?

Quality assurance, monitoring and audit will highlight any areas of relating to equality and diversity or variation to service which will then be addressed accordingly.

9. Consultation and Communication including Public Involvement

A co-designed approach to improve quality in general practice will require engagement with general practice colleagues and will need to form part of the Primary Care Strategy communications and engagement plan.

Appendices

Glossary of terms and abbreviations

BAME	Black, Asian and Ethnic Minority
BHCDG	Building Healthier Communities Delivery Group
EIA	Equality Impact Assessment
GP	General Practitioner
HEE	Health Education England
ICP	Integrated Care Partnership
ICS	Integrated Care System

ICSG	Integrated Care Steering Group
LA	Local Authority
LD	Learning Disabilities
LTP	Long Term Plan
PCN	Primary Care Network
PHM	Population Health Management
QI	Quality Improvement
QoF	Quality and Outcomes Framework
QSG	Quality Surveillance Group
RCGP	Royal College of General Practitioners
VCSE	Voluntary, Community and Social Enterprise

BNSSG Primary Care Strategy 2019-2024 Delivery Plan

Priority	Deliverables	Outcomes
Models of Care		
Prevention Year 1	• Explore and highlight opportunities for prevention across all providers of primary care in the following priority areas: Public Mental Health & Wellbeing; Healthy Weight; Alcohol; Tobacco & CVD • Expand delivery of MECC training across Primary Care	• Opportunities for prevention across Primary Care pathways are identified and benefits highlighted *to enhance our collective commitment to prevention* • Our professionals are better empowered to help people achieve healthier lifestyles and the number of years people in BNSSG live in good health is increased
Year 2-5	• Implement opportunities identified for prevention across all Primary Care providers • Further expand the delivery of MECC training across Primary Care	• Improved physical and mental health and reduced health inequalities for BNSSG population through: - Healthier lifestyles (including alcohol, drugs, smoking, physical activity, healthy weight, sexual health, mental wellbeing) - Increased support for healthier places and communities (to better address wider determinants of health) - Increased uptake of screening programmes to meet or exceed targets and improve earlier detection of disease - Improved vaccination uptake and completion rates to meet or exceed targets and reduce vaccine preventable disease
PCNs Year 1	•PCNs authorised and operational from July 2019. •PCN and GP Locality board governance agreed •Integrated Care Steering Group governance agreed and in place, incorporating PCNs and GP Locality Boards • PCNs recruit to Year 1 Additional Roles • PCN Organisational Development plan formed and offered including PCN Clinical Director and locality leads leadership development programme based on PCN maturity self-assessment • Development of analytics capability to support PCNs including a	•PCNs offer Extended Hours to their population from July 2019 •PCNs established, building key relationships and planning their organisational development (OD) needs •PCNs and GP Provider Locality Boards develop BNSSG

BNSSG Primary Care Strategy 2019-2024 Delivery Plan

Priority	Deliverables	Outcomes
Year 2	range of activity and outcomes data to underpin population health management and quality improvement approach at PCN level • PCNs to support 2019/2020 locality improvement programmes on same day urgent care, frailty and mental health • PCNs contribute to system-wide social prescribing plan • PCNs work with new BNSSG community provider to mobilise multi-disciplinary teams and to operationalise the BNSSG approach to frailty, support to care homes, population health management and personalised and proactive care • PCNs to develop partnership with wider primary and community care and VCSE sector including developing closer working relationships with community pharmacy to develop minor illness referral schemes, healthy lifestyle support and support for people with long term conditions in 2020 and 2021 • Implementation of 5 new national service specifications from April 2020: • structured medication reviews • enhanced health in care homes • anticipatory care (with community services) • personalised care • supporting early cancer diagnosis • Review of Local Enhanced Service offer in BNSSG • PCNs to expand social prescribing offer with referrals to Social Prescribing Link Worker being made from other agencies including community and secondary care providers, other statutory agencies and the VCSE during 2020/2021 • PCN additional roles expands to include physician associates and first contact physiotherapists • PCNs to review practice resilience and look at opportunities for improving resilience and sustainability as a group of practices	wide infrastructure to enable General Practice at scale, ensuring capability and governance in place to participate as equal and effective partners at the ICP Boards from April 2020 •Increase capacity and capability for quality improvement in Primary Care •Enhanced skill mix in Primary Care with increase in people supported by Voluntary, Community and Social Enterprise (VCSE) for non-medical needs • Reduction in avoidable admissions from care homes • Increase in pro-active care planning • Optimisation of use of medicines • Increase in early diagnosis of cancer • Increase in people being referred to community support offers and reduction in demand on statutory services • Increase in measures of wellbeing as reported by people referred for social prescribing • Increase in people using community pharmacies in support of their health and wellbeing • PCNs increase their understanding of resilience amongst their practices and support the sharing of good practice • Support our system to become a mature ICS

Priority	Deliverables	Outcomes
Year 3	including: • Access and workflow • Reviewing approaches to skill mix, sharing workforce and developing common recruitment approaches • Specific focus on urgent primary care in conjunction with IUC • Maximise use of digital innovation both to deliver care and enable care delivery (shared appointment books, digital care plans, provision of online access to patients, remote working, direct booking from NHS 111 and from Emergency departments) • Estates – review local estates and opportunities for maximising estates usage across the PCN group including that of other local providers and inform development of locality estates plans • Shared back office functions and at scale delivery e.g. prescribing hubs. Currently discussions being undertaken with PCNs individually where they have expressed an interest to take this forward. • PCNs to work with other primary and secondary care providers to develop pathway opportunities and support transformation with acute hospital and mental health services e.g. digital first approaches to outpatients and patient initiated outpatient follow up programmes • PCNs support GP Locality Boards to establish Integrated Care Partnerships in 2021 in order to provide place based planning and deliver of care at scale •PCNs to prepare for and implement the new national improved access offer from April 2021	

BNSSG Primary Care Strategy 2019-2024 Delivery Plan

Priority	Deliverables	Outcomes
Year 4	•Implementation of PCN cardio-vascular disease case-finding and locally agreed action to tackle inequalities specifications in 2021 •PCN additional roles expands to include paramedics •PCNs support Localities to deliver improvement programmes using national and/or local investment impact funds whereby funding flows to follow the delivery of care in the community •Refresh PCN OD plan to support PCNs to achieve and sustain Step 3 maturity	•Increase access to primary care •Reduction in health inequalities targeted to local PCN population needs •Increase the number of people diagnosed with CVD in primary care working closely with community pharmacy •All PCNs to self-assess at Step 2 on the NHSE PCN maturity matrix
Year 5	•Primary Urgent Care works in an integrated fashion 24/7 •PCNs provide support and resources to Practices and providers within their footprint and have a culture of developing shared resilience and sustainability •PCNs are the default working within Localities to provide new pathways and models of care in the community	•All PCNs self-assess as Step 3 on NHSE PCN maturity matrix •People in BNSSG experience a seamless 24/7 primary care service •PCNs demonstrate significant growth in care in the community and reduction in secondary care •PCNs are driving and delivering system change •All PCNs continue to self-assess their maturity at Step 3 on the NHS England PCN maturity matrix •People in BNSSG experience improved access to a range of primary and community services, they are encouraged to self-care and when they need more intensive support they work with health and care professionals to set their goals and agree a shared care plan

BNSSG Primary Care Strategy 2019-2024 Delivery Plan

Priority	Deliverables	Outcomes
SDUC Year 1 **Year 3**	•Improved Access established across all Primary Care Networks and delivered against revised specification. •Collaboration between primary and secondary care clinicians to develop community based ambulatory pathways and services to replace current hospital based activity for a range of Ambulatory Sensitive Conditions (ASC). Priority focus will be on: ○ Low risk chest pain ○ Acute headache ○ Abdominal pain ○ Respiratory •Locality provider teams are working on options for provision of community same day urgent care services in their areas, and considering which can be delivered during 19/20 in order to support system capacity over the winter period. Sirona Care and Health, as the adult Community Services Provider will be a key system partner in transforming the out-of-hospital care setting, so that services provide proactive care to meet population needs and a "safety-net" to avoid acute hospital admissions. From April 2020, more services will start to be delivered from Locality Hubs across BNSSG, with some designated as Urgent Treatment Centres. Locality providers will continue to work together to use these shared facilities in Locality Hubs to meet a greater range of urgent care demand and provide support to more clinical pathways. In doing so, providers will help people stay healthy, well and independent in their community.	Patients have access to care delivered as close to home as possible, whether that care is routine or urgent negating the need for Emergency Department attendance.
Quality and		

BNSSG Primary Care Strategy 2019-2024 Delivery Plan

Priority	Deliverables	Outcomes
Resilience **Year 1**	• Triangulation of information from both the data, and from regular announced and unannounced CQC visits to practices, and where necessary to escalate any immediate or emergent issues and concerns to maintain patient safety and promote quality improvement • Support and work with practices on any improvements required with individual CQC domains to ensure all are rated as good or outstanding • Develop with practices a workplan to tackle Antimicrobial Resistance and Healthcare Associated infections including Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infections, Clostridium Difficile infection and E-coli infections, alongside significant reductions in the use of broad spectrum antibiotics. • Finalise the Primary Care Incident Reporting Policy • Establish the BNSSG Primary Care Quality Forum to be made up of quality leads from primary care including optometry, dentistry and pharmacy • Identify the training needs of the primary care quality leads • Implement leadership programmes for Primary Care Network Clinical Directors to improve the culture of quality improvement and patient safety • Confirm the clinical and social outcomes that are being sought including from the Locality Plans and other plans and strategies that impact the work of primary care • Agree how information that will support the monitoring of progress on achievement of the outcomes will be collected and who will collect it • Agree the content and format of a primary care quality dashboard that will align with the Primary Care Network national dashboard that is in development	•Increased positive patient experience ratings and positive feedback •Improved and sustained positive clinical and social outcomes as evidenced by meaningful QoF achievement and personalised care plans •Reduced levels of avoidable harm •All primary care staff have the knowledge, skills and confidence to undertake quality improvement projects. •All relevant Primary Care Services are supported to achieve a CQC rating of Good or above •Practices working together within and across PCNs to understand and compare quality measures that are meaningful and support each other, under the leadership of the Clinical Director(s) •Individual practices and PCNs take responsibility for resilience of the practices in their network and provide mutual support to ensure the sustained provision of primary care services for their population •Practices collaborate within and across PCNs to develop their resilience and to develop at scale solutions to support their efficiency and sustainability – e.g. shared back office functions and centralised prescription hubs. This may also lead to mergers to improve resilience. Nationally, a number of large-scale super-partnerships

Priority	Deliverables	Outcomes
By Year 3	• Agree the content and format of a 'variation report' for primary care to use • Roll out the resilience self-assessment tool and make this available to all practices • Delivering the 2019/20 general practice resilience programme for individual practices identified as requiring support to improve resilience • South Bristol locality is currently undertaking a programme of work to improve resilience across the locality. In year 1 the aim is to have delivered the first set of agreed objectives which relate to the front door of general practice. A further aim is to agree the second tranche of objectives for the South Bristol Resilience Programme. • Continuing to access the Time for Care programme to benefit the practices • PCNs self-assess their resilience and are supported with analytics to help them with this • PCNs are supported with quality and population health management data • Successful delivery of the active signposting contract • All practices to have undertaken work in relation to a minimum of 3 of the 10 high impact actions, enabling time for care to be released by changing ways of working practice. A further aim is to agree the second tranche of objectives for the South Bristol Resilience Programme. • All practices to have completed workflow optimisation training •System-wide resilience support menu and toolkit is available to support practices which makes the most of the capability and capacity of local stakeholders and addresses key practice needs • All practices to have adopted at least 5 of the 10 High Impact	have now been developed. These have the capacity to bid for and deliver extended services, designed to fit local needs, beyond that which it is possible for any individual practice to offer. The scale and variety of services can help facilitate centralised training and new and flexible employment options. This in turn can help attract trainees and salaried doctors, who in the long term might also be interested in becoming partners. Extended services also offer an opportunity to develop the primary care workforce, drawing on professionals such as pharmacists and physiotherapists, and improve integration with other community services. We will support our practices which choose to collaborate on a larger scale.

Priority	Deliverables	Outcomes
By Year 5	Actions • At scale work with other PCNs / localities to support improved resilience and quality • Implement the workplan to address Antimicrobial Resistance and Healthcare Associated infections • Implement the Primary Care Incident Reporting Policy • Respond to the requirements set out in the new national Patient Safety Incident Response Framework • Work with the Regional Medical Examiner system by 2021 regarding deaths in primary care which will provide an additional structure for insight • Regular sharing of quality improvement projects takes place across practices and PCNs facilitated by digital platforms and face-to-face learning opportunities • Populate the primary care quality dashboard and use the information to identify trends and themes in order to inform quality improvement efforts • All stakeholders to use the primary care quality dashboard to understand where primary care quality is being achieved and help to understand where we should focus our improvement efforts • Continue to develop Primary Care Network Clinical Directors in their quality improvement leadership role by implementing formal and informal learning • Develop and implement a training programme for the primary care quality leads • Collect and analyse information that will support the monitoring of progress on the outcomes • All stakeholders use the 'variation report' for primary care to understand where variation is warranted and where it is unwarranted in order to help focus our improvement efforts • Gather information on evidence-informed interventions related to the outcomes we are seeking and use this information inform	

Priority	Deliverables	Outcomes
BNSSG Referral Support Service	decisions about improvement efforts • Continue to consider opportunities for primary care to inform and participate in meaningful research • Write evaluation plans where relevant • Complete the evaluation of work that is being done to improve quality • Continue with actions to develop skills and training on safety to the whole primary care workforce • Continue with actions to develop a culture of continuous learning and quality improvement within all primary care • All PCNs to have undertaken work in relation to each of the 10 High Impact Actions • Achieve the best outcome and the best quality of care for our patients • Get patients the right care, by the right person at the right time and in the right place with minimum delays • Work closely with practices to provide peer review and referral support to BNSSG practices • Work in partnership with local health providers to look at referral processes and pathways and act as a central point to try to establish consistency across organisations. The longer term aim to develop a whole system approach to referral	The referral process itself is conducted well Improved referral quality and reduced variation Improved patient experience of referral process Patients are referred as and when necessary, without avoidable delay. Patients are referred to the most appropriate place first time.
Developing the Workforce **Year 1**	**We will make BNSSG 'The Best Place to Work'** • We will work with Primary Care Networks to improve staff retention, e.g. mentorship, portfolio working, fellowships, developing peer networks/learning sets	• A Diverse high quality empowered workforce who care for the population they serve

BNSSG Primary Care Strategy 2019-2024 Delivery Plan

Priority	Deliverables	Outcomes
	• The Happy App is being piloted in Primary Care in BNSSG; an App that measures how content the workforce are at a given time, with opportunities for staff to highlight any issues to managers, and for successes to be celebrated • We are producing a “how to” guide on portfolio careers in Primary Care • We are developing an outline BNSSG career pathway, agreed across Healthier Together Partners. We aim to embed the career pathway into recruitment, retention and appraisal processes and to create a digital version for access through schools, colleges and potential recruits • We will identify areas of low participation for health care careers across BNSSG, including reasons for low participation We have recruited nine Health Inequalities Fellows in BNSSG working with Public Health focusing on reducing health inequalities in BNSSG • We are working with schools in areas with low participation rates in Health and Social Care to market career opportunities • We are engaging with health and social care BTEC students to attract them into hard to recruit roles • We are creating opportunities for GP Nurses to engage in education, strategy and student outreach projects • We are testing the Paramedics in Primary Care project within BNSSG, testing the viability of developing newly qualified Paramedics into system aware clinicians who can manage their own portfolio career **We will continue to support and improve leadership in Primary Care by** • Continuing to deliver leadership opportunities to GPs • Promoting leadership opportunities to BNSSG’s GP Nurses	• Supporting people to self-care and to be the best they can be • Creating opportunities within PCNs and Localities for staff training and supervision to ensure estates are used effectively • Primary Care will be a supportive training environment for health care professionals, with opportunities for portfolio careers across clinical and non-clinical roles, enabling staff to work flexibly, benefitting the whole BNSSG health and social care system. • Career pathway advice accessible for all health care professionals, schools, colleges, and potential health and social care recruits • Primary Care workforce will be equipped to reduce health inequalities across BNSSG • General Practice Nursing will be a career of choice for newly qualified nurses • General Practice Nurses will be able to return to practice through a well sign posted accessible route • Health Care Professionals working in Primary Care will be developed to deliver the service required for the population they serve

Priority	Deliverables	Outcomes
	through the GP Nursing 10 Point Plan • Promoting leadership development in Primary Care Networks, including leadership in multi-disciplinary teams **We will release time for care in Primary Care by** • Developing an operating model and process for a staffing bank across community, primary care and social care • Piloting of E-consultation to help improve workload levels for GPs and practice staff • Introducing Social Prescriber Link Worker models in Primary Care Networks • Developing the Clinical Pharmacist role across practices in PCNs • Building on our existing work with the national Time for Care programme, referenced in the quality and resilience section • Making every contact count **We will address urgent workforce shortages by** • Increasing placements for Nurses and Allied Health Professionals in Primary Care • Using a consistent approach to 'return to practice' to maximise uptake and impact • Piloting the 'New into Practice' module for newly qualified Registered Nurses and Registered Nurses working in other areas of the system in BNSSG wanting to work in Primary Care • Developing preceptorships in Primary Care and implement Nursing fellowship schemes • Continuing to engage with the NHS England International GP Recruitment Programme, bringing GPs from Europe to BNSSG and place in practices in BNSSG • Developing system wide plans to support the introduction of new roles in Primary Care Networks (PCNs) • Supporting PCNs with new roles to ensure they operate in effective	• Happy, engaged and fulfilled Primary Care workforce

Priority	Deliverables	Outcomes
	multi-disciplinary teams (MDTs) • Promoting 'group consultations' in Primary Care to reduce demand on clinicians, and improve patient experience through peer support • Introducing fellowships to attract GPs, General Practice Nurses (GPNs), and AHPs in hard to fill areas • Raising awareness of GP Nursing Careers with Universities' Under Graduate programmes by working with higher education institutions and supporting the development and roll out of NMC Future Nurse Project, bringing the Primary Care context to the new NMC Under Graduate nursing programme • Promoting GP Nurses as 'first choice' career at point of registration • Supporting the upskilling of staff in social care particularly in care homes and domiciliary care to identify deterioration in residents and to improve communication with GPs and community services • Supporting the development of a school to practice career information platform for use by schools and developing clinicians within BNSSG **We will optimise skills by:** • Increasing the use of apprenticeships in Primary Care in clinical and non-clinical routes, supported by the remaining levy from acute trusts • Work with PCN's to support new roles, embedding and developing the roles within the PCNs • Implement Nurse Preceptorships in Primary Care to support Nurses moving from Secondary Care to Primary Care using an NMC led skills/knowledge passport. • Offering direct support to new Primary Care Network Social Prescribing Link Workers, co-designing a package of support for link workers that may include, for example, peer network meetings, action learning sets, co-mentoring	

Priority	Deliverables	Outcomes
	• Deliver mental health first aid training in Primary, Community and Social Care to include care workers and volunteers • Developing and facilitating peer groups networks and action learning sets and conferences across PCNs, for example, Social prescribers, Paramedics, Pharmacists and Nurses • Supporting portal development for a single point of reference for training and education across BNSSG • Changing back office functions in Primary Care to improve workflow • Offering active signposting to ensure patients see the right person in the right place at the right time • Supporting PCNs to develop links across the voluntary sector through development of social care and voluntary sector task and finish groups • Developing training for volunteers in identifying frail at risk patients and communicating with community and primary care to support social prescribers and PCNs • Launching the Advance Clinical Practitioner apprenticeship • Supporting the Paramedics in Primary Care Project at practice level, offering placement support and continuing to grow the Paramedic Forum • Developing a Physiotherapist Forum, understanding training needs and aspirations • Supporting Primary Care Placements for Physicians Associates by creating a UWE Role Guide and continue to promote the role in practices • Work with local providers to ensure there is a sustainable pipeline of Pharmacists for additional roles in primary care through portfolio careers, rotations and training of sufficient Pharmacists for primary care • Develop and support better use of administrative and management apprenticeships in Primary Care to develop a sustainable Primary	

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Priority	Deliverables	Outcomes
By Year 3 **By Year 5**	Care workforce • Develop motivational interviewing skills in the Primary Care workforce to assist patients with long term conditions set goals and engage with their care • Offering direct support to new Primary Care Network Social Prescribing Link Workers, co-designing a package of support for link workers and building a team of community volunteers to support the link worker • Supporting Primary Care placements for Physicians Associates by creating a Role Guide and continue to promote the role in practices • Continue to develop portfolio working in Primary Care • Digitalised career framework model – embedded into recruitment, career development • Assess the impact assess of schemes reaching out to areas where there is low participation in health and social care careers and develop further, targeted programmes • Next Generation GP leadership programme • Leadership Development for MDTs • Implement a GP nurse bank across primary care and community • We will have an embedded approach for schools to improve our workforce pipeline numbers • Physios, physicians associates and paramedics recruited in significant numbers by PCNs • As part of Healthier Together, we will have a system wide recruitment passport which will be used in every organisation for all inter-organisational transfers to ensure processes are more efficient and reduce duplication in HR processes • Subject to national pilot site outcomes, embed place based placement scheme across BNSSG • Embed nurse preceptorship schemes across PCNs	

BNSSG Primary Care Strategy 2019-2024 Delivery Plan

Priority	Deliverables	Outcomes
	• Implementation of apprenticeship strategy • Primary & Community Care Using Training Hub to develop links across the voluntary sector to ensure appropriate training is available to the voluntary sector primary care interface • Rotational roles will be developed across Primary Care, the Acute Trusts, and the Community providers • A motivated GP Nurse team will be embedded in education, schools and colleges outreach and Primary and Community Care Training Hub strategy building • Development of a workforce management/deployment hub – to include rotational programmes • Have a career framework recognised by all staff, used for appraisal, recruitment, and in schools and colleges • Continue to develop leadership roles in Primary Care in GPs, GP Nurses and Practice Managers to ensure PCNs are well led and effective models of care Support PCNs with a system wide approach to developing and embedding new roles in primary care	• A single, integrated system wide bank • Reduce unspent apprenticeship levy from 75% to 0% • MDT working at scale across PCNs and Localities • More registered Nurse starters than leavers each year • Reduce registered nurse vacancies from 12.6% to 5% • Increase Primary Care placements by 20%
Digital **Year 1-3**	People empowered to take control of their own health and care, anticipatory care, supported self-care and personalised care when they need it, through secure online access to health records personalised health information, digital tools and solutions Telephony for automated appointment booking systems such as patient partner – giving 24/7 access to telephone appointment booking	Patients, carers and families better able to manage their conditions Personalised care with shared decision making Digital solutions for all including people with visual + hearing impairments Patients being able to contribute to their own health record and choose who to share it with

Priority	Deliverables	Outcomes
	Reduced local health inequalities and unwarranted variation Insights to understand demand and capacity patterns and pre-empt deterioration of health	A population health solution - identifiable, pseudo-anonymised and de-personalised data is shared to ensure wider population health planning, management and development of pathways Effective risk stratification tool in place
	Staff across the *Healthier Together* partnership are able to access the digital information and services they need to do their job, regardless of location including: - Health and social care records - Test requests – in particular ICE - Test results - Care Plans - Discharge information - Decision support - Easy access to information about local health and social care services Implementation of read/write access to Connecting Care care plan with write back into local systems Sunquest ICE – review local configuration to improve functionality for cross organisational working or consider testing the market for alternative solution Cross organisational appointment booking.	Shared care record with read and write capability where appropriate Care planning - information sharing to provide care plans and communication across the system to make it easy to provide and manage care Staff enter information directly in to digital system do not enter the same information into multiple IT systems Single, fully functioning requesting system for cross organisation ability to order and take samples/tests Infrastructure in place to support collaborative working for patient care and MDT working Continuity of Care Improved staff health and well being Improved recruitment and retention - BNSSG primary care a more attractive career choice

Priority	Deliverables	Outcomes
	Real time sharing of information between health and social care settings, organisations and geographies, as well as between professionals and patients Structured messaging using FHIR standard between organisations, improving efficiency, data quality and improving medicines reconciliation Connecting care patient held record NHS App / Patient Access / Evergreen giving patients access to their up to date information	Improved access to appropriate healthcare advice at the right time with the right person Optimised patient outcomes and quality of care One digital solution - all information will be digital, structured in appropriate coded formats and shared electronically as structured data by default Medicines reconciliation on transfer of patients between organisations to be facilitated by electronic structured messaging to improve patient safety and efficiency Continuity of care Patients empowered to engage in the management of their health by having access to their up to date health information
	All staff are appropriately and regularly trained to make best use of digital technologies	All digital solutions are used to maximum capability – patient outcomes and experience is optimal

Priority	Deliverables	Outcomes
	Clinicians and patients can communicate with each other using a shared digital record that is be easily accessed by patients and clinicians alike, using mobile technology Use of systems such as Consultant Connect to facilitate access for primary care to specialist advice Use of advice and guidance systems for quick access to advice for primary care clinicians	Remote and collaborative working to move care to where it is most needed and make the most of limited resources Patients, carers and families will have remote/virtual clinical consultations and receive clinical advice using tools such as online meetings, videoconferencing, email or instant messaging Health and care professionals can contribute remotely to discussions about patient care with colleagues across the system Improved delivery of care home and housebound care Continuity of care
	Improved access to appointments when needed to the appropriate person within the appropriate timeframe. - Patient Access - Care navigation - Mi-Dos - Online consultations - NHS App - High speed internet	IT solutions interoperable with EMIS Patients, carers and families can access healthcare advice when they need: - Supported self-care - Signposting - Appointments when appropriate, with the right person, at the right time with the right service Patients, carers and families could have remote/virtual clinical consultations and receive clinical advice using tools such as online meetings, videoconferencing, email or instant messaging Professionals can electronically refer and book patients directly into appointments, including but not limited to

Priority	Deliverables	Outcomes
		professionals from Community Services, 999, acute, Primary Care, integrated urgent care clinical assessment service, social care, voluntary services and mental health Reduced workload for practices.
	Assistive technology to remotely monitor patients	Supported self-care, independence and social participation Improved delivery of care home and housebound care
	Partnership working – Office 365, EMIS X, Resource Publisher, FHIR Messaging, cross organisational record access, cross organisational test requesting	IT solutions interoperable with EMIS Infrastructure in place to deliver 24/7 primary care Data is recorded consistently across PCNs and integrated Localities Infrastructure in place to support collaborative working for patient care and MDT working Infrastructure in place to deliver locality priorities across PCNs and Integrated Localities: - Same day urgent care - Frailty

BNSSG Primary Care Strategy 2019-2024 Delivery Plan

Priority	Deliverables	Outcomes
		- Mental Health

BNSSG CCG General Practice Quality Assurance Process Standard Operating Procedure

SOP Version No.	V2
Author's Name:	Jacci Yuill
Author's Job Title:	Lead Quality Manager-Primary Care
Dept. / Service	Nursing and Quality
Current Service Lead / Reviewer:	
Signed off by:	
SOP valid for:	☐ 1 year ☐ 2 years ☒ 3 years
Publication Date:	TBC
Expiry Date:	
Next Review Date (3 months before expiry):	
Distributed to:	

1. Purpose

The purpose of this document is to set out the standard operating procedure (SOP) regarding the proposed approach and process for the delivery of targeted support for practices in greatest need of support to improve quality. Current identification is through the Primary Care Quality and Resilience Dashboard and the practices rated red and amber within it or another source i.e. Practices themselves, incident reports, complaints or external agencies. To date work has been undertaken with those practices who have red ratings. In order to better understand what quality support and improvement of care practices require to improve quality, BNSSG practices who are rated Red or Amber will undertake a Quality Improvement Assurance Programme.

The reason for this process is to have an overview and consistent approach to where practices are in relation to the blue, green, amber and red ratings captured within the CCG Primary Care Quality and Resilience dashboard, what support is required regarding their improvement, provision of the required support and monitoring of improvement.

This SOP provides outlines the process to support to practices as follows:

- Monthly review at Primary Care Quality, Resilience and Contracting meeting to identify the red and amber practices
- Testing of the dashboard across all practices.
- Oversight of quality measures within the dashboard to ensure that they are clearly defined and include defined thresholds.

- Define those who will be responsible to support the practices in the Quality Improvement Programme
- Quality Stocktake Tool to identify quality issues
- Development of practice Quality Improvement plan and Memorandum of Understanding agreement between practice and CCG
- Review of implementation of improvement plans through regular meetings between CCG, practice and provider(s)
- Dashboard management and oversight to demonstrate improvement in quality of care provided by practice through reporting to PCOG/PCCC
- Being able to report by Primary Care Network(PCN)/Locality or Area
- Quality escalation process

It is acknowledged that the CCG will also receive self referrals for support regarding specific quality queries and requests which will continue to be provided and not be part of a formal programme.

2. Scope

This Standard Operating Procedure will cover only the process for the delivery of targeted support for BNSSG GP practices rated red and amber in the Quality Improvement Programme and will not apply to those who are rated green or blue.

3. Introduction

The CCG identification of practices or groups of practices which may benefit from support to improve quality begins with the Primary Care Quality and Resilience dashboard which has been established to meet the requirements of the Primary Care Commissioning Committee (PCCC). The dashboard has been developed by the CCG Business Intelligence team, which along with soft intelligence about practices, enables the Quality, Resilience and Contracting Sub-group of Primary Care Operational Group to operate an early warning system for practices which may benefit from support to improve their quality and resilience.

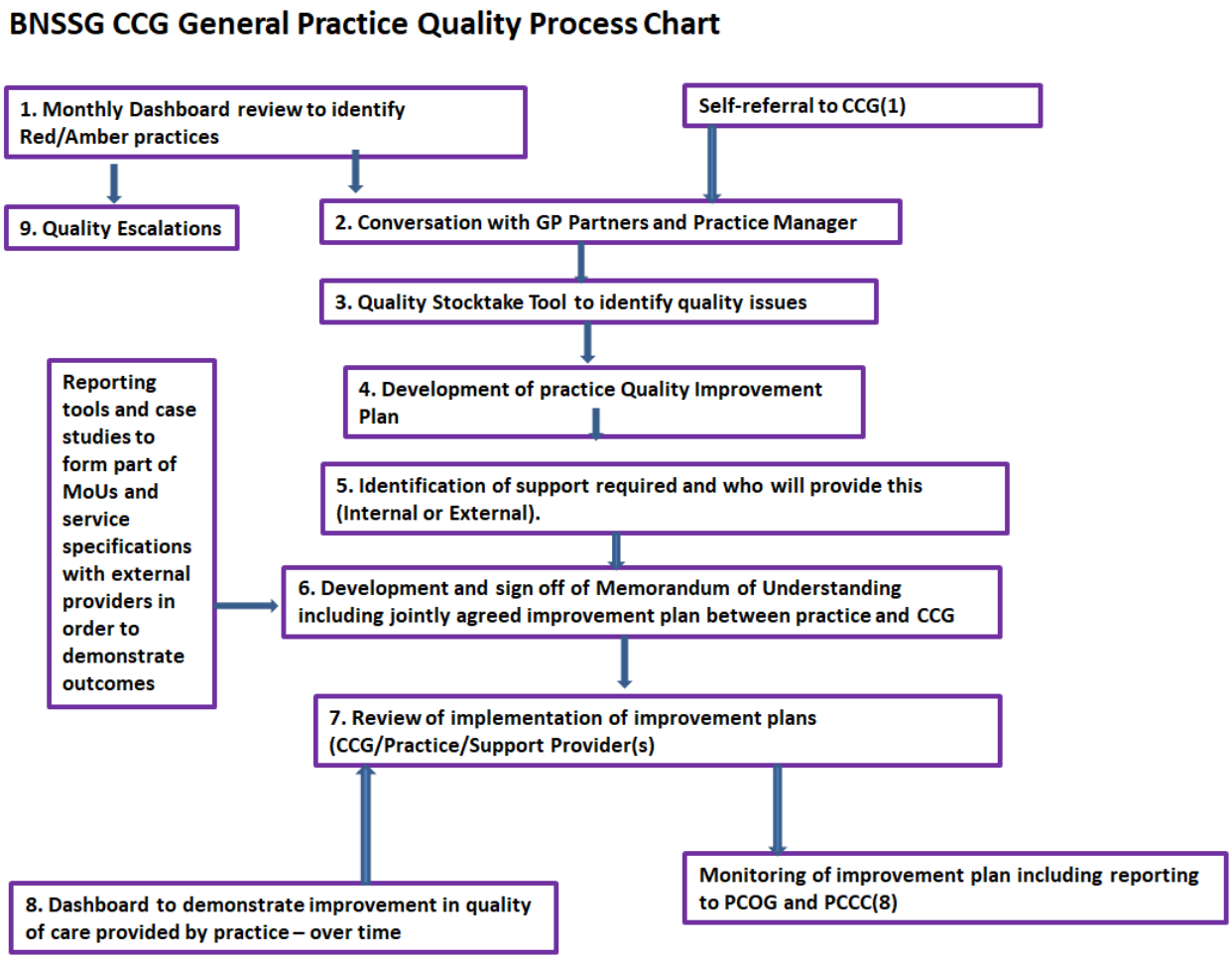
The dashboard was developed by combining the previous Primary Care Resilience and Quality dashboards to provide a strategic overview and comprehensive reporting tool based on the most recent available data. The aim of dashboard is to provide the first step in identification of practices which may require support and is a prompt for an initial conversation with a practice and the gathering of further information.

The plan is to now use this process to report to PCCC quarterly on the position of the red and amber practices and the status of Quality Improvement plans in place with these practices.

4. Procedures for the delivery of targeted support for practices rated red and amber

Process	Responsible
1.Monthly dashboard review to identify red/amber GP Practices	Primary Care Quality, Resilience and Contracting meeting (Internal monthly)
GP Practice self-referral to CCG(1)	BNSSG GP Practices
2. Conversation with GP Partners and Practice Manager	Jacci Yuill; Susie McMullen(PC Development); GP Lead; Area Team; PC Head of Contracts
3. Quality Stocktake Tool to identify quality issues-send to practice	Jacci Yuill(Lead) with support from Quality Support Manager; Practice Manager; Area Team
4. Development of practice Quality Improvement plan	Jacci Yuill(Lead); GP Lead; Susie McMullen; Area Team; PC Head of Contracts
5. Identification of support required and who will provide this (internal and external)	Jacci Yuill; Susie McMullen; GP Lead. External: if required commission and then work with the external provider regarding implementation of the plan.
6. Development and sign off of Memorandum of Understanding including jointly agreed improvement plan between practice and CCG	Jacci Yuill(Lead); Quality Support Manager
7. Review of implementation of improvement plans through regular meetings between CCG, practice and provider(s)	Jacci Yuill /Susie McMullen/Fiona Budd(BI)/Quality Support Manager/Area Team/Internal or External Support; PC Head of Contracts
8. Dashboard management and oversight to demonstrate improvement in quality of care provided by practice through reporting to PCOG/PCCC	Jacci Yuill, Susie McMullen and Fiona Budd
9. Quality Escalations	Refer to Escalation Plan

Quality Process Chart:



5. Inclusion of quality measures in the dashboard and definition of thresholds

The overall quality score is based on CQC rating, CQC population group ratings, Family and Friends test submissions, Prescribing, Respiratory, Diabetes, Cancer measures, Cardio-Vascular Disease, Dementia and childhood immunisation measures. Each domain is Blue, Red, Amber, Green (BRAG) rated. These scores are combined using a multiplicative approach to give an overall quality score. All measures are updated annually with the exception of cervical screening data, which is quarterly.

Examples of the measures included are described in the table below along with the frequency of data issue and refreshing in the dashboard:

CQC rating (Ratings data is refreshed monthly, but only a small number of practices are rated in any month, so only those with a new inspection will change)	**Score**
Overall 'Outstanding'	1
One 'Outstanding' domain	2
All domains 'Good'	3
One domain 'Requires Improvement'	7
More than one domain 'Requires Improvement'	10
CQC population groups ratings	
More than one domain 'Outstanding'	1
One 'Outstanding' domain	2
All domains 'Good'	3
One domain 'Requires Improvement'	4
More than one domain 'Requires Improvement'	5
Family and Friends test submissions-updated monthly	
More than one submission missed over last 8 months	3
One submission missed in last 8 months	2
No submissions missed	1

The majority of quality measures are updated annually, with the exception of cervical screening data, which is quarterly. The Annual Quality Outcome Framework scores comprise a major part of the score which can present difficulties when analysing as the data is not current. Demonstrating current improvements with this annual data set is therefore not easy as it is old. System wide data sets are available however it is not possible to use this under current data sharing agreements due to their link with performance management.

6. Responsibilities

Director of Nursing & Quality; Deputy Directors of Nursing & Quality; Head of Clinical Governance and Patient Safety

- Oversee the governance required regarding the red and amber practices
- Support and advise on quality escalations and provide leadership
- Report to PCCC

GP Lead

- Support the development of practice Quality Improvement Plan
- Work with resilience and quality lead to identify support required, who will provide this and support conversations which need to be undertaken
- Provide support to review practice improvement plans
- Support Quality Escalations and provide leadership

Lead Quality Lead Manager-Primary Care BNSSG CCG

- Review the quality and resilience dashboard and identify practices requiring support.
- Undertake quality improvement conversation with GP Partners and Practice Manager.
- Support the undertaking of the quality stocktake tool.

- Develop practice quality improvement plan with Resilience and Area Team.
- Commission external support if required for practices to develop and implement an improvement plan if required with resilience and External Support.
- Develop and sign off a Memorandum of Understanding with support from quality team
- Review the implementation of improvement plans with Resilience, Business Intelligence, Area Team and External support.
- Report to PCOG and PCCC
- Escalate quality concerns according to the escalation plan.

Business Intelligence Analyst-BNSSG CCG

- Support data analysis of BNSSG GP Practices.
- Provide reports to PCOG and PCCC regarding the analysis and interpretation of the dashboard reports

Quality and Resilience Manager-BNSSG CCG

- Review the quality and resilience dashboard and identify practices requiring support.
- Support the development of the practice quality and resilience improvement plan
- Work with Quality Lead to identify type of support required (internal/external) and commission external support if required for practices to develop and implement an improvement plan.
- Review the implementation of improvement plans with Resilience, Business Intelligence, Area Team and External support.

Primary Care Head of Contracts

- Review the quality and resilience dashboard and identify practices requiring support.
- Support quality improvement conversation with GP Partners and Practice Manager with Quality and Resilience Lead.
- Support the undertaking of the quality stocktake tool.
- Support practice quality improvement plan.
- Review of implementation of improvement plans through regular meetings between CCG, practice and provider(s) of external support
- Escalate concerns to Director of Commissioning

Area Team-BNSSG CCG

- Support quality improvement conversation with GP Partners and Practice Manager with Quality and Resilience Lead.
- Support the undertaking of the quality stocktake tool.
- Support practice quality improvement plan.
- Review of implementation of improvement plans through regular meetings between CCG, practice and provider(s) of external support

BNSSG GP Practices

- Identify quality issues and concerns to BNSSG CCG
- Work with the support offered to enable quality improvements

7. Supporting documents and useful resources

BNSSG CCG General Practice Quality Process Chart
Quality Stocktake Tool
Escalation Plan

8. Principles

The consideration of the quality ratings of practices using the dashboard and the standard operating procedure (process) may cause issues around the confidential and sensitive nature of the contents. The recommendation will be as follows:

- Practice reports are only shared with individual practices as part of the quality improvement programme work.
- Anonymised practice reports can be shared within a PCN/Area or Locality with the consent of the practice and alongside joint working for improvement plans with the Locality Teams.
- Dashboard reports could be shared with individual practices in preparation for CQC visits or when undertaking work on action or improvement plans.

In must be taken into consideration that the dashboard, alongside soft intelligence, is only a thermometer and prompt for an initial conversation. After which further more detailed quality information will be collected as part of the agreed process in this Standard Operating Procedure.

The dashboard uses publicly available data and then uses a BNSSG CCG approach to analysing the data and providing each practice with a quality rating and rank. Data update frequency ranges from annually to monthly.

The terms of reference of the Quality, Resilience and Contracting Sub-Group of PCOG include that the dashboard is used in combination with soft intelligence about the resilience of practices and the quality of service. This is also part of the process which is central to the BNSSG CCG General Practice Sustainability & Resilience Support Toolkit which will operate alongside the Quality Process.

Early warning of issues affecting quality of care and patient safety is dependent upon the relationships of CCG has with Care Quality Commission to provide any alerts, rising incident reporting through DATIX, area teams identification of concerns and external agencies such as Avon Local Medical Committee/One Care as the lack of live data available for use in the dashboard doesn't support early warning. There is therefore a risk that issues affecting practice resilience and quality of care are not identified until the issues are at an advanced stage which results in a greater level of support and resource being required in order to recover or manage the position. This risk can mitigated through the continuation and furthering of CCG Area Team relationships with practices, highlighting the availability of support where appropriate and working with the Primary Care Development Team to provide support where it is needed.

There is also a risk associated with the number of practices requiring support to improve and the availability of human and financial resources to work with practices in sufficient depth that quality is improved to a level where the practice has recovered its position.

In the event that BNSSG CCG becomes aware of live issues and risks affecting patient care or with safeguarding implications it reserves the right to escalate information internally or to external agencies and will inform the practice in the event that information is being escalated. The governance and internal escalation route shall be the Director of Nursing and Quality and the Medical Director Lead for Primary Care. The reporting will be through:

- QRC
- PCOG
- PCCC
- Quality Committee

9. Appendices

Quality Stocktake Tool
Escalation Plan

Patient Safety	Outcome	Update
Do you put time aside for clinical audit and are these carried out?		
Do you have an audit calendar and maintain it?		
Do you hold regular training events across staff groups?		
Do your staff complete their stat and man training including children and adults safeguarding training?		
Are staff fully trained in their own roles?		
Do you monitor staff performance and link staff development and training plans to their objectives?		
Is poor performance seen to be managed in your practice?		
Are complete records kept of basic safety checks, e.g. fridge temps?		

Incident Reporting	Outcome	Update
Do you have an internal system for reporting Significant Events (SEA's) and Serious Incidents?		

Are you reporting your SEA's/SI's via Datix?		
Do you have an internal system to report a clinician of concern to the GMC/NMC/NHS England?		
Do you have a whistleblowing policy?		
Are you confident that staff will report?		
Do you have a children and adults Safeguarding Lead within your practice?		
Are your SEA/SI meetings multidisciplinary, including both clinical and admin?		
Are you identifying themes and trends from your SEA/SI's and putting plans in place to rectify the learning?		
How is learning from incidents shared in the practice?		
Are you sharing your SEA/SI learning with the PCN's/Localities/other networks?		
Do you have a standardised approach to policies, procedures (business) and pathways (clinical)?		
Do you allow sharing of staff across the PCN (with whom?) and good practice? (subjective)		

Patient Experience	Outcome	Action
Do you submit your Friends and Family feedback promptly?		
Do you have a Patient Participation Group?		
Are you aware of the most recent GP Patient survey results?		
Do you work with Healthwatch?		
Do you have an action plan in place to identify issues within the practice that arise from the patient survey?		
Have your patient survey responses improved from previous years?		
Do you participate in your Area Patient Participation Group?		

Complaints and Compliments	Outcome	Update

Do you have an easy process for your patients to follow to make a complaint?		
Do you monitor and respond to complaints and feedback on NHS Choices?		
Do you have an agreed, standardised process for managing complaints?		
Do you meet your own complaints policy timeframes?		
Do you discuss complaints, NHS Choices comments and friends and family feedback at team meetings and review any themes regularly?		
How do you share learning from complaints and patient feedback and is this triangulated with patient incidents?		
Do you take action to escalate complaints which reflect a problem with the system?		
Clinical Effectiveness	**Outcome**	**Update**
Do you have a Quality Lead?		
Are the Quality Leads sharing strategically?		
Are your Quality Leads members of the forum (Forum to be confirmed?)		
What is your CQC rating, is it good overall?		
Do you have at least one Excellent rating with CQC?		
Is your QOF exception reporting appropriate, and are all staff working to the same understanding?		
Are you working to establish meaningful clinical and social outcomes on both a population and individual level that can be measured to track and inform quality improvement?		
Are you sharing benchmarking information without judgement such that organisations are encouraged to jointly explore the information and take action where there is unwarranted variation?		
Do you pool your intelligence, reviewing your performance with your peers?		
Do you share data to inform system wide planning?		

Is there a culture of improvement where staff are encouraged to be innovative?		

Infection Prevention and Control(IPC)		
Do you have an Infection Prevention and Control Lead?		
Do the IPC Leads work with the Locality/PCN's/System?		
Do staff understand their roles and responsibilities in relation to IPC?		
Does the practice audit handwashing procedures, cleaning equipment and regimes?		
When were all the staff trained in IPC/PPE/Handwashing and have they got evidence of this?		
How are you managing the supplies of PPE equipment?		
Have you identified any risks in supply provision of PPE and business continuity should there be an outbreak?		
Are policies and procedures maintained and followed in line with current relevant national guidance?		
How do you ensure that the practice prescribes anti-microbials within the BNSSG formulary and that the practice responds manage infections effectively?		
Are you aware of what levels of Health Care Associated Infections there are in the practice population and is there data reporting/monitoring at a practice/Locality/PCN level to identify any issues?		
Have you got winter resilience business continuity plans in place?		

Safeguarding	**Outcome**	**Update**
Are Best interest decisions appropriately documented?		
Is the 'This is Me' documentation completed and use of clinical practice?		
Is there evidence of staff assessing mental capacity of patients, both		

subject and time specific? **Discharge planning** **Refusing care**		
Have Deprivation of Liberty Safeguard (DoLS) applications been made where required and in a timely manner?		
Is there evidence that relatives and next of kin are appropriately consulted?		
Advocacy Are staff aware of Independent Mental Capacity Advocates? Has an appropriate and timely referral been made?		
Do staff understand how and when to make a safeguarding referral?		