Primary Care & Community Services: Improving quality in primary care
<table>
<thead>
<tr>
<th>Document Purpose</th>
<th>Best Practice Guidance</th>
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<tbody>
<tr>
<td>Gateway Reference</td>
<td>12432</td>
</tr>
<tr>
<td>Title</td>
<td>Improving Quality in Primary Care</td>
</tr>
<tr>
<td>Author</td>
<td>DH/Primary and Community Care Strategy team and Primary Care Contracting</td>
</tr>
<tr>
<td>Publication Date</td>
<td>30 Sep 2009</td>
</tr>
<tr>
<td>Target Audience</td>
<td>PCT CEs, PCT Chairs, Communications Leads, PCT Directors of Commissioning, PCT Directors of Primary Care, SHA Directors of Primary Care, SHA Directors of Commissioning,</td>
</tr>
<tr>
<td>Circulation List</td>
<td>SHA CEs, Directors of Finance, GPs, Communications Leads</td>
</tr>
<tr>
<td>Description</td>
<td>This document is to promote continuous quality improvement in primary care services</td>
</tr>
<tr>
<td>Cross Ref</td>
<td>N/A</td>
</tr>
<tr>
<td>Superseded Docs</td>
<td>N/A</td>
</tr>
<tr>
<td>Action Required</td>
<td>N/A</td>
</tr>
<tr>
<td>Timing</td>
<td>N/A</td>
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For Recipient's Use
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Executive Summary

Improving the quality of care – in terms of safety, effectiveness and patient experience – is a central motivation for everyone working in the NHS, and over the past decade there has been impressive progress in improving the quality of primary care services. We need, however, to reduce variations in quality and to ensure that high quality is a consistent part of everyone’s primary care experience. This will be particularly important given the key role that primary care will need to take in driving improvements in quality and efficiency simultaneously in the light of the expected future financial context.

No single element or individual can improve quality in primary care alone. It involves a package of measures including:

• guidelines and standards to bring clarity to quality
• measuring quality
• publishing information on quality
• recognising and rewarding quality improvement
• providing leadership
• safeguarding essential levels of safety and quality
• staying ahead through innovation.

These measures and their significance to primary care services are described in the seven elements of this document, alongside practical ideas, tools and resources that Primary Care Trusts (PCTs) can use to support and enable quality improvement for patients.
We know that individuals within the NHS are already adopting the approaches needed to promote continuous quality improvement. The next challenge is to apply these methods universally and systematically in a way that will lead to sustainable improvements in quality for all patients. To achieve this transformational change, PCTs will need to ensure that best practice is embedded in all the areas above.

It is essential to prevent this becoming a mechanistic exercise. We must always remember that the measures outlined above are a means to an end – to promote and deliver high quality primary care for all. The most important thing is for managers and clinicians to embrace this common goal, to make quality the organising principle for everything they do and to work in partnership to deliver ongoing quality improvement in primary care for patients and local communities.

“The one thing that has remained constant is our aspiration to make quality the organising principle for everything we do. It is a focus on quality that will make services more efficient; that will drive and inspire people to think of new ways to provide care through innovation; and it is a focus on quality that will move the NHS towards concentrating on prevention as well as cure.”

Rt Hon Andy Burnham MP, Secretary of State for Health, High Quality Care for All: our journey so far, June 2009

PCTs have an essential role as local leaders of the NHS in creating the environment for cultural change. Their objective should be to harness the energy of primary care practitioners and help them realise the ambition of continuous quality improvement,
a concept that sparked such enthusiasm in the NHS Next Stage Review.

This document sets out best practice guidance to help primary care commissioners make this improvement part of everyday practice. PCT commissioners, working with practice-based commissioners, need to have open and transparent discussions with providers as well as patients and the public about:

- their aims for the health of local people and the quality of services available to them
- how they should measure and assure quality
- what support they can provide to help everyone become as good as the best, and at the same time encourage the best to become even better.

We should make no apology for raising the bar and aiming for innovative, transformational changes in quality of care and the health of the population. This means looking holistically at the health needs of local people and the health services available to them, with a view to delivering services, where possible, in a more integrated, productive and innovative way.

This invigorated culture of quality can be achieved through transparency, support, peer-to-peer review and strong leadership – both from PCTs and within clinical practice.

The wider financial and economic challenges that society is facing have brought into sharper focus the importance of fostering a culture of continuous quality improvement. Evidence shows the importance of a robust system of primary care for
health economies\textsuperscript{1} and that high-quality health systems and healthy populations require strong and effective primary care services\textsuperscript{2}. High quality primary care is central to a productive health service. Getting it right first time for patients across pathways is both efficient and delivers better quality of care as Andy Burnham said in his maiden speech as Secretary of State for Health to the NHS Confederation conference in June, “The quality agenda is also the efficiency agenda”.

Primary care professionals are crucial to achieving better health, care and value:

- GPs and nurses in general practice see over 800,000 people a day – that is around 300 million contacts every year
- dentists see around 250,000 people a day
- an estimated 1.6 million people visit a pharmacy each day, of which 1.2 million do so for health-related reasons.

GPs play a pivotal role in coordinating NHS care, particularly for people with long-term conditions, and in helping patients to access wider or more specialised NHS services through the thousands of daily referral decisions they make. GPs and other primary care professionals have a real opportunity to make preventative interventions and to improve decisions on referrals and prescribing. They can both improve the quality of care for patients and avoid unnecessary costs elsewhere in the system.

\textsuperscript{2} Contribution of Primary Care to Health Systems and Health. Milbank Quarterly, September 2005. Starfield, Barbara; Shi, Leiyu; Macinko, James
PCTs can facilitate quality improvement through their commissioning role. For example, commissioning a patient centred, easily accessible anti-coagulation therapy service, with clear specifications for monitoring and assuring quality is likely both to improve the quality of care and to save money. This is also an example of how PCTs can encourage clinicians to redesign services to meet local requirements in innovative ways. NHS Bradford and Airedale, for example, has accredited seven community pharmacists with special interests (PhwSI) to conduct anticoagulation clinics. This provides care closer to home for patients and helps reduce time taken at hospital appointments in secondary care.

Having such a service in place can help improve quality of life for patients by reducing drug-associated complications and cutting emergency admissions meaning a reduced risk of stroke and mortality, especially for those who may have trouble accessing such a service normally.

PCT commissioners can use this document to help identify what needs to change and work with providers and the public to create higher quality care that is safe, effective and results in a better experience for patients.
Introduction

What is the purpose of this guide?

This is part of a series of supportive best practice guides to help PCTs become world class commissioners of primary care services.

The purpose of this guide is to support PCTs, as commissioners of primary care, in working with local clinicians and other stakeholders - including patients - to promote continuous quality improvement in primary care services. It builds on, and should be read in conjunction with World Class Commissioning – Improving GP services, Improving dental access, quality and oral health, Improving pharmaceutical services, Improving eye health services and Transforming Community Services Quality Framework: Guidance for Community Services. The guides are being supported by a series of regional events to help PCTs address the strategic, leadership and operational challenges in driving up the quality of primary care commissioning.

The guide reinforces the NHS Next Stage Review vision set out in High Quality Care for All – of an NHS in which quality is the organising principle. The main focus is on supporting PCTs and clinicians to make local improvements in quality of care, but the guide also explains the action being taken at national level to support local quality improvement. This includes the role of the National Institute for Health and Clinical Excellence.

3 Continuous quality improvement means a regular assessment of quality, using data analyses to highlight, understand, and make necessary changes to deliver better patient care.
4 http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Policyguidanceandtoolkits/index.htm
(NICE) in developing quality standards, the development of the assured menu of indicators for quality improvement, quality accounts, practice accreditation and the work of the Care Quality Commission (CQC).

The principles set out in this guide cover all primary care services – medical, dental, pharmaceutical and eye health services. However, we recognise that these services are at different stages of development in the quality improvement process, for instance in the collection of data on quality. As a result, this guide sets out more detail on the quality framework for GP and dental services.

The focus of this document is on the quality of care delivered by the practice rather than the individual practitioners. However, ways of improving individual clinical performance through revalidation, appraisal and education processes can overlap with systems and information used to promote quality at organisational level, such as the Quality and Outcomes Framework (QOF), patient surveys and accreditation.

**Who is this guide for?**

This guide has been developed for senior managers responsible for commissioning primary care services. It also includes a section with key questions for PCT Boards.
Context

*High Quality Care for All*, the final report of the NHS Next Stage Review, set out an ambitious vision to put quality at the heart of everything we do. It defined quality of care as effective, safe and providing patients with the most positive experience possible. It placed a particular emphasis on the need to measure what we do as a basis for transforming quality.

*Our vision for primary and community care*, published as part of the Next Stage Review, set out a vision for how primary care and community services will continue to grow and develop - a continuously improving service, where essential standards are guaranteed and excellence is rewarded.

More contractor-specific documents such as the *Review of NHS Dental Services in England*, an independent review by Professor Jimmy Steele published in June this year, and the White Paper *Pharmacy in England: Building on strengths – delivering the future* published in April 2008 have also made it clear that the provision of high quality care for all is central to developing the vision for the future of these primary care services.

*The Year: NHS Chief Executive’s annual report 2008/09* published in May this year, highlighted the Department of Health’s (DH) continuing commitment to the quality agenda, which has the potential to ensure greater efficiency and better
quality of care for patients. It stressed how important it is that the NHS continues to identify efficiency savings so we can continue delivering high quality care for every patient.

To help ensure this going forward, David Nicholson advised the NHS to prepare to make significant improvements in productivity and efficiency during the next spending review period. He suggested the required savings could total to £15-£20bn over a 3-year period. The exact level of efficiency improvements required will not be known until the overall level of health spending for this period is set out. He emphasised that the focus should be firmly on improving quality and efficiency simultaneously. To support this work from the centre, Jim Easton has recently been appointed as the National Director for Improvement and Efficiency.

**Distinctive features of primary care**

The commissioning of primary care is complex and has a number of distinctive features. These present challenges in measuring and commissioning quality improvement, but also present unique benefits and opportunities in creating services that meet people’s needs in terms of holistic, continuous care near to the patient’s home.
Many of the distinctive features of primary care will be familiar to PCT commissioners and are set out in detail in the aforementioned commissioning guides, with suggestions on how to address them as world class commissioners. They include the challenges broadly common to all primary care contractors:

- a large number of independent providers
- providing services from a wide range of community-based premises
- operating within a range of contractual and governance arrangements.

The role of primary care in providing high quality ongoing health provision is also very different to episodic care in acute hospitals where the aim is that patients should leave ‘better’ than on admission. The challenge for primary care is maintaining a therapeutic relationship with patients, particularly those with long-term conditions requiring continuing care, and managing the care of many people with co-morbidity.

**World class commissioning**

Effective commissioning of primary care services is central to improving quality and productivity as well as implementing the regional visions for health and healthcare developed as part of the Next Stage Review. It is essential that PCTs are able to understand the value that can be gained by investment in primary care and that they work with clinicians both to achieve continuous improvements in quality and reduce unnecessary pressures and costs in secondary care.
“World class commissioning is delivering more strategic and long-term planning of local health services. We have strong levers in place to unlock efficiency gains by using commissioning to build more efficient pathways and reduce investment in services that don’t deliver on quality and value for money. But we need to drive more value from commissioning, including looking at more pooling of resources.”

David Nicholson, NHS Chief Executive
The Year: NHS Chief Executive’s annual report 2008/09

Competency 8 of the world class commissioning (WCC) assurance framework11 (see box on page 14) relates specifically to continuous quality improvement. To demonstrate the highest levels of competence in this area, it is recommended that a PCT have in place a clearly embedded approach to quality improvement throughout its organisation, clear milestones to actively track progress and staff with the capability to deliver the quality improvements needed. It is also recommended that a PCT should have strategies for monitoring the impact of specific initiatives on quality and on health and wellbeing outcomes and reporting arrangements to transmit data directly to key decision makers and throughout the NHS.

11For more detailed information see the World Class Commissioning Assurance Handbook: Year 2 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_105117
**Competency 8:** Promote and specify continuous improvements in quality and outcomes through clinical and provider innovation and configuration

PCTs are the driver of a continually improving NHS. They must ensure that they develop the necessary capabilities and capacity to drive continuing improvements in quality. PCTs seek innovation, knowledge and best practice, applying this locally to demonstrate the improvements in the quality and outcomes of commissioned services. In partnership with local clinicians (e.g. PBCs), and providers, they will specify required quality and outcomes, facilitating supplier and contractor innovation that delivers at best value. Through open and effective commissioning and decommissioning decisions, PCTs transform clinical and service configuration, meeting local needs and securing world class improvements in outcomes and quality.

Many of the other competencies also relate to the delivery of quality improvement in primary care. Some ideas of the competencies which specifically link to the seven elements of the quality framework are set out at the end of this document with key questions of what PCTs will be looking to achieve to reach level 4 competency.
The quality framework and primary care

What it means for primary care

High Quality Care for All called for the achievement of high quality care to become an obsession within the NHS. It set out seven elements for achieving this ambition.

These seven elements form a strategy to implement quality improvement over a period of years, for all NHS services, including primary care. This guide takes each of these seven elements and describes what they mean for primary care, in terms of both local PCT activity and the national programme being established to support this local quality improvement.
Element 1: Bringing clarity to quality

We are all trying to improve the delivery of best, evidence-based care to all those that need it. However we recognise it can be particularly challenging for primary care commissioners and clinicians to keep up with the latest developments and ‘best practice’ in the treatment of a large number of conditions.

This is why the first step in the journey is to provide easy access to the latest evidence and medical guidance and then to develop definitive evidence based standards of high quality care. These national enablers then lead onto the development of clear criteria and measurable indicators of quality of care set out in element 2.

NHS Evidence

NHS Evidence, managed by the NICE, brings the world’s best evidence and best practice information to the consulting room or surgery via a new online portal – providing quick and easy access at the touch of a button. NHS Evidence is for everyone in health and social care who takes decisions about treatments or the use of resources – including clinicians, nurses, public health professionals, social workers, commissioners, service managers, academics and researchers.

NHS Evidence is built around a powerful search engine that provides access to a comprehensive range of information types, including research literature, practical implementation tools, guidelines and policy documents. At the same time, it empowers individual patients by enabling them to learn about their conditions and ‘best practice’ treatments and will give patients confidence in what they read on the Internet.

12 NHS Evidence http://www.nice.org.uk/nhsevidence/
From October, users will be able to upload and share their own content (such as local service models and policies) and customise the service based on their own preferences; to access evidence that is tailored to their needs and to receive alerts about new information. Furthermore, NHS Evidence will identify the best evidence by searching, sorting and prioritising a range of helpful and relevant information with the most reliable data from authoritative, trustworthy sources clearly marked.

NHS Evidence is already proving its worth with nearly a million visits per month.

NHS Evidence includes tools such as the Map of Medicine. This is a tool for achieving clinical consensus throughout a healthcare community, which is being used by an increasing number of primary care practitioners to:

- display evidence-based clinical knowledge in an easy-to-use pathways format, reflecting the patient journey, and
- provide a framework for creating local pathways using modified or new content specific to a healthcare community.

The map creates an overarching benchmark for clinical process, a framework for sharing knowledge across care settings, and a tool for mediating a multi-disciplinary dialogue about the care process. A version of the map is also available to patients via the NHS Choices website.

PCT commissioners can use NHS Evidence to help them, for example, when commissioning services to improve oral health. The portal can direct them to the latest guidance the DH has produced in conjunction with the British Association for the Study of Community Dentistry. The latest publication entitled
Delivering better oral health: an evidence based toolkit for prevention outlines a clear set of measures that dental teams could implement for patients based on their age and risk of disease, as well as a paper by NHS Primary Care Commissioning, which advises on the steps to commissioning to improve oral health.

“As a working family doctor I honestly believe that NHS Evidence will make a real and positive difference to the care I give my patients. Presenting information that has been sorted, sifted, and prioritised will allow users – both clinical and non-clinical – to have the confidence to know that they are using the best information to develop frontline patient care and treatment.”

Professor David Haslam, GP, Huntingdon and National Clinical Adviser, Care Quality Commission

Quality standards
Professionals and patients will also be able to access new definitive quality standards through the NICE website and via NHS Evidence. Working in co-production with the NHS, other standard setters and patients – including the Royal College of GPs and the Faculty of General Dental Practice, which is part of the Royal College of Surgeons – NICE is developing a library of around 150 quality standards to bring clarity to the range of clinical evidence and guidance currently available to clinicians, commissioners and patients. NICE quality standards will be a set of specific, concise statements acting as markers of high quality, cost effective care across a pathway or a clinical area, based on the best available evidence. We expect these standards to support PCT commissioners, and increasingly practice-based commissioners in managing commissioning across pathways.
The first NICE quality standards are currently being piloted and are due to be available in March 2010. They will cover stroke, dementia, specialist neonatal care and venous thromboembolism (VTE) risk assessment. For each condition, the quality standard will make clear what quality care looks like, which will in turn help to end variations in the quality of care that patients can experience from one place to another.

As part of NICE’s new role in helping improve quality in the NHS – and following a public consultation – from April 2009, NICE also took on responsibility for managing a new more independent process for reviewing and developing indicators for the GP QOF, detailed in full in element 4. This puts NICE at the heart of a process that will ensure that future QOF indicators will address topics of importance to patients, professionals and the health of the public, and help professionals make the best use of NHS resources. Central to that is the need to ensure that all indicators proposed for inclusion in QOF are based on best available evidence of clinical and cost-effectiveness, with strong links between the new QOF process and NHS Evidence.

NICE is also currently developing a guide to support PCTs in commissioning high quality services that are based on NICE guidance. This guide will provide PCTs with robust evidence-based national recommendations that can be used to inform local decision-making and implementation tools that in turn can be used to support the planning, prioritisation and commissioning of services.
Bringing clarity to quality – PCTs will want to consider:

- Using NHS Evidence to help them in their commissioning activities
- Using the NICE quality standards as they are developed to support commissioning across pathways of care.
Element 2: Measuring quality

“We can only be sure to improve what we can actually measure.”

Lord Darzi, High Quality Care for All, June 2008

The next stage in achieving high quality care requires us to unlock local innovation and improvement via the power of quality information. This section sets out:

- the role of PCTs in measuring the quality of local services
- some useful tools which can help
- where to get help in identifying suitable indicators
- using the data to support quality improvement.

Role of PCT in measuring the quality of services

Measurement and information is an essential part of understanding the quality of services, but the real key is what to do with that information to create quality improvements in patient care. PCTs have an important role in collating and assuring local information, which when properly interpreted can help show clinical teams where they most need to improve, enable them to track the effect of changes they implement and highlight examples of high quality care that can be shared both locally and nationally to effect wider change. Without good comparative information, PCTs and clinicians cannot effect and support quality improvements or provide information for patients and the public (element 3).
The implementation of this vision was reinforced in Measuring for Quality Improvement: the approach\textsuperscript{13} a letter to NHS Chief Executives, Medical Directors and Directors of Nursing in November last year. This letter set out expectations and the support available for teams across the NHS to collect meaningful data about what they do before developing their own indicators of quality.

In line with these principles, PCTs will want to work with their clinicians to agree a robust and balanced set of quality metrics for the different primary care contracted services. The process of developing and agreeing this collection of meaningful data with providers is in itself extremely valuable. It can stimulate a focused discussion with contracted providers about current levels of quality and performance, existing strengths and weaknesses, and priorities for the future at a local and national level. This discussion should be the basis for agreeing quality metrics or indicators, and defining a shared understanding and common goal for improving the quality of services for patients.

Agreeing a set of local indicators does not mean creating a unique set of purely local metrics. Although there may be circumstances where it is appropriate to develop some local indicators taken from examples of best practice, many of the indicators that PCTs choose to agree with providers will be taken from nationally collected data sets. These national data sets bring with them the benefit of being able to benchmark information across providers. The important part is agreeing a set of locally appropriate and relevant indicators.

\textsuperscript{13} Measuring for Quality Improvement: the approach
The starting point for agreeing these metrics will be different for each provider and improvements will vary. However all will want to consider having an agreed plan in place for showing improvement over time, as well as support and the sharing of good practice from providers with similar profiles and demographics. The purpose is to pull quality up towards the best and help the best get even better, not to impose sanctions on the worst.

**Dental Quality Framework: NHS Manchester**

A new dental quality framework has been developed collaboratively with commissioners, dentists and patients in Manchester. The key performance indicators (KPIs) within the framework provide the basis for the measurement of quality and oral health improvement within NHS Manchester contracts or contract variations. The overall aims of this activity are to increase access and achieve sustained improvements in oral health and NHS dentistry.

The scheme is based on earlier work in Salford and Oldham which sought to build primary dental care around a dental pathway. The pathway selection for patients is based on a need and risk assessment. Information from a clinical examination, medical history and behaviour/social history is used. The approach is supported by the contract specification and key performance indicators relating to quality of service and clinical outcomes have been developed and tested. The pathways are designed around evidence-informed protocols for preventive interventions and treatment. The pathways support selection
of appropriate recall intervals. Importantly, the indicators are not static. Robust evaluation is integral to the work and the pathways and indicators are evolving with time as the services, clinicians and commissioners learn and develop.

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Useful tools
There are a number of tools which can support PCTs and clinicians locally to measure quality improvement including:

Quality scorecards
The commissioning guides we have published have sections on the importance of transparent use of information in the ‘making it happen’ chapter and include details of quality frameworks or quality scorecards that many PCTs already use. These scorecards can draw together and triangulate data from a variety of sources, including national and local data and can be used to support quality improvement as well as other key initiatives such as Quality Accounts, which we will come onto later in element 3.

Together, this balanced set of data enables PCTs and providers to reach an objective and rounded view of quality and can encourage self-assessment and peer review. PCTs can access examples of scorecards at the NHS Primary Care Commissioning website as well as a step-by-step guide\textsuperscript{14} which can be adapted for all kinds of primary care contractors. There is also specific guidance and suggested definitions for dental scorecards\textsuperscript{15}.

Although a number of examples are readily available, the

\textsuperscript{14} Step by Step guide to developing quality scorecards www.primarycarecontracting.nhs.uk/346 (login required)
\textsuperscript{15} Suggested definitions for dental scorecards www.pcc.nhs.uk/360 (login required)
process of developing and agreeing this locally with providers is a valuable one. The process itself stimulates discussion about local performance, identifies strengths, weaknesses, and local priorities.

In developing a quality scorecard, PCTs can be clear about what the information is being collected for, and how it will be used to improve quality. The process can be time-consuming and, therefore will need planning and resourcing. Key steps to develop a quality scorecard are:

1. develop a vision – with all stakeholders, especially the service providers
2. develop a strategy
3. establish measurable objectives
4. establish a framework for objective measures and indicators and agree it with providers
5. ensure proper periodic review

Ideally, the scorecard should both benchmark trends across the health community and support individual provider development. It should help PCTs and primary care providers go forward together. We know that the inclusion of ‘benchmarkable’ information is powerful when used in a discussion about quality improvement. It enables providers who need to improve to see how they perform better in relation to their peers or those with a similar demographic profile. PCTs can help facilitate learning and support on how to improve, and spur them into action.

The development of a quality scorecard will represent a significant change in approach, culture and relationships between commissioners and service providers, and must be supported like any other change management process. Effective arrangements will be dependent upon shared ownership of the process, and it is important that expert information management and analytical skills are available to engender confidence in the robustness and presentation of the data. This works best when there is strong collaborative working between clinical leads, public health, informatics and commissioning teams. Trained assessors, who have the confidence of their peers, can work with and support practices and challenge performance. PCTs may want to introduce incentives and educational support for both leading edge and struggling practices. The aim is to encourage and support continuous improvement, and ‘raise the bar’.
PCTs will want to build relationships with service providers by effective engagement and regular communication. There should be protected time for evaluation and discussion. It is important that the process is transparent, including how the information is used, what incentives and support are available and when sanctions are necessary.

Clinical Dashboards
Clinical teams and PCTs are using other new methods to better measure the quality of the service that they provide to their patients. Clinical dashboards are an example of one of the new techniques being used. A clinical dashboard is a toolset developed to provide clinicians with the relevant and timely information they need to inform daily decisions about the quality of patient care. It gives clinicians easy access to real-time data being captured locally, in a visual and useable format, providing
comparisons to national datasets where available. Based on the first clinical dashboard prototypes developed, this technology benefits local clinical teams in many ways. The main benefits derived can be summarised as:

- improved decision making to manage clinical care
- facilitates immediate targeted decisions to improve patient care and avoids delays of data cleansing processes
- improved quality of care as peers compare performance
- reduced time and effort to capture and report information
- increased staff satisfaction (and hence performance) as teams feel ownership of the quality of care delivered locally
- improved data quality as a result of information being displayed locally and feeding back into more accurate original capture – reinforcing ‘capture once, use many times’ behaviour.

Twenty-two teams across the NHS are joining in this pilot. A GP practice dashboard has been developed with and is being piloted by Bolton PCT, where three GP practices are working with the acute trust and PCT to collect and display information on a range of quality improvement measures that have been agreed locally.
“From the outset it has been clear that the dashboard is a powerful tool to help clinicians understand the quality and effectiveness of their care. The dashboard in Bolton integrates a wealth of data related to practice performance, in addition to providing real-time data on patients’ urgent care attendances and hospital admissions – providing an invaluable tool to integrate and proactively manage care across our local health economy – and providing the means to unlock the potential of practice-based commissioning”

Dr Anne Talbot, GP Clinical Director, user of GP Clinical Dashboard – NHS Bolton

Primary Care Commissioning Support application

The DH has developed an application with the input of over 20 PCTs and other stakeholder groups to enable the effective assessment and commissioning of GP services. It contains publicly available data on 101 different metrics. The application:

- gathers existing primary medical care data and presents it in a simple, actionable format
- presents analysis on current and future population needs, and supports commissioners’ planning to adjust primary care capacity to meet those needs
- presents PCTs with a set of indicators enabling benchmarking at both GP practice and PCT level, this can also be configured locally for practice-based commissioning (PBC) clusters
- allows PCTs to enter additional data about their GP practices to enable more detailed comparisons and insights.

16 For more information, please contact pccsteam@dh.gsi.gov.uk
The application is designed to generate insights that will enable PCTs to:

- assess their commissioning needs and develop strategies to meet them
- identify areas where the PCT and GP practices are performing well relative to peers and highlight areas that may deserve further attention
- understand practice change dynamics, identifying areas of high quality where providers continue to improve year on year. This information could support future PCT investment decisions in extended services.

The 101 metrics seek to provide a rounded picture of GP services in each PCT to help PCTs map their baseline. They can then use this information to begin discussions with local providers about the quality of their services, maybe as compared to other local providers, or one in another part of the country with a similar demographic, by comparing to their ONS cluster. PCTs can share this information with providers, and then work with them to decide locally which of the indicators in the application
or other indicators best capture quality at individual GP practice level. Many providers have also found the insights within the application very helpful in their own quality improvements. The following extract from the application user guide demonstrates how it can be used:

<table>
<thead>
<tr>
<th>Step</th>
<th>Example questions</th>
<th>How the GP Services application can help you answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mapping the baseline: Where are you now? Assess needs Identify what needs to change</td>
<td>How effective are we at maintaining the health of our diabetic population compared to PCTs with similar populations? Are these results spread equally across our GP practices, or are high performers that can share good practice or leadership with other providers</td>
<td>Using the application you can perform several analyses on diabetes management, for example you can look at the QOF measurement of HbA1c under 7.5 and see whether you are in the lowest or highest quartile of PCTs in England</td>
</tr>
<tr>
<td>2. Developing the vision: Where do you want to be? Patient offer Strategic service moves</td>
<td>What’s a realistic aspiration for your PCT – should it be aspiring to be above average, top quartile, or top 10%? Who are the standout practices or PCTs you could learn from to further improve toward your aspiration</td>
<td>You could use the application to identify the three most improved practices in your PCT on the HbA1c indicator over the past year as a first step to identifying best practices to spread</td>
</tr>
<tr>
<td>3. Making it happen: How do you get there? Transparent information Increase choice and capacity Performance development</td>
<td>What structural moves could I make that might have an impact on HbA1c results?</td>
<td>You could use the application to check to see whether structural factors like increased capacity, access, or expenditure have a history of correlating with good results on HbA1c</td>
</tr>
</tbody>
</table>
The PCTs that have helped develop the application and the six PCTs who have more actively piloted it found that it combined data credibility, relevance and ease of use.

**The NHS Information Centre**

The NHS Information Centre\(^{17}\) (The NHS IC) is England’s central, authoritative source of health and social care information. It acts as a hub for high quality, national, comparative data for secondary uses, delivering information for local decision makers to improve the quality and efficiency of frontline care. The NHS IC publishes QOF achievement, prevalence and exception reporting data annually at national, SHA, PCT and practice level. This includes a statistical analysis, data tables and an interactive database that allows comparison achievement by individual practices with the PCT and national average.

The NHS IC also runs the national datasets service. This service undertakes the co-ordination, development, adoption and ongoing maintenance of national datasets in England. The programme of work is driven by the need for quality information to support planning, delivery and monitoring of services within health and social care. There are currently few data standards in primary care but this will be further developed via the GP extraction service (GPES).

**General Practice Extraction Service (GPES)**

GPES\(^{18}\) is a centrally procured primary care data extraction and analysis service that will obtain information from NHS GP systems in England with the aim of improving patient care and service delivery.

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\(^{17}\) The NHS Information Centre http://www.ic.nhs.uk.

\(^{18}\) http://www.ic.nhs.uk/services/in-development/general-practice-extraction-service
Some of the benefits of GPES we can expect include:

- improving the coverage and quality of current primary care audits and allowing the development of future audits
- providing a factual foundation for the allocation of resources and payments in order to improve the efficiency and outcomes of patient care
- improving national and local public health surveillance to target areas of need such as infection control, immunisation and sexual health programmes
- providing information to support the commissioning of local care services to secure health improvements and address inequalities
- providing a focus for the development of clinical and data standards in primary care
- helping PCTs to meet the requirements of relevant equality legislation.

The use of a combination of these tools described in the section may, for example, identify a need to focus across the PCT on health inequalities or the needs of a specific group. There are a number of ways PCTs can analyse the data across the dimensions of inequalities (such as gender, age, socio-economic group, ethnicity etc) that will help focus attention on those with greatest need for care. For example, the GP patient survey data can be broken down by age, ethnicity & disability and there are plans in place as part of the forthcoming GPES project to allow more sophisticated data analysis of these sort of categories from GP systems in England.
NHS Comparators

NHS Comparators\(^\text{19}\) provides comparative data to enable commissioners and providers to investigate aspects of local activity, costs and outcomes.

Over 140 comparators are included. The data currently being used include:

- secondary care activity (SUS)
- GP list size (population data)
- QOF
- prescribing

It is designed to make information easily available and understandable to a wider audience, allowing clinicians and managers to investigate comparative access rates and performance at aggregate level by GP practice, PCT level, and provider level or above.

Local knowledge is usually necessary for clear interpretation but the comparators may indicate areas where activity or clinical practice is out of line with peers, with possible quality of care implications or areas with potential cost savings.

Commissioners can use NHS Comparators to identify and investigate differences in referral and access rates to secondary care.

\(^\text{19} \text{ NHS Comparators } \text{http://ic.nhs.uk/nhscomparators} \)
NHS Benchmarking

NHS Benchmarking\textsuperscript{20} is a network that enables PCTs to share best practice and learn from each other. At any time, the NHS benchmarking network is running a number of specific projects on topics suggested by members. Member organisations have the opportunity to collect data and submit it which is then compared and good practice identified. Contributors have access to the detailed data from other contributors so that they can see how they are performing in comparison to others. The network produces anonymised benchmarks for over 500 primary care indicators provided directly by PCTs including value and health gain from local enhanced services (LES).

Public Health Observatory (PHO) data

One important facet of understanding the whole health economy is to look at public health information about the community. One way to access this information is via the Community Health Profiles\textsuperscript{21} available through each PHO. It is important to consider the wider determinants of health, such as the social and educational underpinnings, to understand how well a community functions. Health profiles provide a snapshot of health for each local council in England using key health indicators, which enables comparison locally, regionally and over time. They are designed to help local councils and the NHS decides where to allocate resources and tackle health inequalities in their local area.

\textsuperscript{20} NHS Benchmarking http://www.nhsbenchmarking.nhs.uk/ Needs login
\textsuperscript{21} community health profiles http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES Safari HTML\ Shell\ Open\ Command
Some PHOs also produce very useful practice profiles\textsuperscript{22}, including the Eastern region PHO, which has useful descriptors of different primary care databases\textsuperscript{23}.

**World class commissioning (WCC) data packs**

The WCC data packs\textsuperscript{24} are an online resource, produced by the Information Centre on behalf of the DH. They bring together data from multiple sources to provide a profile of PCTs, enabling them to monitor trends and compare their performance against national data and that of their peers. This resource facilitates decision making at all points of the commissioning cycle with specific regards to planning, procuring, monitoring and evaluating services.

The 2009/10 data packs cover around 250 indicators and are designed to help PCTs prepare for the second round of the WCC panel assessments in early 2010. The data is regularly refreshed, providing an essential resource for commissioners throughout the entire commissioning cycle.

The 11 WCC organisational competencies set out the knowledge, skills, behaviours and characteristics PCTs must achieve in order to become world class commissioners. Competency 5 is aimed at ensuring all commissioning decisions are based on sound knowledge and evidence. The competency examines how well PCTs manage knowledge and undertake regular needs assessments, using knowledge management, actuarial and analytical skills. By identifying current needs and

\textsuperscript{22} Practice Profiles \ http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILESSafariHTML\Shell\Open\Command

\textsuperscript{23} Different primary care databases \ http://www.erpho.org.uk/topics/pc/pc.aspxSafariHTML/Shell/Open/Command

\textsuperscript{24} The resource is available online at: \ www.wccdatapacks.ic.nhs.uk
anticipating future trends, PCTs will be able to ensure that current and future commissioned services address and respond to the needs of the whole population, adding life to years and years to life.

The WCC data packs provide PCTs with the information they can use for this purpose.

**Primary Care Information Service (PRIMIS+)**

PRIMIS+ is a service provided on behalf of the NHS IC by the University of Nottingham. It helps GP practices improve patient care through the effective use of their clinical computer systems. It provides training and assistance to information or data quality facilitators and other appropriate staff employed by PCTs or local Health Informatics Services (HISs). These facilitators then “cascade” their knowledge and skills to GPs and practice staff in their local health communities. It also provides data analysis tools to help practices monitor their data and benchmark against other anonymised practices at local, regional or national levels.

The current PRIMIS+ contract expires in March 2010 and the NHS IC is in the process of designing and procuring a replacement service - the Healthcare Data Quality Service (HDQS). This is being designed to improve data quality and information management skills. It will support frontline staff to ensure the right information quality, governance and standards are applied in data systems and to data collections, analysis and reporting.

**Quality Management and Analysis System (QMAS)**

The Quality Management and Analysis System (QMAS) is a national IT system which gives GP practices and PCTs objective evidence and feedback on the quality of care delivered to
patients. It supports the QOF element of the GP contract and has been in operation since 2004.

QMAS shows how well each practice is achieving against national QOF indicators and looks at recorded prevalence in major disease areas. Access to the system is also provided to PCTs so that practices and PCTs can share information on achievement throughout the year and therefore encourage and support case finding and care of those patients within the indicator groups.

As practices are rewarded financially according to the quality of care they provide, it is essential that the payment rules that underpin the General Medical Services (GMS) contract are implemented consistently across all systems and all practices in England. QMAS ensures that this is achieved.

The NHS Business Services Authority dental services (NHSDS)
The NHSDS25 holds national data about NHS dental activity, treatments and payments. It provides monthly management information reports to PCTs and SHAs. NHSDS also provides a national level monitoring service through patient questionnaires and through the clinical monitoring activities of the dental reference service. Reports on these activities are provided to PCTs.

Patient reported outcome measures (PROMs)
PROMs is a means of assessing the effectiveness of care from the patients’ perspective. The DH is exploring actively the potential

25  NHDS www.nhsbsa.nhs.uk/dental
for the routine collection and use of PROMs data in a primary and community care setting. The initial focus is upon six long-term conditions including asthma, chronic obstructive pulmonary disease (COPD), diabetes, epilepsy, heart failure and stroke.

**Identifying suitable indicators**

Clearly some of the tools set out above, such as the primary care commissioning support application, include indicator sets that PCTs can use in measuring and supporting quality improvement. Although this can provide a useful starting point for local discussions, the importance of identifying locally appropriate indicators cannot be underestimated. This section sets out national sources of information, existing indicators or work planned and underway, which can provide a useful resource for PCTs when considering suitably meaningful indicators to measure quality improvement locally with providers.

It is important to understand what constitutes a good indicator so that the most appropriate can be selected and the potential advantages or weaknesses understood. The Good Indicators Guide: Understanding how to use and choose indicators, published by Association of Public Health Observatories (APHO) and the Institute for Innovation and Improvement is a short practical resource which provides a good starting point to work from.

Indicators should be:

- clearly described
- measurable

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• easily recorded and collected
• examples of universal practice to allow for effective benchmarking.

Indicators for Quality Improvement
The Measuring for Quality Improvement (MQI) programme started the process of identifying and assuring indicators aimed at enabling the NHS to improve the care it delivers. Earlier this year, the NHS Information Centre published the initial set of indicators for quality improvement\(^\text{27}\) aimed particularly at staff in clinical teams. The initial menu is made up of existing indicators which are supported by clinicians and NHS professionals as effective quality indicators; these cover ten key pathways of care using the three key domains of quality – safety, effectiveness and patient experience.

The primary care indicators that are included come largely from the QOF. This does not mean that these QOF indicators are more important than other QOF indicators, or that other QOF indicators are not “assured”, or ones derived from other sources are not important. The QOF indicators included have been chosen because of their relevance to the care pathways set out in the menu.

These indicators are not a new set of targets, nor are health economies expected to use all criteria – and they are certainly not meant to stifle local innovation in measuring quality. These indicators are intended to complement those already being used by practitioners and services and build on existing processes for developing and assuring primary care.

\(^{27}\) Measuring for Quality Improvement: Indicators for Quality Improvement
http://www.ic.nhs.uk/services/measuring-for-quality-improvement
The indicators are intended to be a resource for PCTs and local clinical teams for a variety of purposes, providing a set of robust metrics from which they can select as a basis for local quality improvement and benchmarking. In time it will encompass all sectors of healthcare that increasingly reflect pathways of care rather than providers of care or single professional approaches. As they become adopted, they will offer consistency and support comparison and benchmarking across services. This information may be used by commissioners and providers which can then be incorporated into contracts and specifications relevant to local patterns of service provision.

The indicators for quality improvement do not yet cover the breadth of primary medical care, nor are there any specific indicators for dentistry, optometry or community pharmacy currently. Nationally, we are working with the NHS Information Centre alongside the NHS and professional stakeholder organisations to develop this wider range of quality indicators across primary care. There is also specific work being planned or implemented in the less well developed areas of primary care metrics:

- the dental clinical effectiveness and outcomes Group, made up of key stakeholders, including the British Dental Association, general dental practitioners and patient representatives are currently looking at developing quality indicators for dental pathways and dental health outcomes, as part of the recommendations of the Steele review to develop a common set of national indicators that can be used locally to measure the quality of processes and outcomes delivered by providers in a meaningful way.
the dental access programme is also looking at KPIs to help PCTs in procurement and contracting of new services. These KPIs are being developed as part of a new model contract which will be available for PCTs to use at their discretion when contracting with dentists.

as set out in the pharmacy White Paper, we are planning to develop a set of pragmatic, easily measurable indicators that will demonstrate the quality and outcomes of pharmacy service provision.

The eye care strategy group is planning to identify, and if necessary, develop evidence-based pathways for key eye conditions to support commissioning decisions.

As part of this overall approach, a set of indicators is also being developed for community services by the Transforming Community Services Programme\(^{28}\), some of which may also be of value to primary care.

Governance arrangements are being developed to ensure that newer indicators can be tested and developed, and processes are being agreed for adding and retiring indicators.

We are currently assessing what presentation or analytical tools users would find helpful to make use of the indicators to support quality improvement activities. This is likely to build on a range of tools that have already been produced, such as that published by the NHS Information Centre, but also recognising analysis already being carried out at local and regional level.

\(^{28}\) www.dh.gov.uk/tcs
Public Health Observatories
The established network of PHOs produces information, data and intelligence on health and healthcare that provides practitioners and healthcare organisations with valuable intelligence.

The Association of Public Health Observatories (AHPO) publishes a range of resources and technical briefings, including health profiles for every local authority and region across England.

PCTs will wish to ensure that they make effective use of this resource to augment their own public health and epidemiological resources.

Quality Observatories
As Quality Observatories develop in each SHA area, they will provide a new capacity to analyse and develop quality information, and together with the existing skills and resources of PHOs will enable healthcare organisations to continuously improve the quality of healthcare – and improve the health of the local population. It will be important for PCTs to ensure effective relationships are developed with existing PHOs and the newly established Quality Observatories to share this experience and expertise, benefit from analytical support and interpretation of data and to ensure a coherent approach to indicators and quality improvement.

PCTs will also want to ensure that they have adequate capacity within their own organisations and easy access to suitable clinical advice, epidemiological skills and informatics support to effectively measure quality and understand how this data

29  http://www.apho.org.uk/
can be used and what this means for the quality of services provided locally. That might mean there is a training need for some existing staff. Whilst not everyone needs to be able to manipulate data in spreadsheets, everyone should be able to make sense of the results and judge their value.

**Using the data to support quality improvement: what could PCTs do?**

Measurement and information is an essential part of quality improvement but the real key is how that information is used to create improvements in patient care and health outcomes. As world class commissioners, PCTs can use tools such as the development of a quality scorecard with providers, or the use of the primary care commissioning support application (see page 26 - 29) to both highlight good practice and learn from it in order to disseminate it more widely across the patch or to identify areas for improvement.

Once the PCT has identified and prioritised areas for improvement, providers will need help to make that improvement a reality. For some providers, simply presenting the information or highlighting areas where improvement is needed will be enough. They will be able to put their own plans in place for improvement using the tools and information the PCT has shared with them to enable tracking the effect of changes they implement. PCTs can support these providers further by sharing examples of high quality care initiatives that they could use in their improvement. There are a number of sources for this sort of information, PCTs could recommend publications such as Improving access, responding
to patients: a how to guide for GP practices. This guide brings together good practice from around the country along with the benefits and drawbacks of different systems, services and approaches, with top tips and step-by-step guides to support practices improve access, quality and efficiency and respond to the ever growing needs and expectations of their patients.

Using data to make a real difference to quality of care for patients: Milton Keynes PCT

By drawing together and benchmarking local performance data, Milton Keynes PCT recognised that GP practices who had on average achieved poor diabetes QOF scores for several years had a correspondingly high emergency hospital admissions for diabetic emergencies.

It became clear that the care for adults with diabetes had tended to be centred on secondary care and that local primary care teams had become relatively deskillled in the management of diabetes. This led them to look at a redesign of local diabetes care to refocus services to create higher quality patient-centred care in primary care.

The PCT established a task group to develop a pilot diabetes improvement team, consisting of: two diabetes specialist nurses; sessions from two consultant diabetologists; input from a GP with a special interest in diabetes; a lead practice nurse who is a care planning expert; and some administrative and management time from a local entrepreneurial general practice.

30 http://www.networks.nhs.uk/practicemanagement/1253
31 sponsored by the Department of Health, and developed in partnership with the NHS Alliance, British Medical Association, National Association of Primary Care, Institute for Healthcare Management, AMSPAR, Royal College of General Practitioners and the Family Doctor Association,
Together, this group concentrated on:

- up-skilling clinical staff in the four practices with the 10% worst diabetes QOF scores, resulting in at least three of the practices halving the exception reporting for diabetes QOF in 2008-9 results; and

- rolling out care planning - helping those patients with diabetes take control of their condition and developing a tailored package of care to meet their individual requirements. In the last year, 18 of 27 practices have received training and support for care planning implementation.

The next stage will be to increase the number of patients receiving community-based care, and expanding the services into a fully fledged intermediate care team.

Contact: Diane.Gray@miltonkeynes.nhs.uk

However, some providers may need a higher level of support, such as training or commissioning specialist external support. As with all the contractor specific commissioning guides we have already published, there may be concerns that direct support will distort the market or compromise the PCT role as commissioner. However, we are clear that commissioners do have a legitimate role in directly supporting providers. The principles and rules for cooperation and competition\(^\text{32}\) state that it is expected that when commissioners work with providers to ensure a quality service is provided to patients, their approach must be transparent, fair and non-discriminatory. Direct support should be explicitly linked.

to the overall approach to managing quality and performance described in the contractor specific guides and PCTs should clearly define the circumstances in which they will provide support.

The contractor specific commissioning guides all set out details of the different kinds of support you could provide. These may address a specific issue, such as difficulties with appointment systems or poor quality premises, or be a broader package of support to help practices develop as organisations.

**Using quality information to create service change: Sutton and Merton PCT**

The department of public health at Sutton and Merton PCT conducted a primary care needs assessment project.

For approximately six months, one of the PCT public health consultants analysed routinely collected data at a public health level, presented at a practice level to enable comparison with the PCT average.

The data was presented as a series of bar charts with each practice displayed as one bar against a number of domains, taking into account the demographics of the population served by that particular practice.

As Dr Nav Chana, chair of integrated primary care commissioning in Mitcham says, “as a PBC cluster it is vital to understand what is going on and how to drive up quality. Using these more complex “adjusted” metrics highlights where the anomalies that need discussion lie, rather than focussing on “outliers” from a quick glance at unadjusted figures.”
Dr Chana’s PBC cluster has used this data to understand the differences between practices and the reasons for them. They have then shared this information across the practices as part of their own educational and developmental process. They have run an educational event at which each practice is invited to discuss the data in a safe, educationally facilitated way so they can learn and discuss how to improve services in the future.

The data has prompted Dr Chana to think about redesigning some services, “in my practice, where we have a high number of elderly people in a fairly deprived area, we are talking about redesigning services to offer more smoking cessation interventions, psychological interventions and to optimise proactive COPD care at home for domiciliary patients who find access to the practice difficult.”

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Measuring quality – PCTs will want to:

• work with their clinicians to agree a robust and balanced set of quality metrics for the different primary care contracted services and thereby define a shared understanding and common goal of improving the quality of services for patients

• use tools, such as quality scorecards, and advice on identifying suitable indicators, set out in this element to support them in this

• ensure that the information collated is used to identify areas for improvement and

• support providers to take action to make that improvement a reality creating better patient care and health outcomes.
Element 3: Publishing quality information

‘The NHS is accountable to the public, communities and patients that it serves.’

NHS Constitution, January 2009

As commissioners of primary care services, PCTs need to ensure that accessible, reliable and comparative information about the availability and quality of local primary care services is available to the public. This gives providers a powerful incentive to match or outperform their peers; and encourages PCTs to take the lead in improving the quality of services. It also enables the public to make informed choices about which services and providers they wish to access.

The commissioning guides already published which cover the four primary care contracted professions include a section on information for patients and the public in the Making it happen chapter. They detail specific information that might be useful for local people to know when making choices about the relative merits of different providers of the same primary care service, such as opening times, how to get there, services offered.

“An NHS that gives patients and the public more information and choice, works in partnership and has quality of care at its heart”

Lord Darzi, High Quality Care for All, June 2008
**NHS Choices**

From the autumn, patients will be able to compare GP practices on a range of information through NHS Choices. This will include details on opening hours; whether the practice is accepting new registrations; details of staff including female doctors; transport information, their catchment area, and results from the national GP patient survey, which now collects data on a wider range of basic quality measures. In the future, this facility will be rolled out for dental and optical practices and pharmacies.

The ‘scorecard’ type service will also contain information collected through a new ‘patient feedback’ mechanism (also due to go live in the autumn). This will enable patients to rate their practice, answer questions about the quality of services and leave comments for others to see.

This helps patients to make a more informed choice about where they want to be treated. It is important therefore for PCTs to encourage local practices to take ownership of their profile on NHS Choices and regularly update their key information on the site. This paints a more detailed local picture, reflecting the issues that matter most to local people, including information about the quality of these services.

Information will also be made publicly available by the CQC once primary medical and dental care providers are registered with them and it is likely that some of the information generated from GP practice accreditation, (set out in more detail in element 4) once it is introduced will be publicly available to inform patients and the public.
Research on public information about the quality of primary care services: NHS West Midlands

NHS West Midlands commissioned and funded the Health Services Management Centre at the University of Birmingham to develop the systematic provision of information on the quality of primary care services because it recognised that health and health services were difficult for the public to navigate. The Investing for Health project has a series of reports which examine evidence and good practice relating to the content, format and delivery of information for patients and the public, giving practical information, advice and guidance in a concise and easy to follow format on the following issues:

- what types of information do patients and the public need to make choices about primary care?
- the impact of information about the quality of services.
- what types of information do people find empowering?
- under what circumstances do patients and the public use health information to change behaviour?
- what skills do people need to access and understand information?
- what information formats are most effective and most suitable, particularly for those with low literacy levels and from less empowered groups?
- what support do people need to make informed choices?

The research broadly concluded that if patients and the public are going to be empowered to use information about the quality
of primary care then the content should be relevant, accessible and designed to suit different needs – it is the fit between information and its intended user which is critical. It found that the key to producing information which meets this standard is to involve a range of consumers in the development process from the outset.

The researchers also concluded that the content should include details about aspects of care that patients find important, although recognising that different groups may value dimensions of quality differently. A range of different styles of information would be useful – examples could include statistical information from patient surveys; contextual information such as services provided and details of the types of health professionals working at a practice and patient stories of how people experienced differences in quality of care and what they did in response to these.

This research could be extremely useful in the development of local quality accounts as well as patient information more generally to support patient choice locally.

For more information see http://ifh2.westmidlands.nhs.uk/ifh-key-documents/cat_view/12-investing-for-health-key-projects/24-real-time-patient-experience-feedback/60-communications/100-hsmc.html
Quality accounts

In order to cement this public accountability for quality, High Quality Care for All committed all providers of NHS care to produce annual quality accounts, just as many currently provide financial accounts. Information about the quality of services will be available to patients in a readily accessible format. They will make it clear to patients where an organisation is doing well and where there is room for improvement as well as providing an opportunity for providers to tell their quality improvement story and explain what they are doing to improve service quality.

Although we expect quality accounts to include a core national element, real quality improvement will only be delivered if it is driven locally by the Boards, clinicians and managers in NHS organisations. This is why the content will largely be locally determined to ensure that providers are able to publish information against the strategic priorities they have identified for improvement. Quality accounts will need to be accessible to members of the local community and should be developed in partnership with patients and other local stakeholders.

We are very keen to prevent duplication of effort. Quality accounts should be “owned” by the local contractor, but use information that has already been gathered – one data set, many uses.

We expect that providers of primary medical and dental care will be required to publish quality accounts between 2011 and 2012, subject to further testing and discussion with interested parties.

34 Quality Accounts
The first priority for quality accounts has been to agree how they will work for Acute Trusts. Testing has been conducted this year with acute providers in NHS East of England and NHS Foundation Trusts across the country in preparation for the first wave of Quality Accounts to be published for acute service providers in respect of the financial year 2009-10.

We know there are distinctive challenges for primary care providers producing their own quality accounts, both in terms of capacity and capability and potentially in the metrics available to include. This is why we are working with commissioners and primary care providers, as well as the Royal College of GPs, the British Dental Association and other stakeholders to test out quality accounts for primary care. This will help inform guidance and the sharing of best practice, which we will produce to support the introduction of quality accounts for primary care.

**Publishing quality information – PCTs will want to:**

- ensure that accessible, reliable and comparative information about the availability and quality of local primary care services is available to the public.

- encourage local GP practices to take ownership of their profile on NHS Choices and regularly update their key information on the site.

- be aware of the plans for quality accounts for primary care and support provider readiness for their production.
Element 4: Recognising and rewarding quality improvement

Organisations that improve the quality of care for their patients should rightly expect that the system recognises and in some cases financially rewards them for the effort and investment that they make. For primary care this includes:

- the QOF;
- commissioning levers that PCTs can use locally to recognise and reward quality including the Commissioning for Quality and Innovation (CQUIN) payment framework
- incentives in place for a broader range of clinicians to participate in practice-based commissioning
- accreditation schemes.

QOF

The QOF is an approach to improving quality of patient care through an incentive scheme. Although voluntary, the QOF is part of the GMS contract and any changes to it are negotiated with the British Medical Association’s (BMA) general practitioners committee. It is not confined to practices on the national GMS contract and has almost universal coverage of the registered population in England.

The purpose of QOF is to provide initial incentives that embed evidence-based care within general practice. Practices receive payments against quality indicators which are adjusted according to list size and prevalence of disease. This means that around
15% of practice payments nationally are dependent on quality of care rather than how many patients practices have on their list.

Changes agreed with the BMA as part of the 2009/10 GMS contract will strengthen the prevalence weighting. By April 2010 payments will be more in line with need in terms of numbers of patients with long term conditions and further incentivise case-finding. NHS Primary Care Commissioning provides a wealth of practical advice on QOF assessment, including a three-volume management guide on the subscription part of their website.35

We have fulfilled the commitment we made in High Quality Care for All to establish a new, more transparent process for reviewing the clinical indicators in the QOF. Furthermore, we developed better indicators that promote health, help address health inequalities and create better incentives for continuous quality improvement. From April 2009, NICE has become responsible for the process to review clinical and health improvement indicators and develop new indicators, making their first recommendations in August this year.36

Priorities for recommending new indicators are made by an independent QOF advisory committee, based on the impact on health and inequalities. The new process will ensure that all indicators proposed for inclusion in QOF are based on best available evidence of clinical and cost-effectiveness. It is important that indicators are regularly reviewed and are able to evolve, for example, through modification of thresholds, or be replaced, in an instance, where the activity being measured has become part of standard clinical practice and therefore should

35  http://www.pcc.nhs.uk/
36  Available at www.nice.org.uk
no longer be incentivised. NICE will also provide information based on the assessment of cost-effectiveness evidence to inform the financial value of indicators. The final decisions on which indicators will be included in QOF and on the payment levels will depend upon negotiations between NHS Employers and the BMA.

We remain committed to empowering the local NHS to have a say in how investment should be used to the benefit of their populations. Where indicators from the NICE menu are not included in the national QOF, they will be available for PCTs to adopt for local quality schemes using local contracts, together with clinical and cost effectiveness evidence. Over time, we will need to review the balance between national and local investment for quality of care to ensure that PCTs are able to address the particular health needs of their local populations, whether this is through the QOF or LES.

Although there are no national QOF schemes for the other contracted providers, a number of PCTs have developed their own local schemes for other providers.

**Pharmacy QOF: Doncaster PCT**

In April 2008, NHS Doncaster launched and implemented a local QOF for pharmacy contractors. The scheme has been developed along similar principles to that already established for general practice.

Indicators were developed with the support and contribution of the pharmacy primary care development groups and the local pharmaceutical committee. The objective of the scheme is to encourage pharmacies to implement processes, practices and
systems that go beyond the basic contractual expectations and deliver services that are recognised ‘best practice’. The indicators developed for the pharmacy QOF reflect this aim.

NHS Doncaster has recruited and trained a multi-disciplinary team to conduct annual review visits. The first year of the pharmacy QOF demonstrates excellent levels of achievement and excellent progress in improving the quality, processes, practices and systems.

The underpinning evidence from the QOF also strengthens contractor’s compliance with standards for better health and governance.

Indicators for the 2009/2010 QOF have been further developed to ensure continuous quality improvement.

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Local commissioning levers to reward quality

“A system that rewards quantity alone is no longer appropriate: it misinterprets the purpose of dental care, reducing it to a shopping list.”

Professor Jimmy Steele, NHS Dental Services in England

PCTs may wish to create other local incentives for providers to improve quality. This might include:

- treatment of a particular condition, such as primary prevention of heart disease or improving oral health
- developing services for a particular group, such as services for substance misuse or to stop smoking, or
• setting higher standards for a specific group, such as people living in particularly deprived areas, the homeless or travellers.

PCTs can already use contractual mechanisms to incentivise providers. These include introducing a LES for contractors, or building the requirement into the core specification for local contracts. When developing local incentives, which can be either long-term or short-term, PCTs should make sure that:

• they are not paying twice for activity that should be provided as part of the core contract

• incentives support reductions in health inequalities, for example by focusing on those members of the local population who have the greatest need for specific interventions

• indicators agreed to measure quality are outcomes focused rather than quantity focused

• they are not creating a culture in which providers expect additional payment before implementing good or effective clinical practice or improving service delivery

• the effectiveness of the enhanced service is audited – and the audit is used to inform further development.
Local commissioning of community eye care services: NHS North Lincolnshire

NHS North Lincolnshire has commissioned a community based optometry referral scheme to provide patients experiencing recently occurring eye conditions with faster access to appropriate care closer to home, reducing referrals to secondary care and generating cost savings.

Building on the specialist knowledge and skills of optometrists, the scheme has been developed in partnership with local optometrists and GP practices and the local optical committee. Participation in the scheme is linked to completion of an accreditation scheme, with agreed local standards and appropriate safeguards for patient safety.

12 out of 18 opticians in North Lincolnshire participate in the scheme and 440 patients were seen during 2008/09, and a local audit has shown that only 15% of patients seen were referred to secondary care and has received positive patient feedback.

Geoff Wayte, a local optometrist who was instrumental in helping establish the scheme, said: “Patients certainly seem to appreciate the rapid access to treatment which this scheme offers, and I consider this to be a successful patient-centred service.”

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In examples of the best local commissioning available, PCTs have developed local schemes to build quality measures into contracts and have invested time in engaging with both patients and providers. Non-monetary support is another way of encouraging quality. PCTs might want to provide training, equipment or
back-fill of staff time to enable completion of a specific task or initiative. PCTs such as Southwark use protected time for all their practices by providing the equivalent of out-of-hours cover, allowing occasional closure of the practice during the day for service development and learning together.

**Innovative commissioning of low vision service: Gateshead PCT**

An innovative low vision service integrating optometry and vision rehabilitation in one seamless process is provided in Gateshead in a community setting, thereby reducing the demand on secondary care. Service users were involved in service design and evaluation, which also helps to reduce need for people to travel out of the borough to access the hospital based low vision service. The patient receives a full optometric and vision rehabilitation assessment, appropriate low vision aids and a follow-up home visit to help them make maximum use of their remaining vision, remain safely in their own homes, and maintain their independence.

The service offers:

- a flexible appointment system, with a person-centred assessment
- information in appropriate accessible formats
- low vision follow up care
- a range of referral routes
- reduced waiting times for low vision and rehabilitation services
- a domiciliary service where appropriate

The service is a partnership between Sight Service, Gateshead Council and the PCT. It is based at Bensham Hospital within the premises of Sight Service, the local voluntary organisation for visually impaired people. This means that patients also have immediate access to a range of other services, advice and information, avoiding the need for onward referral and delays.

The service provider submits performance monitoring information on a monthly basis in accordance with the PCT’s Community Contract. Optometrists work to the General Optometric Council Standards and the service works to national low vision standards. The service has an established audit process including an annual independent audit led by the RNIB clinical lead. Patient satisfaction surveys are carried out and outcomes are shared with the team. As one satisfied patient said:

“If you go to the hospital, you’re just a number. But you come down here and they see you as a person.”

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CQUIN payment framework

Another local lever available to commissioners is the CQUIN payment framework. It came into effect in April 2009 for providers of acute, mental health, community and ambulance services on national standard contracts, but can also be applied beyond these sectors. The framework is designed to support the cultural shift to put quality at the heart of the NHS, making a proportion of provider payment conditional on achievement of locally agreed goals around quality improvement and innovation.
and so embedding quality considerations at the heart of commissioner-provider discussions.

The framework is not intended to replace nationally negotiated primary care incentive schemes, such as the QOF for GP services. Unlike the QOF, the CQUIN framework is a national framework for local schemes, reflecting local quality improvement priorities agreed between local commissioners and providers. CQUIN goals should be ambitious and focussed on continuous improvement beyond minimum standards or contractual requirements. Commissioners may want to consider using the framework, alongside other contractual levers, to apply the principles of the CQUIN framework to primary care and community providers on local contracts, such those for out of hours services, locally enhanced services or integrated care pilots.\(^{37}\)

**Practice-based commissioning or ‘clinical commissioning’**

*Clinical commissioning: our vision for practice based commissioning*\(^{38}\) published earlier this year set out the support and entitlements that practice-based commissioners can expect, and the principles that should underpin vibrant, productive partnerships between PCTs and PBCs.

PBC provides a framework which local clinicians can really use to drive continuous quality improvement and innovation across the whole system, securing better value for money in the process. Successful PBC will combine the local knowledge and professional expertise of GPs and other clinicians with increasingly powerful tools. These datasets give deeper insights.


into the impact on individual patients of wider changes in services or pathways. PBC will be able to identify often small changes that can radically improve quality of care for local patients and value for money.

Not all clinicians want an enhanced role in commissioning. But we want to make sure that those who do and are demonstrating evidence of their success have the incentives, support and opportunities – both nationally and from their PCT – to develop as clinical leaders to take PBC to a new place. We know from speaking to clinicians, PCTs and other stakeholders that a lack of consensus over the right balance of incentives has been one of the barriers to progress with PBC. Section 7 of the PBC vision sets out what we see as the natural evolution of PBC (with the right leadership from both PCTs and from clinicians) where clinicians are able to take on more explicit accountability for the use of health resources. Where high performance has been established, we envisage world class commissioners increasingly devolving areas of their budget (e.g. for particular conditions or pathways) to clinicians so that they can secure more integrated and preventative care that meet the healthcare needs of the local population.

**Breaking new ground in PBC: Bexley PCT**

When PBC began in Bexley the PCT was in financial deficit, says Dr Joanne Medhurst, lead for the Bexley PBC federation of consortiums. ‘PBC was thought to be a way of helping to control expenditure in the trust and to bring us back into financial balance. And for two years running it has achieved that.’
The federation is an umbrella organisation representing three consortiums, covering about 210,000 patients. Initially set up to drive PBC, it now operates on a strategic level, while 26 GPs across Bexley lead on clinical services.

Dr Medhurst says Bexley has been able to come up with some groundbreaking PBC initiatives because federation members sit on the PCT board, and GP clinical leads are consulted on any major service issue.

Major schemes include a cardiology service where virtually all aspects of the specialty, other than interventions, are carried out in the community.

The GPs receive real delegated budgets for prescribing, Dr Medhurst explains. If practices make savings they can use them, but they are also accountable for any losses.

To date, PBC activities have resulted in freed-up resources of £4m, which are being used for local incentive schemes and to pay staff for PBC work. The money also funds a ‘GP credit scheme’, where five newly qualified, local GPs work four to six sessions a week in different practices. This frees up doctors to work at the PCT on PBC projects.

A PBC provider company is being set up, which all GPs are eligible to join. ‘The PCT asked clinicians if, as well as being part of a service redesign, they would like to provide services. We decided to create a large, local company to give us more credibility when tendering than if we were working in a fragmented way,’ says Dr Medhurst.
Practice accreditation

“Patients deserve high quality care, regardless of where they live. GPs and their teams want to do the very best for their patients and professionally-led accreditation is a way forward which will help drive up the quality of care provided by every practice for every patient.”
Professor Steve Field, Chairman of the Royal College of General Practitioners

Accreditation schemes are already being used in different parts of the NHS, enabling clinicians to lead the way in healthcare quality. Accreditation and peer review have been used in different ways in different healthcare systems. Research suggests that accreditation can:

- ensure minimum levels of quality
- promote continuous quality improvement
- increase a provider’s reputation with service-users
- promote capacity-building and organisational learning, and
- enhance patient safety.

In the UK, the function of quality assurance will be met by CQC registration (see element 6). We believe that practice
accreditation could fulfil a complementary role by promoting continuous quality improvement and providing information on quality to patients and the general public.

More widely, it is clear that accreditation has not had a clear unifying purpose across different schemes. As such, following the publication of *High Quality Care for All: Our Journey So Far*[^39], the Academy of Medical Royal Colleges are leading work to develop a common approach to accreditation. This work will be considered by the national quality Board at their meeting in December 2009, ahead of being publicised more widely.

In primary care, we are committed to promoting the use of accreditation to drive continuous quality improvement. We have supported the Royal College of General Practitioners to develop an accreditation scheme for GP practices called primary medical care provider accreditation (PMCPA). This scheme has been piloted in 32 practices across England with positive feedback from practice staff. The scheme involves mixed teams (drawn from GPs, other professions and lay assessors) who will undertake a rigorous assessment of the systems used by GP practices to ensure the safety and quality of the practice. As well as assessing compliance with minimum criteria, it will pinpoint areas where practices have most scope to improve quality. This will act as a spur for continuous improvement.

Practice accreditation can complement the broader quality and clinical governance initiatives led by PCTs and support GP appraisal and QOF assessment. The evidence collected to support practice accreditation may also be useful as part of

the evidence to support revalidation, for example, participation in clinical audit, which is set out in more detail in element 6. Together with the planned publication of quality accounts, practice accreditation could provide tangible evidence of quality improvement to patients and the public and enhance the reputation of the NHS. PCTs may wish to encourage GP practices to participate in the scheme and work with them to address where there is scope for improvement.

Whilst there are currently no plans in place for national accreditation programmes for the other primary care contracted professions, there are a number of examples of local accreditation schemes in place across the country.

Dental practice accreditation scheme: Heart of Birmingham PCT

The dental practice accreditation scheme (DPAS) is a collaborative initiative between Birmingham dentists and Heart of Birmingham PCT to improve the quality of care for patients. Using recognised standards such as the BDA “good practice scheme”, they have developed management systems and training which are regularly checked and audited. Patient representatives gave their advice about issues including signage and ease of access.

The PCT visited each dental practice and produced an action plan in co-operation with the dental teams. Funding has been directed where it was needed, for example to purchase more dental instruments and high technology washer disinfectors, and follow-up visits are undertaken to check on improvements. The action plans included innovative tasks such as placing health exchange workers in reception areas to advise clients about their general health improvement.
Analysis of statistics from the dental services division was followed up with targeted record keeping audits to monitor treatment planning skills and provide probity and value for money for the tax-payer. A tailored education programme was delivered by the dentist and dental nurse tutor to enable the teams to fulfill their action plans. Peer review of case studies and a health promotion project added to the educational value. Attendance at the postgraduate forum has improved.

To gain accreditation, practices will have to show compliance across seven domains, and any practice with inappropriate exception reports will need to demonstrate normal returns for at least 2 quarters to gain accreditation. A record keeping audit showed more complete records compared with a control group. Independent infection control audits have also been made and there is compliance with an enhanced clinical governance checklist.

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Quality accreditation scheme for primary care: NHS Nottinghamshire County
Following both a pilot and consultation, the quality and safety team for NHS Nottinghamshire County have developed a quality accreditation scheme for primary care - ADVANCE. It will enable GPs, dentists, community pharmacists and optometrists to improve the quality of patient care, experience and safety through the development and implementation of robust systems and processes. Four schemes have been developed, one for each contractor groups.
This scheme will also provide practices and pharmacies with the mechanism to achieve accreditation for quality following an assessment and accreditation visit. It has been incentivised through a LES.

Practices and pharmacies are required to work towards and achieve a full range of quality standards from a framework set out in three levels as follows:

**level one** – contains indicators considered to be a priority, e.g. infection control, safeguarding children

**level two** – contains quality indicators relating to national regulatory standards

**level three** – contains quality indicators considered to be as “Gold Standard”, using other national and local documents and guidelines

The three levels must be achieved in a minimum of one year, and a maximum of four years. Practices are assessed after each level, and accreditation awarded if fully compliant with all the indicators in each level. The assessors have been recruited and trained.

Each practice receives a pack that contains the indicators, guidance, a toolkit (which identifies a set of minimum criteria for each indicator), contacts for support, and CD Rom of model procedures and templates.

Benefits include:

- enabling practices to develop robust systems and processes within the practice in order to facilitate
continuous improvement of patient care, experience and safety

- demonstrating to patients and the public that the practice has achieved a quality award
- enabling GP and dental practices to prepare themselves for the new practice registration requirements
- providing a method of demonstrating to the PCT that the practice has achieved a quality award to support an application for PCT funding initiatives, or be considered as part of a tendering process
- supporting practice development
- facilitating good team working and communication within the practice.

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Recognising and rewarding quality improvement – PCTs may want to:

- develop their own local quality incentive schemes using local contracting routes, including use of the CQUIN payment framework
- encourage GP practices to participate in the GP scheme and work with them to address where there is scope for improvement
- develop their own accreditation schemes for wider primary care services.
PCTs will want to:

• support GPs to become practice-based commissioners, develop in their role, and where high performance has been established, devolving areas of their budget (e.g. for particular conditions or pathways) to clinicians so that they can secure more integrated and preventative care that meet the healthcare needs of the local population.
Element 5: Providing leadership for quality

‘Clinicians have a clear leadership responsibility to deliver on quality and the optimal utilisation of resources. We ‘spend’ most of the money, commit most of the resources, who best to challenge where clinical quality is poor and to always improve on the best.’

Dr David Colin-Thomé, National Clinical Director of Primary Care

We know that enabling the systematic improvement in the quality of local services cannot be achieved without engaging and empowering frontline staff to make necessary changes. We also know that PCT Board and executive level engagement is essential to make this happen.

Clinical leadership and involvement is a critical and integral part of the commissioning process. PCTs as world class commissioners will need to ensure demonstrable clinical leadership and engagement at every stage of the commissioning process. Clinicians are the local care experts who understand clinical needs. They have close contact with, and good knowledge of the health status of the local population. By encouraging clinical involvement in strategic planning, service design and quality improvement, world class commissioners will ensure that the services commissioned reflect the needs of the population and are delivered in the most personalised, practical and cost effective way possible. We know that with the forthcoming demand for efficiencies in the system, that the role of clinical leadership is more important than ever in creating better health, better quality care and better value.
“Clinical leadership and engagement are essential if PCTs are to become world class commissioners. We need to have clinicians from all sectors engaged in care pathway redesign and leading change.”

David Nicholson, NHS Chief Executive

**Practice-based commissioning**

PBC has the potential to transform care services by putting clinicians at the heart of PCT commissioning and strategic planning. Groups of family doctors and community clinicians will develop better quality services for their local communities, across the whole health economy, not just in secondary care.

“The case for the greater involvement of clinicians in commissioning through PBC, leading transformational change within local health services remains as compelling as ever”

Dr Johnny Marshall, Chair, National Association of Primary Care

As described in element 4, *Clinical commissioning: our vision for practice based commissioning* was published earlier in the year to firmly position PBC as providing the clinical leadership that should be at the heart of world class commissioning, ensuring a relentless focus on high-quality services. We know that where we have empowered local clinicians they have risen to the challenge and delivered real improvements for their patients. The document provides clarity on what GPs can expect from PCTs and details the support available to help turn PBC aspirations into action.
Primary care clinicians have a central role in using NHS resources to deliver high quality care for all. PBC local clinicians have much greater power and influence, working in partnership with PCTs, to shape how these resources are invested so that they deliver better health, care and value for local practice populations and the taxpayers.

Whilst not all clinicians want an enhanced commissioning role, PCTs will want to make sure that those who do have the support and opportunities to develop as clinical leaders.

PBC group creating improved services for patients: Croydon PCT
A consortia of practice-based commissioners in Croydon PCT has worked with Norbury women’s health clinic to create a one-stop, GP-led service for women with menstrual problems with senior clinical input at an early stage.

This initiative was established with the purchase of a £25,000 ultrasound scanner, purchased by the PCT; with the consortia bringing in a gynaecology consultant, a GPwSI, a sonographer, nurse and healthcare assistant.

To date, average waiting time to see a senior clinician have been reduced from between 8-10 weeks to 2 weeks, with less than 10% of patients seen by the clinic needing referral to secondary care, where all were previously seen in secondary care.

As Dr Shah, a GP in Norbury women’s health clinic says: ‘the delivery of quality care to women in Croydon has been successful due to partnership with PBC Croydon and local secondary care.’

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Local clinical leadership

Evidence suggests quality improvement programmes that fail to engage doctors, and that are not sensitive to the nature of medical practice, tend to have a limited impact. It is therefore essential that PCTs support and engage their local GPs as well as nurse practitioners, practice nurses, dentists, optometrists and pharmacists to help deliver continuous quality improvement. PCTs have access to a range of local clinical leaders across the breadth of primary care, some of whom will be members of the PCT Board or members of the professional executive committee (PEC), but also officers of local representative committees (LRCs) and PCT advisors. PCTs will want to ensure that they have the right people round the table, covering all the contracted professions, and that the experience of these individuals are effectively harnessed both as champions for the quality agenda on the PCT Board and with their local clinical colleagues. PCTs can support the development of these individuals and manage succession planning, working with the Deaneries to ensure leaders of the future are developed.

The Steele dental review found that examples of excellent commissioning of dental services at a local PCT level primarily occur where there is a clear infrastructure in the Trust, supported by demonstrable leadership – both clinical and executive.

Clinical advisory groups

The NHS Next Stage Review was driven by the NHS and each region published its own vision for improving health and healthcare services. Local clinicians in health and social care – in partnership with patients – met in care pathway groups to

40 NHS Alliance discussion paper 2006, Royal College of Physicians 2008
consider the best available evidence and set out coherent visions for the future.

SHA medical directors are responsible for overseeing the implementation of local clinical visions, providing clinical leadership and work closely with professional executive committee chairs to spearhead quality improvement. The senior clinical leadership team within each SHA, supported by an SHA clinical advisory group, will harness the expertise and commitment of local clinical leaders. PCTs want to engage with these groups when implementing their own plans for quality improvement and ensure that the universal strategic plan improves the health of people in the UK.

Quality Observatories
As referenced to in element 2, each SHA will develop a quality observatory to support organisations to go further, providing local leadership and championing local improvement – building on existing analytical arrangements – to enable local benchmarking, development of metrics and identification of opportunities to help frontline staff innovate and improve the service they offer.

National leadership
At a national level, clinical leadership from the professional bodies across the four contracted primary care professions is of crucial importance in bringing large groups of clinicians on board as well as facilitating the sharing of best practice. As are the clinical leaders at the DH: Dr David Colin-Thomé, National Clinical Director for Primary Care; Barry Cockcroft, the Chief Dental Officer and Jonathan Mason, National Clinical Director
for Primary Care and Community Pharmacy. These national clinical leaders have been involved in the development of *High Quality Care for All* and the primary care and community services strategy (PCCS) and continue to be involved through the:

- **PCCS clinical advisory group** which includes representatives from across the four primary care contracted professions and advises on the continuing implementation of the PCCS

- **National Quality Board** brings professionals, regulators and patient groups together to ensure the whole NHS system is aligned around the quality agenda. Membership includes Professor David Haslam, President of the Royal College of General Practitioners and Sir John Oldham, GP and Managing Director of Quest for Quality;

- **National Leadership Council** aims to develop leaders at every level of the NHS.
Providing leadership for quality – PCTs will want to:

- ensure they have demonstrable clinical leadership and engagement at every stage of the commissioning process
- ensure that those GPs who want to become practice-based commissioners have the support and opportunities to develop as clinical leaders
- ensure that they have the right people round the table at key decision making forums, covering all the contracted professions, and that the experience of these individuals are effectively harnessed both as champions for the quality agenda on the PCT Board and with their local clinical colleagues.
Element 6: Safeguarding quality

“Although we have made good progress, we cannot be complacent about safeguarding quality. Our patients demand it and we must continue to rise to the challenge.”

Professor Mike Pringle, Department of General Practice, University of Nottingham

All organisations providing NHS care should ensure that care meets the levels of safety and quality that patients and other service users rightly expect. PCT commissioners and Boards should assure themselves that the services they have commissioned meet these levels of safety and quality and take any action where appropriate if they do not.

**Care Quality Commission registration**

The CQC will ensure that providers of health and social care continue to meet essential levels of safety and quality through ensuring compliance with registration requirements. One of the key principles of the new system is that there should be a coherent approach across public/private providers and health and adult social care. This will assure patients and people using services – irrespective of where they receive care – that these services will meet national requirements for safety and quality. All organisations that provide a service appertaining to the treatment of illness, injury, or surgery which are known as regulated activities will be required to register.

Following consultation, the Government announced the intention to bring primary medical and dental care providers within the scope of the registration system. For the first time, all the approximately 8,500 GP practices and 9,000 high street
dental practices will be required to register with the CQC, regardless of whether they provide wholly private or wholly NHS services, or a mix of both, and will be subject to meeting consistent essential levels of safety and quality. Providers will not be allowed to operate unless they are registered.

The need to ensure providers are adequately informed of the changes and given sufficient time to prepare for them means the earliest it would be possible to begin registering GP and dental practices would be from April 2011. Given the amount of information held by the dental services division of the NHS Business Services Authority on NHS dental practices, all providers of primary dental care will be required to be registered from April 2011. However, in the case of primary medical care, while we expect the process to begin in 2011, we are still working with key stakeholders to confirm when it will be possible to bring all providers into registration. We hope to announce this in due course, but expect that the latest that all GP practices will be required to be registered will be April 2012.

The CQC’s role in registering providers of services will complement and help strengthen a PCT’s core responsibility for managing primary care contracts: provide broader information about primary care services to the general public, and tackle unacceptably poor or unsafe performance. The approach must be light-touch, risk-based and proportionate. The CQC will work with patients and the public, the NHS and the professions to develop this approach in practice and to determine where best to deploy its regulatory focus.

Although primary care services provided by GPs and dentists will be registered with the CQC, it is not proposed that there should
be any requirement for community pharmacy to be routinely registered. This is because the current legislative systems for services provided by pharmacies are felt to be sufficient to protect patients. However, in the future, pharmacies may expand their activity to include regulated activities, which will need to be registered. The Government recently consulted on the establishment of the General Pharmaceutical Council as the new regulator for pharmacists, pharmacy technicians and pharmacy premises from 2010. These changes are designed to modernise and strengthen the regulation of pharmacy professionals to make the protection of patients and the public the first priority.

Without registration of retail pharmacy premises with the pharmacy regulator (current and future), community pharmacy providers would be unable to hold a contract to provide NHS pharmaceutical services. It is expected that registration with the future regulator will be subject to compliance with statutory essential levels of safety and quality. Subject to final decisions on setting these levels in relation to premises and parliamentary approval, PCTs will need to establish a close working relationship with the pharmacy regulator, facilitating local intelligence on pharmacy premises to ensure rapid follow up of any problems revealed by their assessments.

The new standards for pharmacy premises are likely to be introduced in 2010 (although there will be a two year grace period for premises to complete any work required to meet the new standards), and there will be an important role for PCTs and community pharmacy providers to inform the development of the standards.

In some, more rural, areas where a community pharmacy may not be viable, patients can receive their medicines from the surgery’s own dispensary. A voluntary dispensary services quality scheme42 (DSQS) is in place, which demonstrates a commitment by dispensing practices to achieving standards around governance, training and simple reviews of the use of medicines by patients. However – these requirements are not compulsory – which creates a disparity between dispensing by pharmacies (where qualifications and standards are defined by the pharmacy regulatory body and in regulations) and dispensing in GP practices. To enhance the service offered to patients, some dispensing practices employ a pharmacist or pharmacy technician. PCTs could also commission other pharmaceutical services to take place within dispensing practices.

It is not proposed that there should be any requirement for providers of primary ophthalmic services to be routinely registered. However, the DH is committed to keeping this under review. This is because the current legislative systems for primary ophthalmic services i.e. the NHS funded sight test, are felt to be sufficient to protect patients. However, in the future providers of enhanced primary eye care services i.e. services over and above the NHS funded sight test may include optical practices who are commissioned to expand their activities.

**Professional regulation**

A critical part of the drive to improve levels of quality in the NHS is to strengthen the quality of care provided by everyone who works in health and social care. Professional regulation will help to deliver the high quality workforce needed to ensure the safe,
respectful and effective care that patients expect, by supporting professional desires for high standards, excellent education and safely enabling new professional roles.

The Professional Standards Programme\(^{43}\) is integral to the delivery of the Next Stage Review’s central focus on quality. The programme seeks to raise the already high standards of the overwhelming majority of professionals, whilst ensuring that the small number of staff who let people down are swiftly identified and then dealt with fairly and quickly.

The key components of the programme are:

- increasing public and professional trust in the professional regulatory bodies
- ensuring, through revalidation, that those who provide care continue to be up to date
- ensuring through improvements to local appraisal and clinical governance that health professionals are raising further their high professional standards
- for the very small majority of professionals who fall short of their high professional standards, ensuring that there are fair and effective local systems to identify them and ensure appropriate remedial, performance or regulatory action to safeguard patients
- extending regulation to unregulated professionals and health and social care workers, where that is proportionate and will bring significant benefits to patients and service users

\(^{43}\) Professional Standards Programme

http://www.dh.gov.uk/en/Managingyourorganisation/Humanresourcesandtraining/Modernisingprofessionalregulation/DH_085902
• reforming the national regulatory systems for investigating and adjudicating on complaints about health professionals to enhance public and professional confidence in these systems.

The programme works on the general principle that risk to patients is most effectively managed at the point closest to the risks – at the point of delivery – and that it is for national organisations to provide the leadership, legislative framework, systems and resources to enable that risk to work well.

**Revalidation**

Currently to practise medicine in the UK a doctor is required to register with the General Medical Council (GMC). From 16 November 2009, all doctors will need a licence to practice in addition to their GMC registration to undertake any form of medical practice in the UK, including, but not limited to, writing prescriptions, holding a post as a doctor in the NHS, and signing death and cremation certificates. The GMC has asked all registered doctors to decide whether they need or want to hold a licence for the activities that they undertake. It will be the licence to practice, rather than the registration, that will give a doctor the legal authority to undertake the activities currently restricted by law to doctors who are registered with the GMC.

Doctors taking a licence will be subject to the requirements of revalidation when it is introduced.

PCTs will need to ensure that general medical practitioners take appropriate action and assure themselves that they remain registered with the GMC and have taken a licence. There is an existing requirement in the performers list regulations that
doctors will participate in the PCTs appraisal system.

The primary aim of medical appraisal so far has been to identify personal and professional development needs. The purpose of introducing a strengthened appraisal in the NHS in England is twofold - raising quality and assuring safety. First, it seeks to assure that all doctors meet the standards required to ensure patient safety by forming a key part of the evidence that doctors will provide to participate successfully in revalidation.

Second, it seeks to support and develop doctors to improve the quality of care experienced by patients. It will do so by ensuring more consistent clinical governance and appraisal arrangements for doctors, which enables a practice to be objectively and fairly assessed against clear standards and support them: to further develop skills and experience through life-long learning to improve patient care.

For the public, revalidation will provide confidence that the doctor from whom they are receiving treatment is up to date and fit to practise. For doctors, revalidation will support them by providing a framework through which they receive information about their performance. This will help identify their strengths, and key learning and development needs. Revalidation will provide an objective process for doctors to demonstrate that they remain up to date and fit to practise.

Health organisations, including PCTs have a responsibility to ensure that their staff and contractors are up to date and fit to practise. Revalidation will shift what has been a reactive process into a proactive one. It will help to foster a culture of continuous learning within the NHS, improving the quality of the service and health outcomes.
The Royal College of General Practitioners (RCGP) has published a Guide to the Revalidation of General Practitioners\footnote{RCGP Guide to the Revalidation of General Practitioners http://www.rcgp.org.uk/_revalidation/revalidation_guide/the_guide_-_section_by_section.aspx}. The guide set out the College’s proposals for the evidence that will be required to support revalidation. It has yet to be agreed by the GMC but provides a useful source of information.

The DH has set up an NHS revalidation support team to work with stakeholders and lead the piloting, evaluation, further development and implementation of enhanced appraisal arrangements. Proposals for developing NHS medical appraisal will be set out later in the year and will set out a framework to ensure that appraisal is sufficiently robust to become the primary basis of revalidation. This will need the development of:

- a common framework for appraisal and assessment
- a common national quality framework for appraisal
- effective local clinical governance systems.

The paper proposes an appraisal process whereby doctors provide a portfolio of evidence that reflect the 12 attributes of the GMC module for good medical practice. This will involve:

- mapping evidence used in appraisal against the 12 GMC attributes; and
- assessment of that evidence against a set of standards that are laid out in the paper.

This evidence will be used by the appraiser and the doctor who is being assessed to inform an assessment of performance leading to a statement that considers:
• the doctor’s fitness to practise
• the doctor’s evidencing of progress towards revalidation
• the doctor’s progress in previous years’ personal development plans
• the current personal development plan.

This scheme will contribute to better patient care by achieving the twin aims of effectively supporting and developing doctors, and measuring the quality of medical performance.

PCTs will want to raise awareness of the requirements and ensure that GPs on their performers list are appraised annually and that GP appraisers are familiar with the evidence that will be required for revalidation. PCTs will also want to make sure their appraisal and clinical governance procedures are robust and ready for revalidation. Each will need to consider the synergy between the evidence needed to support separate but overlapping initiatives such as GP practice accreditation which could be useful as part of the evidence for revalidation. They should also be looking at how to support revalidation by aligning data collection so that information can be used to support revalidation as well as other purposes. Much of the supporting evidence is qualitative – for example, participation in audit, including significant event audits (SEAs).

In the future, revalidation will affect all regulated health professionals. The eight non-medical health professions regulatory bodies45 are making progress with their plans for revalidation and are in the process of gathering evidence that will

45 which includes the General Dental Council, General Optical Council and the Royal Pharmaceutical Society of Great Britain
inform their models. The regulators will then thoroughly test and pilot concepts and models prior to implementation from 2012 to ensure that revalidation is fit for purpose.

**Tackling concerns**

PCTs should ensure that they have clear effective processes and the capacity and skills to investigate concerns over the performance, conduct and health of individual practitioners working in primary care. For individual doctors, dentists and optometrists this will be through effective operation of the performers list arrangements. The DH consulted in autumn 2008 on introducing similar requirements to include pharmacists, their registered staff and dispensing appliance contractors. The results of this are being considered and a final decision will be announced as soon as practicable.

The recent report of the working group on Tackling concerns locally\(^{46}\) sets out the principles of best practice for how local systems of clinical governance could be strengthened to promote continuous improvement in the quality of care and enable healthcare organisations to identify and deal with those healthcare professionals whose performance, conduct or health could put patients at risk.

The DH will in due course be updating and promoting guidance and has commended the recommendations to the NHS.

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\(^{46}\) Tackling Concerns Locally: report of a working group

These include:

- early identification and intervention of problems or individuals
- awareness that apparently poor individual performance could be the result of wider system problems
- encouraging and supporting people who wish to raise concerns
- establishing systems for collating and analysing information from a variety of sources (this clearly links to the work that PCTs should be undertaking in measuring quality improvement as set out in element 2. PCTs will use this information to address areas of concern)
- transparent and fair process leading to a clear decision
- robust, quality assured and resourced strategy for remediation, re-skilling and rehabilitation where this is appropriate.

Subject to Parliamentary approval, it is expected designated organisations, including PCTs will be required to appoint responsible officers from 1 October 2010 with specific responsibilities for evaluating the fitness to practise of doctors and the local clinical governance arrangements relating to the performance, conduct and health of doctors. The PCT’s responsible officer will be responsible for all doctors on the PCT’s performers list. It is expected that medical directors will be appointed as responsible officers. Following Parliamentary approval further information will be set out in regulations and statutory guidance.
Subject to Parliamentary approval further regulations will require organisations to share information about performance and conduct which might show a threat to patient safety. The DH will consult on draft regulations in late 2009.

Subject to the results of pilots, the GMC will establish a network of GMC affiliates to support responsible officers.

PCTs will already be aware of the support available from the National Clinical Assessment Service (NCAS) for dealing with concerns about the performance of a dentist or doctor. From April 2009, NCAS has extended its service to include pharmacists47.

The Office of the Health Professions adjudicator is being established to ensure fairness in medical fitness to practise cases. It will be independent of the GMC and the doctor in question.

**The vetting and barring scheme**

The vetting and barring scheme (VBS) is being introduced from 12th October 2009 and is underpinned by the Safeguarding Vulnerable Groups Act 2006. The scheme seeks to ensure vulnerable groups are protected from individuals who are a known risk.

This Scheme places new duties on employers and voluntary organisations concerned with providing regulated activity48 to children49 or vulnerable adults50. The scheme applies to NHS organisations as well as health care providers in the private and independent sector and includes GPs, optometrists, dentists and pharmacists.

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47 http://www.ncas.npsa.nhs.uk/pharmacy
48 For the purposes of the Scheme, regulated activity means any health care provided to patients whether in a hospital, primary care or community setting.
49 Children means any person under age 18.
50 A vulnerable adult means any adult receiving health care of any description.
Employers and volunteer managers of individuals who are concerned with patient care must refer individuals who have harmed a child or a vulnerable adult to the Independent Safeguarding Authority (ISA)\textsuperscript{51}. The ISA will take decisions about which individuals will be barred from working with children and vulnerable adults. It will be an offence to knowingly appoint a barred person to work with children or vulnerable adults from 12th October 2009. New appointments and job changers will be able to register with the VBS from 26 July 2010 and from November 2010; it will be an offence to appoint a person to a regulated activity position if they have not registered with the VBS. From April 2011 the VBS will begin to register existing staff on a rolling programme which will take up to five years.

PCTs will need to ensure that their organisation has policy and procedures in place for making referrals to the ISA where appropriate of the staff they directly employ. They must also ensure their recruitment policy and practice is updated to take into account the introduction of registration with the scheme from July 2010 and the requirement for VBS registration from November 2010.

As commissioners and contractors, PCTs also have a role in ensuring that health service providers are complying with the VBS and arrangements for providers to make referrals in line with their new duties. In due course, it is intended that performers list and other regulations will be amended to include Vetting and Barring Scheme registration as a legal requirement and this will be subject to the approval of Parliament.

\textsuperscript{51} The ISA has provided guidance on their website at www.isa-gov.org
Patient safety

“Delivering high quality services to patients and the NHS is at the heart of primary care and primary care professionals are committed to ensuring the safety of patients. When mistakes do occur it is essential to have procedures in operation to learn from incidents and use clinical audit to inform systems redesign and implementation of changes in day to day practice.”

Sue Sharpe, Chief Executive, Pharmaceutical Services Negotiating Committee

Significant numbers of people are treated and cared for in primary care every day. As more complex care is delivered closer to home, and as patients move across care sectors, the potential for patient safety problems in complex multidisciplinary activity increases. Medical error occurs between five and 80 times per 100,000 consultations, mainly related to diagnosis and treatment; and prescription errors occur in up to 11% of prescriptions, mainly due to errors in dosage. Some people may experience more serious complications that result in hospital admission, which could have been prevented. The current prevalence of preventable medicines-related hospital admissions is estimated at between 4% and 5% of all admissions. Yet the commissioning of simple measures in primary care can prove effective in reducing medication related morbidity and the anxiety, inconvenience and costs associated with admission to hospital.

52 The frequency and nature of medical error in primary care: understanding the diversity across studies
John Sandars and Aneez Esmail
Family Practice Vol. 20, No. 3 © Oxford University Press 2003
Reducing admissions through tailored medicines management support: Bournemouth and Poole PCT
The Specialist Medicines Management Service (SMMS) assists patients and healthcare professionals in solving medication related problems across Bournemouth & Poole. The service provides tailored support to individual people in their own homes, offering solutions through a variety of methods such as; reminder charts, compliance aids, education/counselling and medication reviews.

Benefits of the service:

• fully integrated with the intermediate care teams in the area and works closely with GPs, community pharmacies, hospitals, community nurses and social care staff to ensure seamless patient care

• people are able to remain independent in their own homes

• easily accessible to people with disabilities or mobility difficulties

• people receive education and counselling regarding their medication and long-term conditions, contributing to improved concordance and compliance with their medication

• prevention of overdose through use of secure systems, such as assistive technology

• reduction of acute admissions

• facilitation of safe hospital discharges.
Referrals are accepted from a wide range of health and social care professional including; GPs, community nurses, intermediate care teams, hospital discharge teams, community pharmacists and social care workers.

An analysis of the 138 patients assessed from April to June 2009 has shown a 68% reduction in admissions, with 69 avoided admissions, and an 89% reduction in length of stay amounting to 1267 bed days.

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In June 2009, the National Patient Safety Agency (NPSA) published The seven steps to patient safety in general practice\textsuperscript{54} which describes the key steps for general practice to take to avoid harming the patients they care for. The guide is based on a full reference document, Seven steps to patient safety in primary care\textsuperscript{55} Alongside each step is a set of activities that can be taken to develop policies, strategies and action plans. There are also practical hints and techniques that can be used to promote quality care.

\textsuperscript{54} Seven steps to patient safety in general practice
www.npsa.nhs.uk/sevensteps
\textsuperscript{55} Seven steps to patient safety in primary care
www.npsa.nhs.uk/sevensteps
### Seven steps to patient safety in primary care

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<th>Step</th>
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<td>Step 7</td>
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National Patient Safety Agency, June 2009

PCTs will want to work with their providers to ensure they are aware of seven steps and are implementing it locally as appropriate. PCTs and providers can assess the effectiveness of local safety cultures using the Manchester patient safety framework (MaPSaF) team safety culture assessment tool.\(^5^6\)

### Safer care programme

Local efforts to improve quality of patient safety can be supported by the work of the safer care programme in the NHS Institute for Innovation and Improvement. This programme has been working on two specific products focused around primary care: the primary care trigger tool (PC TT) and the leading improvement in patient safety programme for general practice.

### Primary care trigger tool

Addressing the problem that staff reporting detects only a small proportion of adverse events, the primary care trigger tool\(^5^7\)

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\(^5^6\) Manchester Patient Safety Framework (MaPSaF) team safety culture assessment tool. www.npsa.nhs.uk/hrls/improvingpatientsafety/humanfactors/mapsaf

\(^5^7\) The Trigger Tool Portal can be accessed at www.institute.nhs.uk/safercare/TTP
is a method to allow rapid structured case note review to be undertaken in everyday general practice. Developed by the NHS Institute, the PC TT calculates the average adverse event rate in a practice, and provides a breakdown of the most common adverse events. GP practices using the PC TT are thus able to prioritise their safety improvement efforts more appropriately and to track their effect over time. It is not suitable for benchmarking against other practices.

The new trigger tool is due to be launched in November 2009. An online trigger tool portal will provide the GP Practice with a simple data entry form and real time analysis of their data. The trigger tool also allows practices to identify areas where they can target subsequent improvement projects.

**Leading improvement in patient safety (LIPS)**

The LIPS programme is a modular training course for clinical teams in general practice. Spread over three events totalling five days, aims to give delegates the passion, skills and confidence to understand, measure and improve patient safety. This includes training in the NHS Institute’s new PC TT. The proven improvement tools used are also effective for continual improvement of quality and efficiency.

**Primary Care Pathfinder Programme: NHS County Durham**

NHS County Durham is part of a regional improvement collaborative that links NHS organisations with Virginia Mason Medical Centre. Based in Seattle USA, Virginia Mason is an integrated medical centre that has used lean principles to

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dramatically improve the quality and safety of healthcare\textsuperscript{59}. NHS County Durham has established an innovative programme to implement lean in general practice. This programme aims to support all practices in improving quality and productivity by combining lean improvement projects with the development of clinicians and managers as coaches. The programme is designed to help deliver safer care and better patient experience through improvement work that realises the potential of practice staff. It is about maximising the benefit for patients by increasing the effectiveness of processes. It is also about freeing up time for staff to do their jobs more effectively by removing unnecessary process steps. Benefits include\textsuperscript{60}:

- **safer care processes** - e.g. reduced risk of error by simplifying process steps and improving work procedures;
- **more effective processes** - e.g. improved flow of work and reduced waiting times;
- **improved patient experience** - e.g. better room layouts and reduced interruptions;
- **better staff morale** - e.g. less stressful environments in which to practice.

Eleven practices are currently involved in the programme. The longer-term plan is to spread the method to all practices. To support this, NHS County Durham is exploring innovative partnerships to help practices access expert facilitation and


\textsuperscript{60} Herring L (2009) Lean Experience in Primary Care. Quality in Primary Care. Publication expected in Sep/Oct 2009 includes a case study of an NHS County Durham improvement event in general practice.
develop their lean skills. Potential partners include higher education, commercial and industrial expertise as well as international lean healthcare expertise.

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**Clinical audit**

Clinical audit, at its best, can be a very effective service improvement tool, improving the quality of patient care by looking at current practice, understanding where changes need to be made and modifying it where necessary and then measuring the change. By reviewing whether actions match agreed standards, service providers can identify their own improvement needs and commissioners can access detailed information to support their commissioning duties.

Where clinical audit is conducted well, it enables the quality of care to be reviewed objectively, within an approach that is supportive, developmental and focused on quality improvement. Audits can be simple – aimed, for example, simply at improving blood pressure follow up – or more complex – how can we improve the health outcomes of people with early renal failure in a practice? What is common to them is the idea of improvement. What is also unfortunately too common is not completing the audit cycle – by either not implementing the results (especially where the problem has been identified as lying in another part of the health system) or not following up with a further audit to ensure that change has been made – and sustained. Interventions as well as organisational processes can be audited, however, just looking at improvements are not enough. Understanding why the change has taken place and how it can be sustained and improved upon is what makes clinical audit
Improving Quality in Primary Care

Benefits of clinical audit are that it:

- promotes and enables good practice
- provides opportunities for education and training
- builds relationships between clinicians, clinical teams, managers and patients, and
- leads to improvements in service delivery and patient outcomes.\textsuperscript{61}

Many PCTs have a specific group established to encourage and support local audit in primary care. Where these groups work best they:

- are developed in conjunction with clinicians
- are reviewed by the PCT Board
- include relevant national audits, and
- are linked to the priorities of the organisation and other indicators such as adverse events or patient feedback.

PCT commissioners should ensure, with the agreement of the practices, that they are tapped into the emerging themes taken from the results of these audits. Understanding what the learning points and subsequent actions were and how these will influence future commissioning decisions and well as the management of existing contracts.

\textsuperscript{61} Taken from HQIP ‘What is clinical audit factsheet’ http://www.hqip.org.uk/what-is-local-clinical-audit/
Primary and community care audit group: NHS Gloucestershire

The primary and community care audit group is concerned with improving the quality of healthcare that the NHS provides to patients in the county through clinical audit and data quality support helping health care professionals consistently record the treatment and care given. The team provides assurance to NHS Gloucestershire, Gloucestershire Care Services, and to the public, on the quality of care delivered. It will be increasingly concerned with looking to provide assurance on the quality of care commissioned by local providers.

The group’s work is focussed around the care delivered by family doctors and their teams, and the care provided by community nurses and therapists to adults and children. It also supports audit in the county’s community hospitals and work with the county’s community pharmacists. Recently they have begun to work with the Prison Health Service and local care homes. The programme of work includes participation in national audit projects and a wide range of locally determined projects on key clinical topics. Training for and mentoring of clinicians in clinical audit is an important aspect of the group’s work.

For more information see www.glospccag.nhs.uk

There are a number of useful publications which PCTs can use to help them in planning and overseeing local clinical audits, Principles for best practice in clinical audit produced by NICE and the Clinical audit handbook published by the Clinical Governance Support Team, both set out a number of tools,}

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62  http://www.nice.org.uk/usingguidance/implementationtools/auditadvice/audit_advice.jsp
63  http://www.hqip.org.uk/clinical-audit-handbook/
models and approaches with examples of best practice. Both of which are available through the Healthcare Quality Improvement Partnership (HQIP) website\textsuperscript{64} alongside other useful information and tools to support PCTs in undertaking clinical audits. HQIP is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices, was established in April 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality in England and Wales.

As well as managing the National Clinical Audit and Patient Outcomes Programme, HQIP help create national and local partnerships between clinicians and patients/service users to optimise the impact of clinical audit and seeks to support local audit staff creating seamless links between national and local audit. They also work to ensure that evidence about participation in audit, and the results of audit, are used for secondary purposes. These include work-based learning and support of revalidation of healthcare professionals.

There are more provider specific audit resources available too, for example the Royal Pharmaceutical Society of Great Britain (RPSGB) has a clinical audit unit\textsuperscript{65} which can provide audit templates as well as expertise and advice on designing audit. There is a useful handbook and CD-ROM, Audit to Excellence, which contains tools that will help pharmacists measure the quality of their pharmaceutical service and to make improvements when necessary. The RPSGB also has a specific quality improvement for pharmacy development website\textsuperscript{66} which

\textsuperscript{64} http://www.hqip.org.uk
\textsuperscript{65} http://www.rpsgb.org/registrationandsupport/audit/
\textsuperscript{66} http://www.qi4pd.org.uk/
provides support, advice and resources for pharmacists on clinical governance and audit.

Renal failure audit: Cricket Green Medical Practice
The information technology (IM&T) team at Sutton and Merton PCT picked up an issue from reviewing CHART & PRIMIS data and discussed this with Lisa Eve, Clinical Services Director and audit lead at Cricket Green Medical Practice. As a result, Lisa conducted an audit, looking at patient records and found that there was a simple READ coding issue.

The results from this audit were highlighted as an education and development need within the practice and at their education meeting Lisa ensured all relevant staff within the practice were trained in using the correct READ coding for the condition.

As a result all patients who have chronic kidney disease (CKD) now have this long term condition correctly READ coded on the front page of their electronic records. This audit enabled tidying up of patient electronic records by providing an easy to glance record of patient’s current and past problems. The audit also enabled the CKD clinical lead to implement improved clinical care in the form of identifying patients who have not, as yet undertaken annual urine tests for microalbuminuria.

As Lisa says: “this audit enabled us to focus on CKD, improve identification and correct READ coding of CKD and review the need for recruiting specific members of practice staff in order to deliver targeted clinical care which has the potential to improve patient disease outcomes”.
The audits undertaken were written up, sent to the IM&T team lead at the PCT to enable the review of practice changes and sharing of audit knowledge with other practices.

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**Learning from adverse events**

It is important to learn from mistakes and to prevent them happening again. In general practice this can be achieved through recording and reporting patient safety incidents and through significant event auditing (SEA).

Patient safety incidents can be shared with the NPSA national reporting and learning system (NRLS)\(^67\) – a voluntary, confidential system. Less than 0.5% of incidents reported to NRLS are from general practice, despite the diverse nature of the workload and associated risks. PCTs will want to work with practices to promote and encourage reporting so that lessons can be learned, both locally as well as trends identified nationally so that learning can be disseminated country-wide.

The NPSA has published SEA guidance\(^68\) to will help practices use the tool more effectively, and to identify where a more detailed investigation (root cause analysis\(^69\)) is required. SEA is recognised and rewarded in QOF, will be a key piece of evidence in GP and nurse annual appraisal and will be a requirement for GP and nurse revalidation. PCTs will wish to ensure that SEAs are properly carried out and documented, that there are changes in practice as a result and, with the permission of relevant practices,

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67 NPSA NRLS Incident Report Form
www.npsa.nhs.uk/nrls/reporting/

www.npsa.nhs.uk/nrls/gp

69 NPSA. Root Cause Analysis toolkits and guidance.
www.npsa.nhs.uk/rca
that the lessons learned are shared locally to help others to improve quality.

PCTs commissioners need to ensure they are feeding the lessons learned as a result of SEAs into the commissioning process, using this information:

• to commission new or different services
• manage performance of existing contracts
• as well as building in audit requirements as a measure of quality into LES contracts as a systematic tool to ensure safety and quality.

The Patient Safety First Campaign for England70 has been created to change the culture within the NHS and, by changing practice in specific areas based on existing evidence, has put the safety of patients as the highest priority. PCTs may wish to review the benefits of participation to determine whether this would support the strengthening of a local safety culture.

Managing unsafe or poor performance
The commissioning guides we have already published on the different primary care contractors all have sections on dealing with providers who are not delivering on the safety of care. The guides detail the escalation process that PCTs need to take if performance slips below agreed standards.

As world class commissioners, PCTs should do everything they can to help providers recover and meet the required standards as quickly as possible, however if providers objectively

70 The Patient Safety First Campaign
and continually breach agreed standards, delivering poor or unsafe services to patients, PCTs can use the following formal contractual levers:

- decommissioning enhanced or additional services
- issuing breach or remedial notices
- terminating contracts.

PCTs should seek legal advice before invoking any of these contractual levers.

Whilst these may be of last resort – such as remedial notices, where a practice is given time to put a serious breach of contract right; or even a breach notice, ending the contract, before that stage there are very positive steps the PCT can take to promote better performance, and flag up examples of poor performance. This can be achieved, for example, through the use of multi-professional clinical governance groups, peer review, supporting voluntary accreditation and information sharing. There should be a robust and clear local policy for dealing with performance issues with buy in from local stakeholders. Those involved in the investigatory process, who should be fair and just, should be able to apply an unbiased approach and have appropriate training and support in their role.

The system for managing poor performance is not all that different from quality improvement; it should be driven by the PCT board and handled at a senior level, with a strong clinical input, and have:

- the principle of patient safety and protecting patients from harm as a result of poor performance as paramount
• a clear terms of reference and scope of any investigation
• good information, with expert analytic support
• expert assessors and investigators, who are
  - properly trained
  - with no competing interests
  - who can also intervene in practices
  - understand the need to record and document
    information accurately, and
  - can build on the range of information to triangulate
    evidence where possible
• professional sign up, including from local representative
  committees for
  - definitions of performance
  - indicators
  - types of interventions (which must be tailored for each
    practice)
  - intended (range of) outcomes
• appropriate patient involvement
• practice support and incentives (not necessarily financial)
• educational and development packages for trailing edge
  practices
• sophisticated support arrangements for practices in
  difficulties, such as drop in locums
• exit strategies
• a firm policy on confidentiality both of patient and practitioner data
• clear audit trails of any actions
• written protocols describing all the above.

Safeguarding quality; PCTs will want to:

• have effective clinical governance in place
• be aware of CQC progress towards registration and support provider readiness for registration
• ensure pharmacy regulation is working locally
• help doctors prepare for revalidation with robust appraisal and encouragement and support for continuing professional development
• have policies, processes and clinical expertise available for diagnosing and managing individual and practice performance problems
• have plans in place in readiness for the introduction of the Vetting and Barring Scheme (VBS) from 12th October 2009.
• have a safety culture incorporating the “seven steps”
• increase effective use of clinical audit as an improvement tool, including the use of significant event audits
• use information well in support of all these actions.
Element 7: Staying ahead

“Innovation is the way we achieve sustained improvements across the system and unlock productivity gains. It presents a unique opportunity for clinicians and managers to address long-standing problems and accelerate the pace of new developments.”

David Nicholson, NHS Chief Executive
The Year: NHS Chief Executive’s annual report 2008/09

There is good evidence to demonstrate that if we want to drive up quality, we need to focus on those that have high achievement as much as poor performers. If PCTs can understand what constitutes good quality, how a provider got there and recognise and celebrate that success, then this will stimulate improvement across the locality and provide an opportunity for sharing more widely. PCTs can identify these high quality performers by using the tools set out in element 2.

Innovative commissioning

PCTs as world class commissioners need to create the right environment – one that encourages imaginative solutions that better meet local needs and higher quality, more productive provision of services. PCT commissioners, working with practice-based commissioners and providers can create more innovative services, harnessing the skills of those working across primary care, for example, commissioning services from pharmacists to help those with long term conditions manage their care. Commissioning this sort of service can achieve cost effective outcomes that also improve the quality of service for patients by:

- freeing up GPs’ time
• creating savings, with less medicines waste and potentially less unplanned hospital admissions due to poor medicines management, and

• providing more convenient, easily accessible advice for patients as well as delivering improved health and wellbeing.

Supporting the management of people with asthma through the asthma medicines support service: City and Hackney PCT

Many people with asthma accept symptoms as a normal part of living with the condition, and many are unaware of the steps they can take to gain better control of their wellbeing. While GPs make considerable effort to manage these people, a City and Hackney PCT initiative has demonstrated how community pharmacy makes a direct and meaningful contribution to the management of people with asthma.

The service aims to identify people who are experiencing difficulties with controlling their asthma. It combines the use of a short series of questions, an asthma control test (ACT), with a focused medicines use review. Of those people reviewed:

• 96% experienced daytime symptoms of asthma
• 56% were using their reliever inhaler too frequently
• 41% were forgetting to use their preventer inhaler
• 52% required further patient information and education
• 22% needed help with inhaler technique
• 38% were identified as having poor control due to therapeutic inefficiency, and

• 26% were referred to their GP practice.

At follow-up to reassess asthma control using the ACT, people whose asthma was:

• ‘well controlled’ increased from 5% to 9%

• ‘reasonably controlled’ increased from 36% to 46%, and;

• ‘not controlled’ decreased from 59% to 45%

Building on its success, the service has now been expanded to become CHARM – the City & Hackney airways disease review management. The new service now covers COPD as well as asthma management, and also includes referrals to and support from community COPD nurse specialists and physiotherapists. Initial reports from this new service have shown:

• increased referral to Stop Smoking services

• better understanding of medicines, and improved concordance

• inhaler technique checks and changes in inhaler devices

• higher uptake of Influenza immunization by patients who fall into the “at risk group”.

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The NHS Institute has produced a helpful resource on promoting service innovation – Commissioning to make a bigger difference
– A guide for NHS and social care commissioners71. This publication aims to stimulate thinking and assess the extent to which a given change idea is a service innovation, using methods and tools that support a specific 5-step process framework, with a special focus on world class commissioning, and a ‘culture for innovation’ section describing seven factors that organisational studies show are linked to innovative output.

Clinical practice is constantly improving, offering new opportunities to improve the quality of care. High Quality Care for All highlighted the need for the NHS to embrace and lead change, and set out a range of actions. A number of these initiatives are described in this section. PCTs will wish to ensure that they raise local awareness and encourage staff to take advantage of the opportunities.

Regional innovation funds
Innovation will be driven regionally by SHAs who have a new legal duty to promote innovation. In April this year, a £220 million innovation fund was launched to help identify, grow and diffuse innovation, primarily focusing on promoting innovation in healthcare delivery, improvement and patient engagement. Any member of NHS staff can apply, including PCTs, to help support those NHS staff who struggle to get innovative ideas off the ground and to the patient.

Nine regional innovation hubs for the NHS in England have been funded to manage the commercialisation of innovations arising from the NHS. The hubs have a regional focus and the NHS

innovations network will provide a mechanism for the NHS to add value to its intellectual property and for the NHS innovation hubs to provide industry with a clear and comprehensive interface for collaboration.

Award systems have been established to foster an enterprise and innovation culture to engage a wide range of NHS staff. As well as existing award schemes, such as the health and social care awards, the NHS innovation challenge prizes will be launched in 2009, with awards made of up to £1m, the biggest prizes ever awarded by the NHS. The challenges themselves will be designed to tackle some of the major health challenges we face, such as prevention and treatment of lifestyle diseases, and will be laid down for innovators across the NHS and beyond. These prizes are specifically being introduced to reward breakthroughs in the provision of health services. Many of these areas will lie in primary and community care and so there will be real opportunities for both PCTs and providers to promote emerging best practice and encourage the identification and diffusion of innovative ideas. Prizes have been shown internationally to be an important means of stimulating innovation, and this concept is being taken forward to ensure England remains amongst the best innovators in healthcare.

PCTs have a critical role in supporting, encouraging and promoting innovation amongst their primary care providers – from the genesis of an idea, through to adoption and dissemination of best practice, as well as considering how they could use innovation funds to deliver local services more creatively.
Innovation: NHS North of Tyne

NHS North of Tyne has recognised the importance of promoting and developing innovation and has gained recognition in both regional and national innovation awards.

Innovation is not limited to research but in most cases arises from service development and staff doing their best for patients as part of their everyday job. The Head of Research and Development provides local leadership and has established processes to promote innovation within the Trust and ensure that all ideas, however minor, are assessed for intellectual property (IP) protection. She has strong links with the North East NHS innovation hub to ensure that commercial opportunities are explored and IP is fully exploited. The Trust has an IP Policy and an agreement with NHS Innovations North to manage the development, protection and exploitation of ideas.

One of the ideas recognised in the regional Bright Ideas in Health Awards 2008 was a leg bath developed by a community nurse. During home visits to frail and elderly patients, she recognised the difficulties of bathing leg ulcers using a bucket or basin, and wanted to find something better suited to her patients’ needs. Unable to find suitable alternative equipment she developed the idea of a portable leg bath. The concept has been developed with the support of NHS Innovations North, and has recently been licensed to medical devices manufacturer, MDTi, who plan to launch the product in Autumn 2009. Part of the income generated will be returned to the inventor and her Trust to support service development.

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Integrated Care Pilots

The Next Stage Review highlighted the need for improved integration between health and care services, to improve access to and quality of care within local communities. The programme of integrated care pilots (ICPs) has been established to test and evaluate new ways in which PCTs can commission more integrated services across primary care, community services, hospitals and social care to improve patient, carer and service user outcomes.

ICPs are designed to examine different ways in which health and social care could be provided, and allows communities to base delivery around the needs of the local population, looking beyond traditional boundaries. The 16 pilots, which began in April this year, will run for two years and will be evaluated against a set of national and local measures. The pilots vary from developing new models for managing people’s long-term conditions to helping patients choose their end of life care. They involve a wide range of new partnerships, systems and care pathways.

Although this is a national pilot programme, there are also a number of PCTs working with local clinicians considering how they can take practice-based commissioning a step further by developing integrated care organisations that take on more direct financial responsibility for the healthcare needs of the local population.

72 Integrated Care Pilots
Staying ahead – PCTs will want to:

• ensure they understand what constitutes good quality, how a provider got there and recognise and celebrate that success to will stimulate improvement across the locality and provide an opportunity for sharing more widely

• create the right environment for innovation through commissioning – one that encourages imaginative solutions that better meet local needs and higher quality, more productive provision of services

• raise local awareness of initiatives such as regional innovation funds and awards and

• support, encourage and promote innovation amongst their primary care providers.
Making it happen

Improvements in quality need the right culture, strong leadership, and the right systems. The whole team needs to commit to improving quality – it is neither a ‘bolt-on’ extra nor the sole responsibility of a named individual. Quality improvement should be embraced by everyone and become part of everyday practice—it is everyone’s business.

The effective commissioning of primary care services is central to improving quality; however the delivery of real quality improvement must be underpinned by:

- clear understanding and common purpose
- executive sponsorship and leadership
- Board level accountability
- focus, persistency and partnership working
- appropriate resourcing.

Clear understanding and common purpose

The concept of quality is not new and the term is widely used, but there is not always a clear understanding or agreement of what it means. PCTs as local leaders of the NHS need to ensure that their Board, primary care providers and clinical leaders have a clear understanding of the principles. This quality framework will underpin local strategic planning and the commissioning and delivery of primary care services to ensure that services for patients are of the highest standard, and the patient experience is enhanced.
Having clarity about what we mean by ‘quality’ gives us a common purpose and helps foster a culture of continuous quality improvement.

Executive sponsorship and leadership
Executive sponsorship and leadership, which must include clinicians, is critical for quality improvement. This support needs to be in place both internally and externally. A suggested best practice model would encompass support from the Board; the PEC (representing clinicians from the four primary care contracted professions); the Chief Executive, the Medical Director and the Director of Commissioning. Internally, these leaders need to ensure that the support is in place for a quality improvement programme, while staff working on this programme have the support, capacity and access to the range of skills and expertise required to meet this challenge which helps them become world class commissioners.

Externally, these leaders play a critical role in communication about the programme. Firstly, the executives should lead on the communication to providers around why quality improvement is important. Most significantly, these leaders should be supporting staff in engaging in sensitive conversations with practices around performance where needed, including having the conversations themselves directly, where appropriate and helpful.

Board level accountability
The PCT Board is accountable for deciding what health service the local community needs and ensuring that this is provided appropriately within the resources available. It is in a good position to ensure that organisations work effectively together.
A detailed list of questions a PCT Board will want to reflect on in relation to quality can be found at the end of this document.

**Focus, persistence, ownership and partnership working**
A quality improvement programme will require focus, persistence and ownership in the PCT. It should be clear within the PCT that there is a clear focus and priority given to quality improvement. The PCT will need to be persistent. High quality primary care for all is not something that will be achieved overnight; promoting continuous quality improvement is a journey that PCTs and primary care providers will need to go on together. This ambitious reform programme requires leadership of large-scale, complex change underpinned by a cultural shift, partnership working, and clinical engagement. There needs to be clear ownership in the PCT of the programme to ensure that focus and persistence is maintained.

It is important to develop the local vision and communicate proposals with local stakeholders, beginning with Board level debate while gaining ownership from the PEC, PBC clusters, LRCs, PCT clinical and corporate governance leads, local authorities, patient representative groups and others. In doing so PCTs will need to strengthen links with academic partners, PHOs and the new Quality Observatories to benefit from the expert resources available.

**Appropriate resourcing**
Engaging effectively with providers to achieve continuous quality improvement can pay rich dividends, and not just in terms of better quality: often, broader advances in performance and in improved relationships accompany it. However, reaping the
dividends requires PCTs to make the investment: in a sustained and intensive effort to engage providers constructively, systematically and comprehensively.

The PCT will need to consider the level of day-to-day management support and executive leadership that is required. Resources from the wider primary care team and the medical director may also be required. Experienced and knowledgeable primary care commissioning staff are invaluable. PCTs may need to consider this current capacity and capability within the overall team. A number of PCTs have chosen to call in external support in addition to their internal resource.

NHS PCC is developing a personal development support programme that will consist of tools to help PCT managers translate the organisational world class competencies into their own, personal skills and competencies, and be relevant to their day-to-day work. Its aim is to support people to choose development opportunities that are relevant to their personal development needs and which focus on the organisation’s objectives. The programme will consist of an online portal, aligned with the WCC competencies and the commissioning cycle providing:

- a self assessment tool to identify gaps in personal skills competencies
- information and links to training and development resources, and
- tools to assist integration of WCC organisational competencies to existing processes.
As well as requiring significant time from those PCT staff involved, quality improvement programmes will usually require a different way of working, with a different set of skills. Generating real improvement through the programme will mean not just monitoring providers, but actively challenging and supporting practices through visits and training. It is vital that PCT managers engage as peers with clinicians and provider management staff to address quality improvement issues that may arise.
Questions for the PCT Board

The PCT Board is accountable for identifying the health needs of the local population and for ensuring that appropriate services are commissioned to meet those needs. The PCT Board will wish to receive regular assurances about the quality and productivity of those services commissioned in its name for the population it serves. It may be helpful to consider the following questions when seeking that assurance.

- Is there a named Board member with responsibility for primary care?
- What is the PCT’s vision and ambition for quality improvement in primary care services?
- Does the Board have a clear understanding of the impact of planned improvements on health inequalities and the potential differential impacts on their diverse populations, communities or groups?
- Does the PCT provide sufficient motivation to encourage quality improvements over and above those that are contractually required of primary care providers?
- Does the PCT have a good picture of how current and planned investment in primary care is deployed and the levels of access, quality and health improvement that this produces?
- Does the PCT have clear ways of engaging with the public and local population to understand needs and demand, and to help shape services?
• Does the Board receive regular reports on primary care performance?
  - Are you achieving what you set out to achieve?
  - Does it help you understand what is happening?
  - Have you identified any problems?
• Has the PCT developed and implemented a quality scorecard?
• How does the PCT encourage clinical audit in primary care and ensure the results influence commissioning decisions?
• Has the PCT established effective mechanisms to monitor patient safety and learn from adverse incidents? Does the PCT provide appropriate leadership to resolve those safety issues that span individual providers?
• What is the PCT’s strategy for communications and stakeholder engagement on primary care issues?
• Does the primary care commissioning team have appropriate capacity, skills and support from Directors? Does the team have easy access to suitable clinical advice across primary care, public health skills, informatics support and financial expertise?
• Are there effective links with the PHO and Quality Observatory?
• How does the PCT promote and identify innovation? Does the PCT encourage participation in award schemes, and what level of success has been achieved?
Links to the World Class Commissioning Assurance Framework

This section sets out some aspects of the world class commissioning competencies that relate specifically to the seven elements of the quality framework with key questions of what PCTs will be looking to achieve to reach level 4 competency.

Bringing clarity to quality

WCC Competency 1 – locally lead the NHS

- Has the PCT led and implemented system wide improvements? How does it demonstrate this to the public and the board?

Measuring quality

WCC Competency 4 – collaborate with clinicians

- Can the PCT demonstrate the central role clinicians have played in the identification and delivery of improvements and the metrics that support them?
- Are clinicians actively engaged in the quality improvement agenda and can the PCT demonstrate innovation led by those clinicians?
Publishing quality information

WCC Competency 10 – manage the local health system

• Does the PCT have a commitment to developing primary care provider capability through the sharing of international and local best practice. Do discussions about continuous improvements and their delivery occur regularly and is the underpinning data published?

WCC Competency 2 – work with community partners

• Does the PCT have a reputation as an effective partner endorsed by local stakeholders in relation to how information is published to support quality improvements locally?

WCC Competency 3 – engage with public and patients

• Can the PCT demonstrate how proactive engagement across its communities is embedded in the quality improvements it seeks through the commissioning process?

Recognising and rewarding quality improvement

WCC Competency 9 – secure procurement skills

• Do all primary care contracts include clearly specified and measurable quality metrics?
• Are all specific performance improvements jointly agreed?
WCC Competency 3 – engage with public and patients

- Can the PCT demonstrate how patient experience data systematically drives commissioning decisions that lead to improvements in the quality of primary care services locally. How is this information shared with the public and patients?

Providing leadership for quality

WCC Competency 11 – efficiency and effectiveness of spend

- Does the PCT seek and demonstrate improvements in efficiency and effectiveness in primary care services in terms of the services they directly provide. How does it work with primary care providers to seek improvements in efficiency and effectiveness of those services that they refer into?

WCC Competency 1 – locally lead the NHS

- Has the PCT led and implemented system wide improvements?

WCC Competency 6 – prioritise investment of all spend

- Does the PCT lead knowledgeable discussions about scenarios and different levels of investment in quality improvement and use this evidence to support modelling techniques that inform the final investment decision?
Safeguarding quality

WCC Competency 7 – stimulate the market

- Has the PCT developed a clear specification for the quality, access, productivity and costs of primary care services that will ensure the ongoing safety and quality of the service?

- How will the PCT’s market management strategy to ensure that those providers who can demonstrate the greatest commitments to safety and quality improvement are able to compete effectively for further services that the PCT requires?

Staying ahead

WCC Competency 7 – stimulate the market

- Does the PCT manages the primary care markets to ensure that high quality care continues to be delivered with increasing efficiency and effectiveness?

WCC Competency 5 – manage knowledge and assess needs

- To what extent does the PCT continuously benchmarks itself, to create ambitious improvement aspirations, against similar populations to improve local health outcomes. Does it have clear plans to match the top performers on each benchmark and has it identified key capabilities internally and within its primary care providers to be developed to match their performance?
Acknowledgements

The Department of Health and NHS Primary Care Commissioning would like to acknowledge the work of a wide range of stakeholders for their input into the content of this guide and their support in its production.

The authors would also like to thank the clinical advisory group and members of the editorial group, representing a wide range of organisations, for their leadership, expert advice and contributions.

If you have found this guide useful, have ideas for future topics that should be covered or would like to share an example of good practice in relation to quality improvement in primary care services, please contact the primary care and community services team at pccsteam@dh.gsi.gov.uk or your local primary care contracting advisor at pccenquiries@pcc.nhs.uk.