NHS
Lancashire and South Cumbria
Integrated Care Board

ICB Primary Care Commissioning Committee

Date of meeting	14 March 2024
Title of paper	Primary Care Monitoring and Reporting Framework Update
Presented by	Peter Tinson, Director of Primary and Community Commissioning (Dr John Miles, Clinical Lead for Primary Care Data & Intelligence (Fuller))
Author	Dr John Miles, Clinical Lead for Primary Care Data & Intelligence (Fuller) Sarah Squires, Senior Delivery Manager – Primary and Community Commissioning Kathryn Lord – Director of Nursing, Quality and Patient Safety
Agenda item	9b
Confidential	No

Executive summary

This paper responds to section '*2.1 Quality Arrangements – quality surveillance'* of the MIAA Audit, previously reported to the Committee. It also provides a wider overview and explanation of the data and intelligence available to the ICB with regards to the commissioning of primary care services (general practice, dental, ophthalmic and community pharmacy services) and outlines the responsibilities for who reviews and escalates this intelligence.

The paper outlines the significant pressures being faced by primary care services in Lancashire and South Cumbria and the need to ensure they are supported to face these challenges. This information has been included to provide the context behind what has driven and shaped the approach to develop monitoring dashboards and the proposed next steps for primary care support; which goes above that required by the NHS England Delegation Agreement.

Assurance is provided for the actions being taken in response to the MIAA recommendations, which include the development of primary care service dashboards. These actions have either been completed or due to be completed within the set timeframes.

Advise, Assure or Alert

The purpose of this report is to **assure** the Committee that, as per the MIAA audit, the ICB is meeting its statutory duties for the commissioning and quality assurance of primary care services and has in place the governance structures and arrangements that meet the requirements of the NHS England Delegation Agreement and NHS National Quality Boards recommendations.

Assurance is also provided regarding the progress against of the actions and recommendations identified by MIAA which have either been completed or are on track to be completed within the set timescales.

This paper also seeks to **advise** the Committee of the next steps being taken by the ICB to develop a model to provide proactive improvement support for general practice.

Recommendations

The Committee is requested to note the contents of the report and provide any feedback.

Which Strategic Objective/s does the report contribute to		Tick
1	Improve quality, including safety, clinical outcomes, and patient experience	✓
2	To equalise opportunities and clinical outcomes across the area	✓
3	Make working in Lancashire and South Cumbria an attractive and desirable option for existing and potential employees	✓
4	Meet financial targets and deliver improved productivity	
5	Meet national and locally determined performance standards and targets	✓
6	To develop and implement ambitious, deliverable strategies	

Implications

	Yes	No	N/A	Comments
Associated risks		✓		
Are associated risks detailed on the ICB Risk Register?			✓	
Financial Implications			✓	

Where paper has been discussed (list other committees/forums that have discussed this paper)

Meeting	Date	Outcomes
N/A	N/A	N/A

Conflicts of interest associated with this report

Dr John Miles, co-author and presenter of this paper, is a GP Partner at Garstang Medical Practice and Director of Kepple Lane Pharmacy which are within the Lancashire and South Cumbria ICB's footprint.

Impact assessments

	Yes	No	N/A	Comments
Quality impact assessment completed		✓		
Equality impact assessment completed		✓		
Data privacy impact assessment completed		✓		

Report authorised by:	Professor Craig Harris, Chief Operating Officer

ICB Primary Care Commissioning Committee
14 March 2024

MIAA Audit update on Primary Care Monitoring and Reporting Framework

1. Introduction

1.1 Lancashire and South Cumbria (L&SC) Integrated Commissioning Board (ICB) is responsible for the commissioning of primary care services (general practice, dental, ophthalmic and community pharmacy services) as part of the NHS England Delegation Agreement for Primary Care Services.

1.2 The ICB also has a statutory responsibility for both Quality Assurance and Quality Improvement in commissioned services.

1.3 General Practice, Community Pharmacy, Dental and Ophthalmic contractors are accountable for the provision and quality of their services and are required to have their own quality monitoring processes in place. Primary care providers are required to deliver information to the ICB as per their contractual arrangements.

1.4 Quality is an overarching term which encompasses the patient experience of services, the safety of services and the effectiveness of services. The ICB influences quality improvement by the way it contracts with providers, through its relationships with other statutory agencies in the system and the engagement with stakeholders.

1.5 To enable the statutory and non-statutory function of the ICB to be implemented, the ICB has a governance structure which ensure accountability to the board for its functions. This includes Primary Care Commissioning Committee and the Quality Committee.

1.6 The Quality Committee supports the Integrated Care Board in delivering its statutory quality functions and strategic objectives in a way that secures continuous improvement in the quality of NHS services, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022.

1.7 The ICB will ensure as per Appendix I it is meeting the requirements of the National Quality Boards NHS England's Quality Functions: Responsibilities of providers, Integrated Care Boards and NHS England Guidance.

1.8 The MIAA Primary Care Contracts Assignment Report 2023/24, published in January 2024, concluded that the ICB has implemented governance structures and arrangements that meet the requirements of the NHS England Delegation

Agreement and had already taken some steps beyond the requirements. But the ICB still needs more time to fully embed some of its processes and provided recommendations intended to strengthen risk management.

1.9 This report responds to section '*2.1 Quality Arrangements – quality surveillance'* of the MIAA Audit but also provides a wider overview and explanation of the data and intelligence available to the ICB with regards to primary care services and outlines the responsibilities for who reviews and escalates this intelligence.

1.10 This paper will also provide the context that has driven and shaped the approach to developing monitoring dashboards and the proposed next steps, with the aim of enhancing the quality assurance and proactive support provided to primary care contractors; above that required by the NHS England Delegation Agreement.

1.11 Due to the differing national commissioning and contractual requirements for general practice and other primary care contractor groups this paper is split into three sections:

Part 1. General Practice
Part 2. Dental, Ophthalmic and Community Pharmacy Primary Care Providers.
Part 3. Primary Care Quality Assurance Framework

2. Context

2.1 The challenges of providing assurance of primary care services (General Practice, Dental, Ophthalmic and Community Pharmacy) have significantly changed over the past five years, even though the core contractual standards have remained constant.

2.2 This has primarily been driven by changes in primary care contractor workforce, the Covid-19 pandemic and changes in the demand, capacity and activity of services as well as changes to commissioning bodies and the health service landscape.

2.3 The increasing growth of demand in this time is due to several inter-related factors:

- Population Growth: 1-2% per annum.
- Increase in number of long-term conditions (LTC): a consistent 5%/year
- Increase in multimorbidity and complex individuals: Patients with >2 LTCs
- Shifts in demand from secondary to primary care.

2.4 Despite these challenges the L&SC patient satisfaction of services is consistently above national averages as measured by the annual General Practice Patient Survey report and Friends and Family reporting.

2.5 Primary care services in L&SC are providing more activity than ever before to try and meet this demand. For example, over the past four years there has been a 4% increase in general practice consultations (400,000 additional consultations).

2.6 The demand and limited workforce (L&SC has a significantly smaller proportion of general practitioners (GP) within General Practice than the national average, 35% vs 39%) has led to evolution within the primary care workforce and services:

- Implementation of the new Pharmacy First Scheme.
- Fully utilising skill mix in Dental Services
- 8.4% reduction in full time equivalent (FTE) GPs from 820 to 760 in the past 5 years, mirrored by a 24% increase in non-GP clinical roles, primarily Additional Role Reimbursement Scheme (ARRS) staff, during the same period. However, this is not a like for like replacement.

2.7 For General Practice this has meant that care is becoming GP-led rather than GP delivered. The intensity of GP workload has increased by about 20% resulting in concerns about GP burnout.

2.8 Despite the stability of primary care's core contractual requirements for the past 20 years, the advent of the Long-Term Plan and the changes during the pandemic to contractual priorities, providers have seen an increasing complexity in meeting contractual needs:

- Primary Care Network (PCN) and more recently Integrated Neighborhood Team (INT) development and delivery
- Significant growth in vaccination prioritisation (COVID-19)
- Evolution of the Quality Outcomes Framework (QOF) to include Quality Improvement domains for general practice
- Pharmacy First
- Delays and interim incremental changes to the Dental contract

2.9 Outside of the NHS England requirements there has been a significant change to processes of the other business/estates related requirements, and for general practice to the Care Quality Commission inspections (the CQC have rolled out a new regulatory approach, with information on services gathered in a variety of ways not just through inspections and the rating of the service is no longer be the main driver for when to assess).

2.10 The ICB's initial demand and capacity assessment for 2024-25 suggests that there is not the capacity within the existing primary care workforce to meet the projected demand increases and maintain current levels of workload intensity. For general practice this would require an additional 27FTE GPs and 40FTE other direct patient care staff.

2.11 The recent L&SC Local Medical Committee's (LMC) report on the financial stability and viability of general practices highlights significant concerns. Combined with reduced QOF attainment and associated funding this is likely to significantly reduce general practices' ability to invest in staffing for future years.

2.12 As such there is a need for the ICB to ensure primary care contractors are well supported to face these challenges and limit the impact on the quality of care delivered, contractors' financial stability of and the welfare staff.

2.13 The ICB has the governance structures and processes in place to react to issues and undertakes some proactive activities. However, as identified at the GP Care Delivery Workshop (31 January 2024), more could be done to triangulate intelligence, preempt issues, take early action and offer support before issues arise.

2.14 The approach will need to balance both quantitative and quality information to provide an assessment. This will need the ICB and providers to operate and interact with high levels of mutual trust and engagement. Using an agreed set of intelligence to inform conversations about contractual and quality assurance, whilst balanced with supporting practices in a sustainable manner will enable the ICB to discharge its commitments effectively and safely.

2.15 The approach will also need to take into consideration the comparably reduced ICB Primary Care and Quality people resource available to provide proactive improvement support.

3. Part 1: General Practice

3.1 Background

3.1.1 Under the PGM (the national document that provides guidance on the commissioning of general practice services) the ICB is required to conduct a routine annual review of primary medical care contracts (refer to section 3.2). However, unlike the other primary care contractor groups there are no national 'must do's' or 'blueprint' for general practice assurance or support provided to commissioners by NHS Business Services Authority (BSA).

3.1.2 As such, the ICB inherited six different processes for general practice assurance from its predecessor organisations. Since its inception, the ICB has worked to develop a single assurance approach.

3.1.3 The General Practice Care Delivery Workshop (31 January 2024) focused on the theme of care delivery improvement support in L&SC; bringing together a wide range of stakeholders to consider the current pressures facing general practice and how to best support practices to identify and tackle these challenges. The workshop identified the following themes for future general practice assurance and support models:

- the need to achieve the right balance of accountability/ kindness/ compassion/ support
- reduce silo data and intelligence interpretation
- need for 'subject matter expert' interpretation of data
- the need to establish 'trust' with general practice to build back lost relationships and achieve transparency
- consider place led models to build on existing strong relationships
- prioritised programme of practice visits based on concerns and practices' support needs
- enable general practice to 'support themselves', requires tools and capacity
- include general practice occupational health service

- change in the narrative and perception of general practice

3.2 **Annual review of Primary Medical Care Services**

3.2.1 The ICB has a statutory duty to conduct a routine annual review of every primary medical care contract it holds. This is covered through the General Practice Annual Electronic Self-declaration (eDec) collection which is currently delivered by NHS Digital and NHS England produces national analysis.

3.2.2 For 2023/24, the eDec returns and national analysis are currently being reviewed by the ICB's Primary Care Delivery Assurance Team and any concerns will be reported into the Medical Service Operational Group for consideration, action and escalation. Any quality related information will be received by the ICB Quality team for consideration of next steps.

3.3 **Outline of general practice information available**

3.3.1 There are numerous national general practice data sets however to facilitate the interpretation of this data the Commissioning Support Unit (CSU) has worked with the ICB to develop a range of local data sets and dashboards on Aristotle. These collate national and locally derived general practice and PCN information into user-friendly displays and reports, including those which support the national planning guidance (see Appendix A for examples).

3.3.2 The GP Contracting Dashboard (Appendix B), referenced in the MIAA report, contains a blend of performance and transformation data to support the overall monitoring of general practice, compiling key metrics into one dashboard.

3.4 **Outline of existing arrangements and processes**

3.4.1 The monitoring of general practice performance and quality assurance data is undertaken by several teams within the ICB. Appendix C provides an outline of the ICB Primary Care Team's General Practice Data Review Framework; which details the data reviewed, frequency and where it is reported/escalated to.

3.4.2 Any serious/urgent issues identified are escalated immediately through a reactive pathway and escalated to the relevant ICB team/s as required.

3.4.3 Issues of lower concern and areas for support are raised at the monthly Medical Services Operational Group meetings and then escalated as appropriate to the relevant committee dependent upon the nature of the concern i.e. Primary Care Quality Group which reports to the Quality Committee.

3.5 **General Practice assurance process developments**

3.5.1 The ICBs processes for general practice assurance, outlined above, are primarily reactive, however based on the feedback of the workshop (3.1.3) there is work underway to create proactive support models which will:

- identify practices who may require support,
- create a culture of openness and transparency and a vehicle to promote peer to peer support and improvement,
- improve the triangulation of data and soft intelligence,

- respond to practices' support requirements and ensure that a variety of support offers are available.

3.5.2 The aspiration of improved triangulation between departments and between data and soft intelligence will benefit from the Quality Team's planned introduction of an electronic system for soft intelligence gathering and reporting which will support some triangulation with incident and experience information.

3.5.3 The next steps after January's General Practice Care Delivery Workshop are:

a) Circulate workshop outputs to stakeholders w/c 4 March 2024 for wider sharing with colleagues.
b) Further feedback from stakeholders requested in within 2weeks.
c) Formation of a small task and finish group to develop a draft action plan and support model.
d) A series of further workshops with one being held with support providers to understand what they are currently offering, what they could offer, how this could be coordinated and what resources are required.
e) A paper will be brough back to the Primary Care Commissioning Committee (PCCC) which will outline what support the ICB is able to provide and equally what primary care support providers are able to provide, and any resources required. This is a significant and important piece of work which will be brought back into the Committee in May 2024.

4. Part 2: Dental, Ophthalmic and Community Pharmacy Primary Care Providers

4.1 Background

4.1.1 The monitoring of performance against contractual requirements and quality improvements for dental, ophthalmic and community pharmacy providers is defined in the national policy manuals developed by NHS England and as part of the Delegation Agreement the ICB is required to follow the processes as described in these documents. Sections 4.2 – 4.4 provides further details on these requirements and how they are implemented locally.

4.1.2 Support with some of these processes, related data collection and reporting is received from the NHSBSA.

4.1.3 It is acknowledged that there are additional non-core services that are also commissioned by the ICB, which are outside of the scope of these overviews.

4.2 Dental Services

4.2.1 **Quality and Performance reviews undertaken to support the assurance of contract delivery**

4.2.1.1 Primary care dental services are subject to national minimum contracting and assurance processes, comprising of an annual cycle of reviews;

- a mid and year-end financial reconciliation and recovery process in-line with the national policy book.
- the dental assurance framework (DAF); a standardised approach to contract performance and quality management adopted by all ICBs

4.2.1.2 There are additional non-core dental services which are outside of this scope, for example the urgent care pathway (both in hours and out of hours), Tier 2 Minor Oral Surgery and Specialist Orthodontics.

4.2.2 Data used to support the review processes

4.2.2.1 The NHS BSA processes and aggregates data originating from treatment claims (FP17s), which details patient demographics, treatments delivered, units of dental activity (UDAs) and units of orthodontic activity (UOA).

4.2.2.2 The data is compiled into a range of reports for commissioners and providers via the NHS BSA online NHS England Dentistry Dashboard (eDen system). Examples of the reports available to ICBs are included in Appendix D.

4.2.2.3 The data is also used to report against key performance indicators in the DAF report and is used to report into the ICB Board on UDA delivery.

4.2.3 Annual Review Process

4.2.3.1 The annual review process comprises of a mid and end of year reviews, that are undertaken by the ICB and rely upon the NHSBSA notifying of the number of UDAs and UOAs that Contractors have provided.

4.2.3.2 The reviews look to assess that contractors have delivered at least 30% of the required activity by month six and 96% by the end of the year.

4.2.3.3 Where contractors have been unable to meet the required activity levels the ICB is obliged to follow set processes that in some instances lead to contract sanctions and punitive measures for non-delivery of activity.

4.2.3.4 At the end of the year the ICB will recover the full amount of money (any overpayment to the Contractor in respect of the contract activity delivered) up to the full contract value and a breach notice will be issued.

4.2.4 Dental Assurance Framework (DAF)

4.2.4.1 The DAF is a risk-based model that uses a flagging methodology to rank all contracts against each indicator and highlight outliers. The more indicators a provider is flagged against the greater the potential risk.

4.2.4.2 The ICB dental team and ICB Clinical Advisor meet on a quarterly basis with the NHS Business Services Clinical Advisor to review any contracts identified as a risk using the DAF ‘priority providers’ report.

4.2.4.3 Where potential risks are identified, the next steps may involve:

- writing to the provider to seek further clarity of care delivered,

- undertake a practice visit including the relevant ICB team/s and an audit of clinical notes,
- an arms length review using bespoke NHS BSA reports
- or a combination of all three.

4.2.5 **Reporting and escalation of reviews reported into the ICB**

4.2.5.1 Any Performer concerns are escalated to NHS England's Professional Advisory Group (PAG) via the Dental Clinical Advisor, and any contractor concerns are reported to the Dental Services Operational Group and escalated to PCCC, as appropriate, via the AAA Highlight Report.

4.2.6 **Dental assurance process developments**

4.2.6.1 The assurance process for primary care dental services are nationally defined and implemented by the ICB.

4.2.6.2 In addition to the assurance process, as part of the Dental Access and Oral Health Improvement Programme, a dashboard has been developed to support transformational quality improvement, which was launched in February 2024 (Appendix E). The dashboard will be accessible by place facing colleagues to enable them to better understand provision, access and delivery in their geographies. The dashboard will also support system oversight too.

4.3 General Ophthalmic Services (GOS)

4.3.1 **Quality and Performance reviews undertaken to support the assurance of contract delivery**

4.3.1.1 The ICB monitors the provision of mandatory (high street) and additional (domiciliary) services delivered in primary care optometry practices as directed by the Delegation Agreement and the national policy handbook.

4.3.2 **Ophthalmic Contact/Service reviews**

4.3.2.1 GOS providers are nationally required to undertake review of their compliance against national regulations and contractual requirements every three years.

4.3.2.2 This involves completion of a self-declaration; Level 1 Quality in Optometry (QiO) GOS contract compliance checklist, which is used by the ICB to monitor contract compliance.

4.3.2.3 ICBs also have access to the GOS claims data collated by NHSBSA made available through a newly developed data system 'eOps', which provides ICBs with system, provider and performer level information (Appendix F).

4.3.2.4 In addition to the standard process, the NHS Eye Health Policy Book advises that 5% of contractors are randomly selected for a visit by the ICB, and the ICB visits those contractors who do not complete the self-assessment and contractors where potential concerns are highlighted in the QiO.

4.3.2.5 An action plan is completed during any visit (where appropriate) with agreed dates for the completion of actions/submission of evidence.

4.3.3 Reporting and escalation of reviews reported into the ICB

4.3.3.1 The outcomes of GOS reviews and QiO visits are reported to the Optometry Services Group and any concerns are raised with the Quality Team. Where necessary and depending on the nature of the issues raised, the ICB may refer to the Local Optical Committee (LOC) or Performer Advisory Group (PAG)

4.3.4 Ophthalmic assurance process developments

4.3.4.1 The assurance process is nationally defined and implemented by the ICB.

4.3.4.2 In addition to the assurance process, a dashboard is planned to be developed by May 2024 to support transformational quality improvement. The dashboard will be accessible by place facing colleagues to enable them to better understand provision, access and delivery in their geographies. The dashboard will also support system oversight too.

4.4 Community Pharmacy Services

4.4.1 ICBs have responsibility for monitoring the provision of Essential and Advanced services. This responsibility and how they should undertake it are defined in the delegation agreement and the national NHS England policy manual.

4.4.2 ICBs use the Community Pharmacy Assurance Framework (CPAF) to monitor community pharmacy owners' compliance with the terms of the Community Pharmacy Contractual Framework (CPCF).

4.4.3 Community Pharmacy review processes

4.4.3.1 CPAF is completed on an annual cycle (Appendix H), the administration of the programme is shared with NHSBSA who distribute and collate the questionnaire responses. The associated information and data is collated in a dashboard provided by the NHSBSA detailing which contractors have/have not completed the CPAF questionnaire (Appendix G, chart 1.).

4.4.3.2 The ICB reviews any non–submissions and visit contractors who have not submitted the full questionnaire. As nationally required, the ICB also visits 1–2% of pharmacies that have indicated compliance to validate the answers and observe good practice.

4.4.3.3 Visits are also undertaken in respect to any local intelligence received in terms of pharmacy performance from place colleagues, General Pharmaceutical Council (GPhC) or wider stakeholders.

4.4.3.4 A record is taken of discussions held at the visit and the ICB ensures all agreed actions are competed and notifies the NHSBSA accordingly.

4.4.4 Reporting and escalation of reviews reported into the ICB

4.4.4.1 The annual review programme and visits are overseen by the ICB's Pharmaceutical Services Group, which receives details of the outcomes of reviews and site visits. The Group feeds into the wider ICB governance and where appropriate concerns are escalated to the Primary Care Quality Group and/or the Primary Care Commissioning Committee.

4.4.5 **Community Pharmacy assurance process developments**

4.4.5.1 The assurance process is nationally defined and implemented by the ICB.

4.4.5.2 In addition to the assurance process, as part of the Community Pharmacy Access Programme, a dashboard has been developed to support transformational quality improvement to increase the number of advanced services being provided by the profession (Appendix G, charts 2-5).

5 Part 3: Primary Care Quality Assurance Framework

5.1 The ICB Quality Governance Framework ensures that statutory responsibilities for quality including effectiveness, safety and experience are met in primary care.

5.2 Four quality functions will be included in the ICB's Primary Care Quality Assurance Framework:

1) Monitoring of the effectiveness of services
2) Patient experience, complaints and concerns
3) Patient safety/incidents/outcomes and learning.
4) Professional Regulation (NHSE responsibility but will link in with ICB when relevant and proportionate)

5.3 The processes outlined in sections 3 and 4 will enable the ICBs Primary Care team and the Quality Team to work alongside other ICB teams such as Medicines Optimisation and Safeguarding to triangulate from all sources to ensure Primary Care Services across Lancashire and South Cumbria are delivering high quality health care which is continuously evolving and improving.

6. Conclusion

a. This paper outlines some of the context to our approach, plus the existing assurance arrangements and development plans for primary care contractors.

b. The table overleaf summarises the MIAA recommendations, management action and current status:

Contractor Group	Action	Status
MIAA Audit Identified developments:		
General Practice	a) Development of General Practice Dashboard (Appendix B). b) General Practice Monitoring and Reporting Framework (Appendix C).	• Complete • Dashboard live • Complete
Dental	a) Development of Dental Dashboard to support transformational quality improvement (Appendix E).	• Complete and launched Feb 2024
Ophthalmic	b) Development of Ophthalmic dashboard to be developed to support transformational quality improvement.	• Ongoing • Dashboard launch May 2024
Community Pharmacy	c) Development of Community Pharmacy Dashboard to support transformational quality improvement to increase the number of advanced services being provided (Appendix G)	• Complete • Dashboard live.
• **Aspirations / process of continuous improvement:**		
General Practice	a) Circulate workshop outputs to stakeholders b) Further feedback from stakeholders requested c) Formation of a small task and finish group to develop a draft action plan and support model. d) A series of further workshops e) A paper will be brough back to the Primary Care Commissioning Committee (PCCC) outlining potential general practice support model/s	• Due w/c 4 Mar 2024 • Due w/c 18 Mar 2024 • Apr 2024 • Dates to be confirmed • Due May 2024

c. The paper outlines arrangements and developments of quality functions in relation to Primary Care providers.

7. Recommendations

a. The Committee is requested to note the contents of the report and provide any feedback.

Dr John Miles
Clinical Lead for Primary Care Data & Intelligence (Fuller)

Sarah Squires,
Senior Delivery Manager – Primary and Community Commissioning

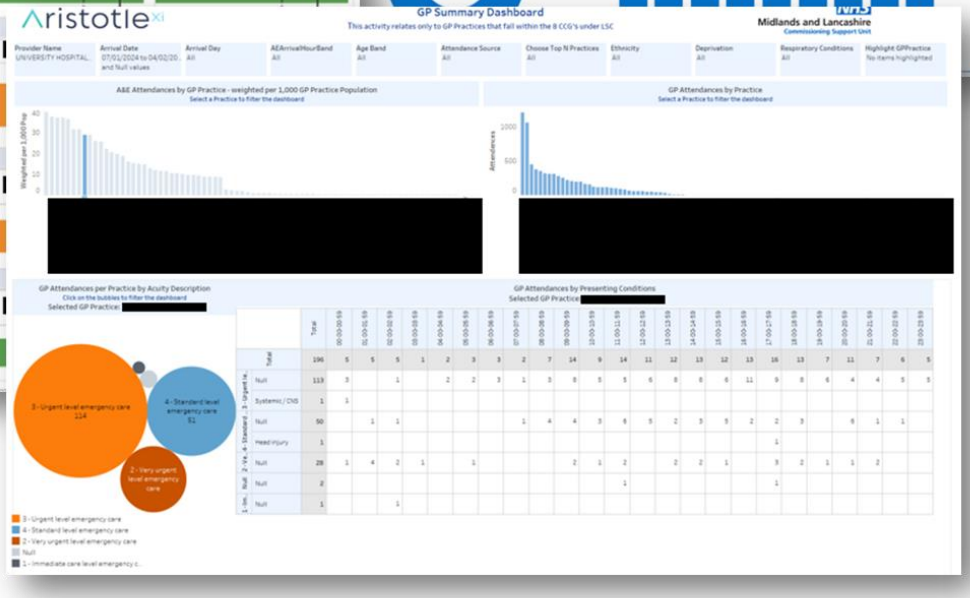
Kathryn Lord,
Director of Nursing, Quality and Patient Safety

February 2024

Appendices

Appendix A. Sample of general practice data and dashboards available on Aristotle.

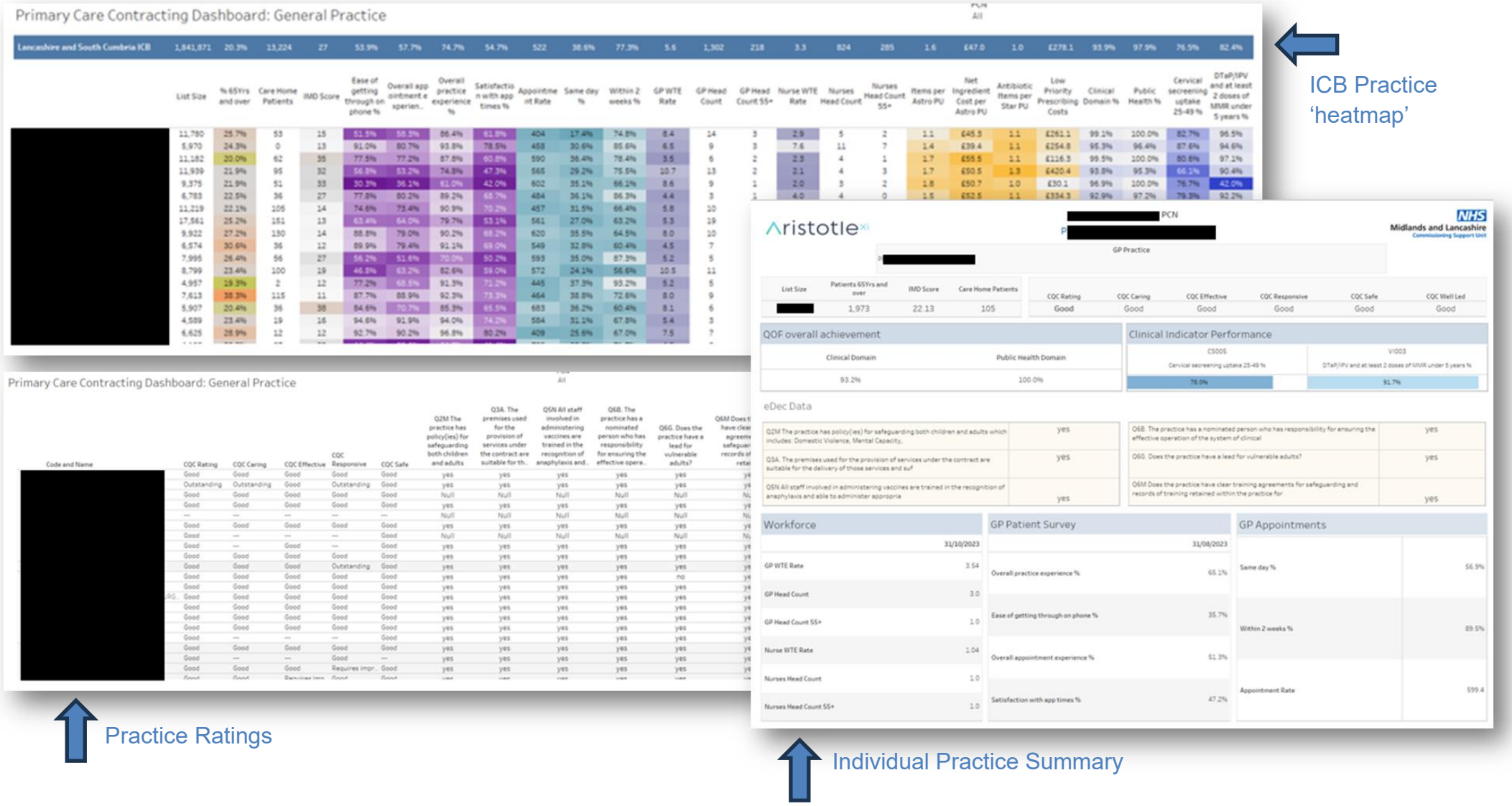
ICB's General Practice Appointment Data (GPAD) Dashboard Extract



ICB's OTiS GP A&E Attendance Acuity Dashboard Extract

ICB's PCN Investment Impact Fund (IFF) Dashboard Extract

Appendix B. ICB's Primary are Contracting Dashboard for General Practice Extracts:



Appendix C. Table Summarising the ICB Primary Care Team's General Practice Data Review Framework

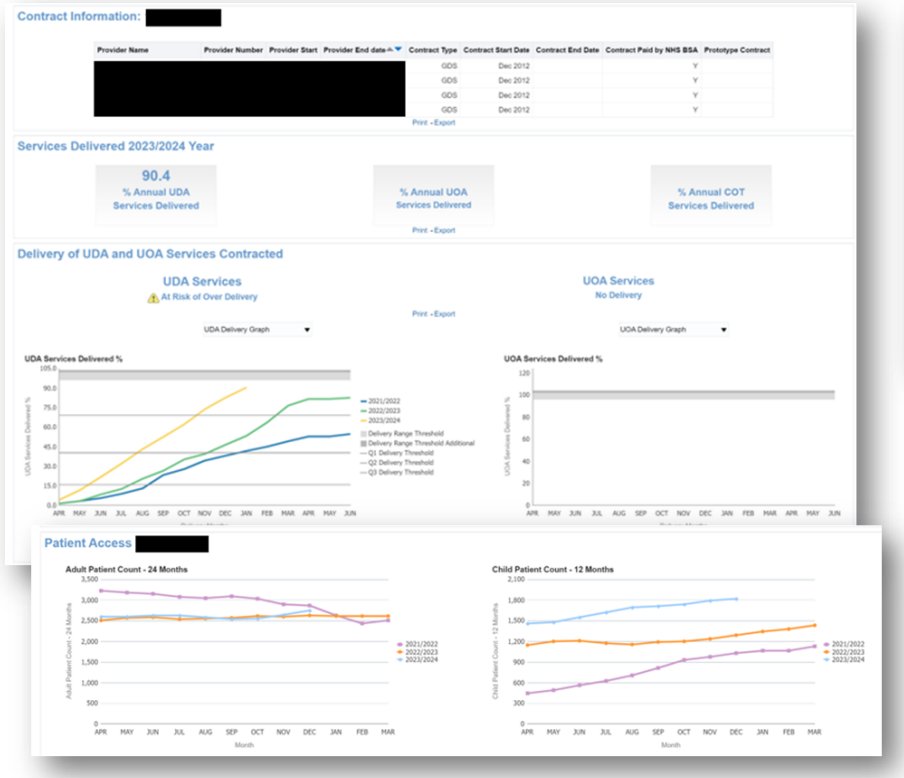
	Place Based Review			
	Indicators	**Sources**	**Frequency**	**Actions**
GP Contract Dashboard	Currently status/activity for: Practice population • GP pt survey • access/experience questions • GPAD data • Workforce Data • Meds Management Data • CQC ratings • QOF • eDEC *Additional metrics to be added in future developments*	Aristotle LSC Primary Care Contracting Dashboard *More detailed and trend information available from specific data sets.*	Monthly	Escalation/triangulation with other ICB as required i.e. Meds Management to gain wider insight and interpretation as required. If nature of concern is urgent/serious escalation through Reactive Pathway. Otherwise Medical Services Group will receive details of any practices/PCNs and escalate as appropriate, ensuring consistency re decision making. Issues and trends to be shared with Place Directors and CCPLs as part of monthly update discussions
GP Access	• Number of appointments • Appt. rate per 1,000 population • % face to face appts • % same day appts • % appts booked and seen within 2wks • % Appts seen by GP • % unmapped appointments • % of DNAs • *Community Pharmacy Consultation Service activity **CPCS service ceased Jan 2024, awaiting new NHSE data for Pharmacy First Service.*	Aristotle LSC GPAD Dashboard NHS England Tableau Analytics NHS Digital Aristotle LSC CPCS Dashboard	Monthly	Escalation into Medical Services Group as detailed above. If impacting upon Place/ICB performance notification/escalation via F&P Report, Board Report, Quality Report (quarterly) as required. Issues and trends to be shared with Place Directors and CCPLs as part of monthly update discussions
GP Workforce	FTE by job role Head count by job role FTE by age band Staff FTE per 100,000 patients	Aristotle LSC Primary Care Contracting Dashboard NHS Digital	6 monthly	Escalation into Medical Services Group as detailed above. If impacting upon Place/ICB performance notification/escalation via F&P Report, Board Report, Quality Report (quarterly) as required. Issues and trends to be shared with Place Directors and CCPLs as part of update discussions
GP Online maturity	• % offer patients the ability to book and cancel appts online • % of patients enabled to book and cancel appts online • Online appt transactions • Online repeat prescriptions • % offer patients the ability to order repeat prescriptions online • % of patients enabled to order repeat prescriptions online • coded records viewed online • % offer patients the ability to view detailed coded records online • % of patients enabled to view detailed coded records online	NHS Digital	Quarterly	Escalation into Medical Services Group as detailed above. If impacting upon Place/ICB performance notification/escalation via F&P Report, Board Report, Quality Report (quarterly) as required. Issues and trends to be shared with Place Directors and CCPLs as part of update discussions

	• Practices enrolled for Online GP Registrations			
IIF	• Vacc & Imms VI-02 - % adults in clinical risk group who received flu vacc • Vacc & Imms VI-02 - % 2-3yr olds who received flu vacc • Cancer CAN-02 • Appointments - ACC-08 • SMI Health Checks (annual)	Aristotle PCN Network DES & IIF Dashboard 2023-24	6 Monthly	Highlight to Medical Services Group as required, as may indicate future instability Issues and trends to be shared with Place Directors and CCPLs as part of update discussions

Appendix D. Screen shots of current Dental Service Data

Dental Contract Profile The dental contract monitoring dashboards that the ICB has access to (eDen), it starts at contract/provider level and then moves up to system level.

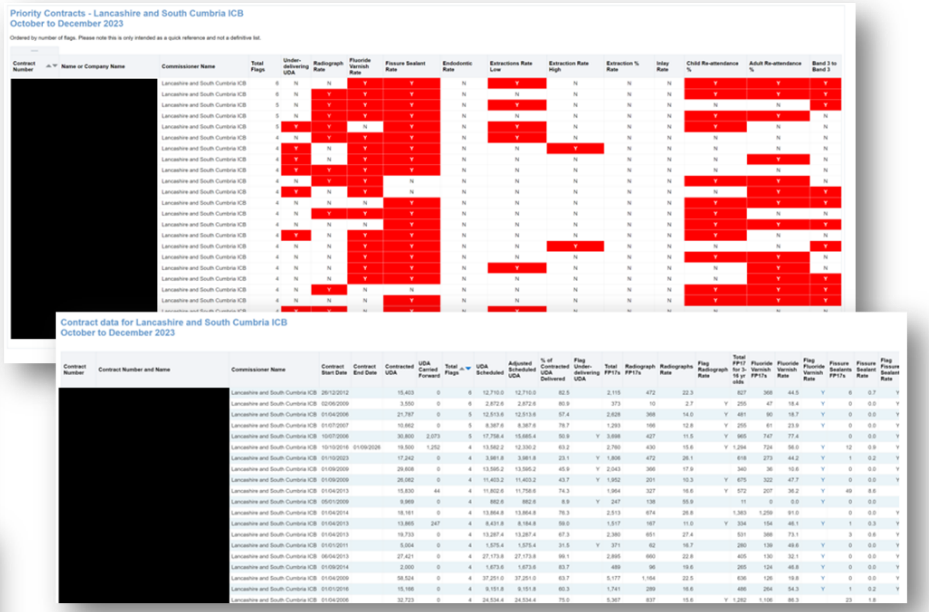
Below is a dental contractor profile showing UDA delivery over the previous three years (including current).



Dental contractor profile showing the number of patients treated over the previous three years (including current)

Excerpts from the Dental Assurance Framework (Priority Contracts). *The Dental Assurance Framework is the national tool that ICB use to monitor quality of patient care.*

Dental Assurance Framework - Priority Contracts
Dental contracts with the most 'flags' for quality and performance concerns.

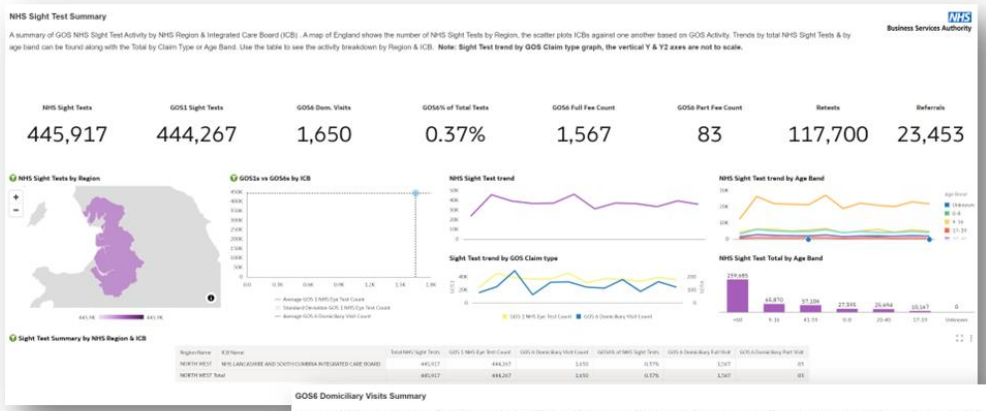


Dental Assurance Framework - All Contracts
provider level information for every contract detailing the Dental Assurance Framework quality and performance metrics (irrespective of flag or outlier status).

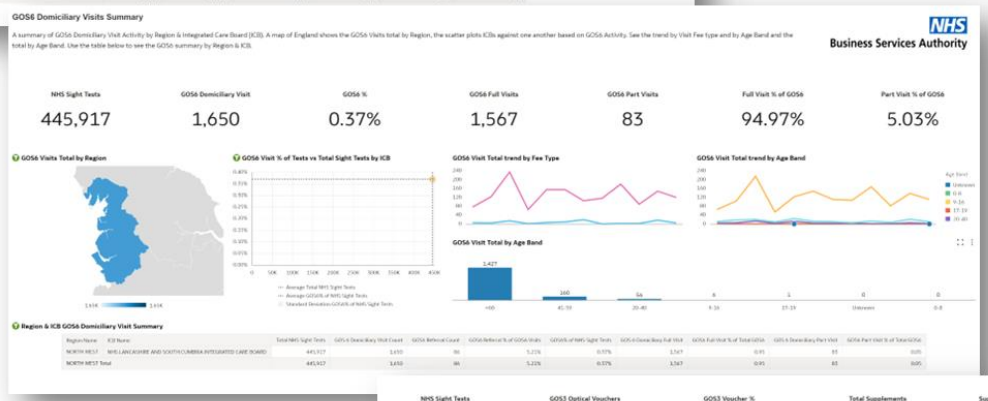
Appendix E. Dental Service Aspirational Developments

Dashboards being developed to support Place extracts of patient access data and contract performance

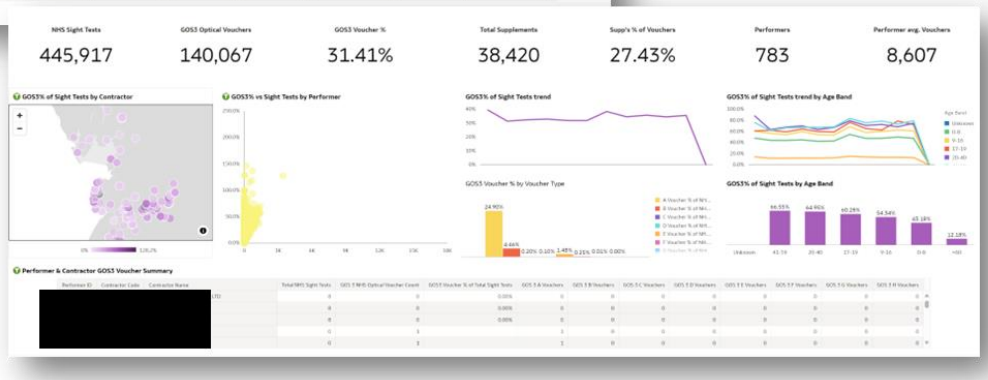
Appendix F. Screen shots of Optometry Service Data



Sight test summary for the ICB



Domiciliary visits summary for the ICB

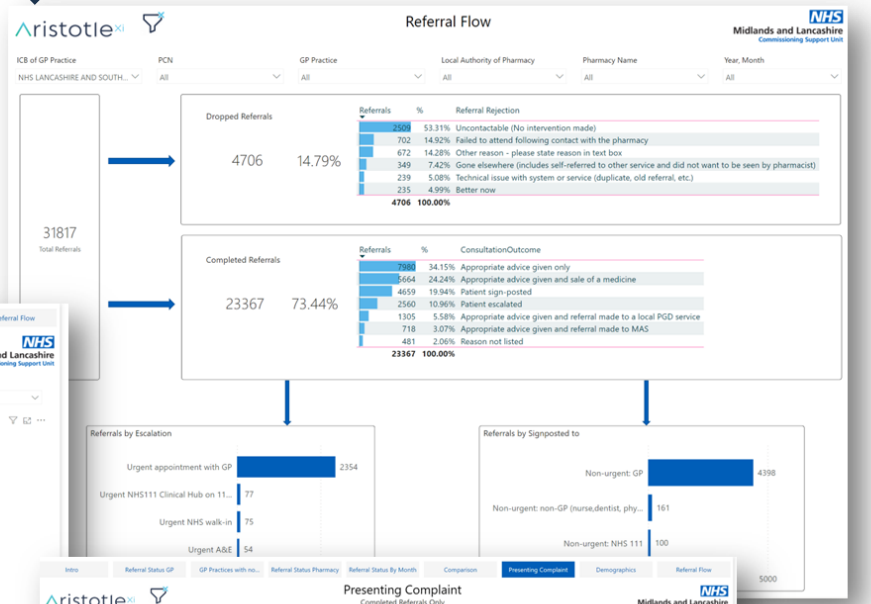


GOS3 (NHS Optical voucher) claims

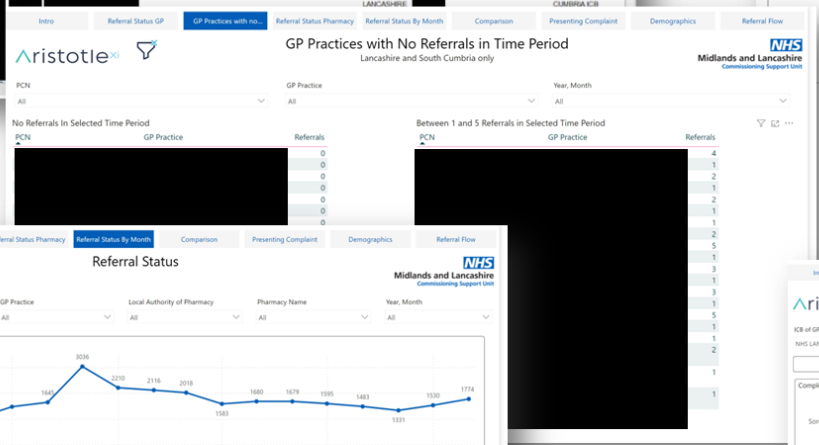
Appendix G. Screen shots of Community Pharmacy Service Data

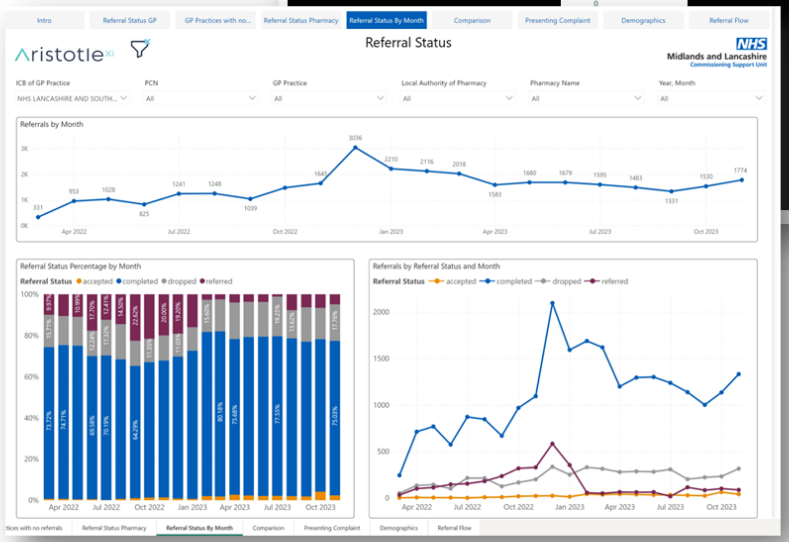
1. GP Practices that have made no referrals to GPCPCS

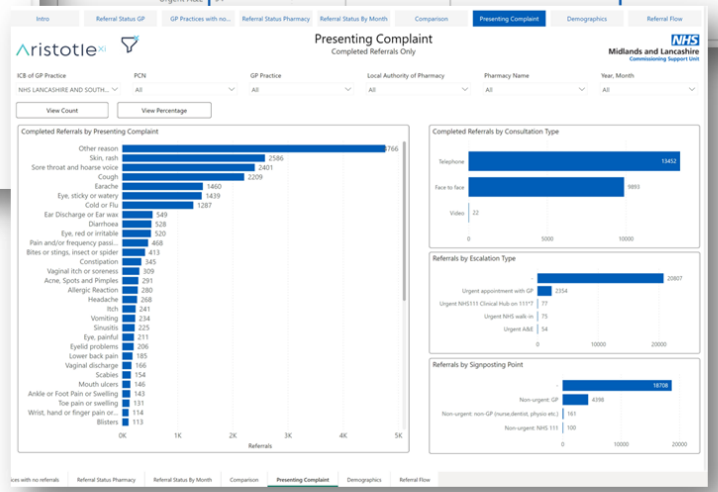
2. GPCPCS referral flow



3. GP Practice referrals as a trend







4. Reasons why patients have been referred by a GP practices and what happened to them when they attended a pharmacy

5. Details of the outcomes of the referrals as they pass through the GPCPCS pathway

Appendix H. Diagram of the Annual Community Pharmacy Assurance Framework (CPAF) Cycle:

Appendix I. Requirements of the National Quality Boards NHS England's Quality Functions: Responsibilities of providers, Integrated Care Boards and NHS England Guidance.

The functions covered are:

1. Strategic management of quality - National Quality Board and NHS England guidance
2. Operational management of quality – Independent Investigations (including Mental Health Homicides); Regulation 28 reports; Professional Standards; Controlled Drugs Accountable Officer Function; Whistleblowing and Freedom to Speak Up; Quality Accounts; Medicines Optimisation; Infection Prevention and Control and Antimicrobial Resistance
3. Patient safety - Insight, involvement and improvement (including medical examiners, patient safety improvement priorities, PSIRF, LFPSE)
4. Experience – Improving patient, service user and unpaid carer experience of care; insight and feedback
5. Effectiveness – National Clinical Audits; NICE technologies appraisals and guidance; GIRFT
6. Safeguarding – Safeguarding Assurance & Accountability Framework (SAAF), including Child Protection information System (CPIS) which includes all children on a protection plan (CPP) and looked after children (LAC); child death overview process (CDOP); Child Safeguarding Practice Reviews (CSPRs); Domestic Homicide Reviews (DHRs); Female Genital Mutilation (FGM); Prevent & Counter Terrorism and Modern Slavery & Human Trafficking; Serious Violence Duty.
7. Mental health, learning disabilities and autism.