NHS
North Central London
Integrated Care Board

Primary Care Services in North Central London – GP Practice quality monitoring and management

Joint Health Overview and Scrutiny Committee

15 July 2022

1. Introduction

NCL Integrated Care Board (ICB) is responsible for commissioning primary care services (general practice) in North Central London (NCL). As a commissioner of NHS services, our main priority is to ensure the continued provision of high quality, safe and accessible services for local people.

There are 180 GP Practices in NCL. We monitor GP practices on an ongoing basis against their contract and wider expectations as NHS services. This briefing summarises how we do this and the mechanisms in place to take action where concerns arise.

JHOSC members are aware that BBC Panorama ran a story in June 2022 featuring the findings from an undercover investigation at a London GP practice (not a practice in North Central London). Key areas of focus in the programme included supervision of Physician Associates and GP/patient ratios. This briefing includes information about how we monitor some of those areas in NCL.

2. Quality and Performance monitoring in the ICB

The ICB is required to manage all primary care contracts in line with the *National Primary Care Regulations and Policy* produced by NHS England. The ICB's Primary Care Contracts team works closely with the ICB Quality team to monitor and respond to any trigger of underperformance or quality concern that is identified. This may be identified through formal contractual reporting processes, via the Care Quality Commission (CQC), through local borough primary care commissioning teams, or through other routes such as whistleblowing.

The NCL ICB Primary Care Contracts Committee (PCCC) is responsible for overseeing GP core and enhanced services. It meets in public and receives a Quality and Performance report at each meeting. The PCCC's remit is to monitor the quality and performance of these services across all five NCL boroughs and to make decisions within the legal and regulatory framework.

The committee is regularly attended by Healthwatch, local councillors and community representatives. Committee membership includes an independent clinical representative, Public Health, ICB Quality, and non-executive/lay members. Following our recent transition to the ICB, our Chief Medical Officer or Chief Nursing Officer will attend as a voting member and our Chief People Officer as an attendee.

The ICB Primary Care Contracts team monitors all contracts on an ongoing basis and submits a regular Quality and Performance report to the PCCC. This reports at practice level and is available in the public domain (on the ICB's website). Examples of the data monitored across all practices includes:

- List size growth
- CQC ratings
- Quality and Outcome Framework (QOF) performance and overall achievement
- Patient experience (GP Patient Survey) and patient complaints
- Workforce (e.g. GP and Nurse : patient ratios)

- Access, including patient online access

The PCCC's Quality and Performance report is being refreshed for the new Committee, following transition from a CCG to an ICB. It will build on these data above, include our most up to date data and look at trends over time. It is expected that the new report will be launched in draft at the first meeting of the new Committee in early autumn.

NCL ICB also commissions a range of Locally Commissioned Services (LCS), which cover areas such as Long Term Conditions, support to Care Homes, Vaccination and Immunisation and Prescribing. Our borough based primary care and medicines management teams monitor these, with overall accountability to the ICB's Executive Director – Place, and on to the ICB Strategy and Development Committee.

NCL ICB have established a System Quality Group (SQG) which includes partners such as the Care Quality Commission and Healthwatch. Its purpose is to routinely and systematically share and triangulate intelligence, insight and learning on quality matters across the system. Its scope includes Primary Care. It identifies system quality concerns/risks and opportunities for improvement and learning, including addressing inequalities. Quality leads will work with providers to support continuous improvement, and raise matters with ICB teams and Committees where they require escalation or formal action.

3. Care Quality Commission

All health service providers are regulated and inspected by the Care Quality Commission (CQC) to ensure they meet fundamental standards of quality and safety. The CQC works with local commissioners to take action under the regulatory and contractual framework where they do not.

When any practice receives an adverse rating from the CQC, the ICB is notified and asked to carry out its own investigation under the terms of the GP contract. This includes reviewing the performance of the practice over several years against established quality indicators which include:

- Quality Outcome Framework (QOF) – Long Term Condition Management
- Cervical Screening
- Childhood vaccinations
- Flu Vaccinations
- Access (opening hours and clinical sessions provided)
- Patient views (GP Patient Survey, NHS Choices and patient complaints)
- CQC inspections findings over several years (if available)
- Annual Contract Review data (compliance data in line with the contract)
- Key Performance Indicator achievement (for APMS contracts only)

The ICB primary care team will also review the CQC's published report for any areas of concern identified to understand whether the practice maybe operating in breach of their primary care contract.

The ICB is required to issue either a Quality Improvement Plan or a contract Remedial Notice to any practice that receives 'requires improvement' or 'inadequate' ratings. The practice must demonstrate and provide evidence of improvement where concerns have been identified. Examples of actions required include revising policies and procedures; addressing opening hours, improving access and appointment numbers; and increasing staff capacity (clinical and non-clinical).

Ongoing review takes place until the practice remediates the concerns. If they don't, more formal contract action will need to be taken (for example, a Breach Notice, with further escalation where this is not responded to adequately).

4. Working collaboratively

On a fortnightly basis, the ICB Primary Care Contracts team meets with CQC and the NHS England Medical Directorate who retain responsibility for the National Performers List. These teams jointly discuss any cases and share relevant information. This includes any individual GP performance cases. NHS England work closely with the General Medical Council (GMC). Any action taken by CQC, NHS England or the GMC that requires local follow up is referred to the NCL PCCC.

NCL ICB will always notify relevant GPs and contract holders that they are entitled to support and representation from the Londonwide Local Medical Committee. They are also entitled to legal or any other representation they deem suitable.

Our priority is always to identify pressures and concerns early and to offer support to resolve and learn. The Primary Care Contracts team, local primary care teams and ICB clinical leads meet monthly in each borough to consider soft intelligence, requests for support and any emerging concerns. The teams also work with practices to forward plan and support continuity of care where there may be partnership changes, retirements, practice relocations or other matters.

5. Workforce - Additional Roles Reimbursement Scheme (ARRS)

NHS England introduced an 'Additional Roles Reimbursement Scheme' (ARRS) in 2019. This provides funding to Primary Care Networks (PCNs) for the recruitment of additional staff. There are 15 types of role designed to respond to the range of patient needs presenting and support multi-disciplinary team working in primary care. Roles include clinical pharmacists, physician associates, paramedics, social prescribing link workers and health and wellbeing coaches.

In North Central London (March 2022 data), 455 whole time equivalent (WTE) ARRS staff are in post working across our PCNs. Practices have also recruited an additional 232 of these staff directly.

Responsibility for the support and supervision of staff lies with the practices and PCNs employing them. There are minimum role requirements and competencies for each of the 15 ARRS role types. Formal clinical training and qualifications are required for all the clinical roles within the framework.

The national ARRS scheme includes detailed expectations around staff supervision, training, support and development and contract length. Where roles are employed

directly by practices, the ICB can assess terms and supervision through normal contractual monitoring processes.

Commissioners can request information where there is a concern, but it is not requested that commissioners routinely request this detail. One exception to this is the Paramedic role, which includes commissioner assurance that they are meeting their education and supervision pathway.

Commissioner responsibilities around the ARRS scheme are described here in the Network Contract DES Specification 22/23 and include contract management and assurance. Commissioners also support PCNs with workforce plans as a whole (submitted to the ICB twice a year) and ensure NHS system-level workforce plans are supportive of Primary Care.

Staff:Patient ratios are monitored on an ongoing basis. Access to sufficient workforce is a challenge across the NHS and strategies and plans are in place to support recruitment and retention. All NCL boroughs have diversified their workforce under ARRS and PCNs are able to determine the best use of these roles to meet the needs of their local population. We are constantly seeking to improve the accuracy of workforce data and ensure reporting reflects overall capacity (low Nurse:Patient ratios for example can be supplemented by Healthcare Assistants or Practice Pharmacist support).

There is no national guidance on the ratio of Physician Associates to GPs. The average GP: Patient ratios are similar across all NCL practices. British Medical Association (BMA) measures GP rate per 1800 patients. We believe there are 109 practices that fall below this ratio. We are working with practices to ensure accuracy and regularity of reporting for example, recent data shows that 83 practices in NCL have not logged on to the National Workforce Reporting System (NWRS) in the last 90 days to review their workforce numbers. We also know that largely Locum GPs are not recorded and therefore not reflected in the ratios above. Our primary care teams are working with practices to support them to update the national workforce dataset monthly to ensure it's more accurate.

There is a really strong focus in NCL on supporting GP recruitment and retention, and a number of schemes in place including expanding our clinical placements for GP trainees (in particular in areas with lower GP : Patient ratios), mentoring schemes, retention schemes, and flexible staffing pools. We are predicting a 3.7% increase in the number of GPs in NCL this year (22/23).

6. Conclusion

In conclusion, NCL ICB, regulators and providers have processes in place to monitor and improve the quality of services and to address any concerns robustly where they arise. We are working to update the PCCC Quality and Performance report and will work with the new ICB Executive Management Team and Board – including our Chief Medical Officer and Chief Nurse – to continually improve our approach. We believe risks are identified and mitigated and we welcome the ongoing support of our Healthwatches, local stakeholders and patient representatives.