NHS
Commissioning Board

Standard operating policies and procedures for primary care

Primary medical services assurance framework

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Primary medical services assurance framework

NHS Commissioning Board standard operating policies and procedures for primary care

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Foreword

This policy has been written at a time of major change and re-organisation within the NHS. It is recognised that the direction of travel has already been established in 'Securing Excellence in Commissioning in Primary Care' and therefore this policy has been developed to meet the commitments of consistency of approach rather than centralisation and local implementation.

The policy recognises that in a model for improvement, data provides only one part of a large picture and used in isolation presents not only risk, but unfair anxiety amongst those providing services or those responsible for oversight of the delivery of those services. Therefore, data must be used alongside other intelligence that is both factual and accurate to gain a full understanding of any potential risk to quality and patient safety.

Whilst the NHS Commissioning Board has ultimate accountability for the safe and effective delivery of primary medical services, it recognises the importance of engaging early, regularly and effectively with those delivering the service, those who receive the service and those who can potentially facilitate and support (eg Local Medical Committees (LMCs)) recovery and improvement in a provider when things may be going wrong,

Furthermore, the policy is not intended to remove or diminish sound; evidence based clinical decisions and judgements, or create perverse incentives to change clinical practice or ways of working which are inconsistent with delivery of high quality patient centric care.

Purpose of policy

1) The NHS Commissioning Board (NHS CB) is responsible for direct commissioning of services beyond the remit of clinical commissioning groups, namely primary care, offender health, military health and specialised services.

2) This document forms part of a suite of policies and procedures to support commissioning of primary care. They have been produced by Primary Care Commissioning (PCC) for use by NHS CB's area teams (ATs).

3) The policies and procedures underpin NHS CB's commitment to a single operating model for primary care – a "do once" approach intended to ensure consistency and eliminate duplication of effort in the management of the four primary care contractor groups from 1 April 2013.

4) All policies and procedures have been designed to support the principle of proportionality. By applying these policies and procedures, Area Teams are responding to local issues

within a national framework, and our way of working across the NHS CB is to be proportionate in our actions.

5) The development process for the document reflects the principles set out in *Securing excellence in commissioning primary care*[1], including the intention to build on the established good practice of predecessor organisations.

6) Primary care professional bodies, representatives of patients and the public and other stakeholders were involved in the production of these documents. NHS CB is grateful to all those who gave up their time to read and comment on the drafts.

7) The authors and reviewers of these documents were asked to keep the following principles in mind:

- Wherever possible to enable improvement of primary care
- To balance consistency and local flexibility
- Alignment with policy and compliance with legislation
- Compliance with the Equality Act 2010
- A realistic balance between attention to detail and practical application
- A reasonable, proportionate and consistent approach across the four primary care contractor groups.

8) This suite of documents will be refined in light of feedback from users.

[1] *Securing excellence in commissioning primary care http://bit.ly/MJwrfA*

Policy aims and objectives

This policy outlines the approach to be taken by NHS CB when managing primary medical care contracts to ensure compliance with quality standards, Securing excellence details the core principles that underpin the operating model for Area Team (AT) staff in their interaction with contractors post 31st March 2013.

This policy recognises that early engagement with LMCs presents the best opportunity to support practices in making effective and sustainable changes to support service improvement should this be found to be appropriate and necessary.

Background

Whilst most health care professionals practise to a very high standard, it is essential that the NHS CB have in place a robust assurance management programme to identify and share best practice, recognise where additional management may be needed and to highlight when things are going wrong at an early stage in primary medical service provision.

The transfer of commissioning and contractual responsibility from 152 separate commissioning organisations to a single NHS Commissioning Board is taking place within the context of an overall reduction in staff, operating in a reduced number of area teams who are responsible for a greater number of contracts. The existence of one single commissioner however offers opportunities for reducing duplication and streamlining commissioning and contract management processes. Management responsibilities sit firmly with the ATs, but recognising Clinical Commissioning Groups (CCGs) have a statutory duty to assist and support the NHS CB in securing continuous improvement in the quality of primary medical services. This means that the future operating model needs to be different to that adopted by any one PCT currently i.e. the transfer of contractual responsibility does not mean a corresponding transfer of current processes and procedures. Change offers an opportunity to refine and reform Primary Medical Care (PMC) and this policy describes the role of the PMC AT manager within a new operating model and the culture, behaviours, processes and relationships that should be adopted by AT staff.

Scope of the policy

Core principles;

1. To promote and prioritise equality including access and treatment for all patients across the full range of primary medical services.

2. To focus on quality, outcomes and relevant patient experience as the main drivers for
   i. Improvement
   ii. Primary care commissioning arrangements

3. To promote a clinically driven system in which GPs and other primary medical service clinicians are at the heart of the decision making process, driving quality improvement and commissioning decisions.

4. To facilitate strong and productive local contractor relationships based on proportionate and sensitive interaction

5. Be responsive to and spread innovation

6. To deliver a consistent national framework, which ensures fair and transparent interventions, implemented locally, with local discretion rooted in cultural and behavioural consistency

7. Make commissioning decisions on the basis of firm data shared with CCGs, health and wellbeing boards (HWBs) and others and complemented by local intelligence

8. To design systems that are fit for the future, allowing for reform and operate with minimum bureaucracy. Such systems will enable whole person patient care, with integrated physical, mental and behavioural services and facilitate shared best practice standards between primary care and specialists.

9. To promote early engagement and collaboration with LMCs openly and transparently in the management of primary medical services.

The policy and the supporting guidance also look to address some expressed concerns associated with a single operating model including;

- Standardised mediocrity
- The stifling of innovation
- Clipboard contract management
- Justifiable variation based as a result of challenging and different health needs, historic variation in investment or very unusual circumstances

1.Types of Contract

Where a primary medical services contractor holds a registered list of patients, and provides the full range of essential services, there are three possible contracting routes. These are:

- A general medical services (GMS) contract;
- A personal medical services (PMS) agreement; or
- An alternative provider medical services (APMS) contract.

A single contractor may hold a variety of contract types with a variety of commissioners. For example, an existing GMS contractor might also hold an APMS contract with the same or another commissioner.

General Medical Services (GMS) arrangements are governed by the GMS Regulations (SI No.2004/291, as amended from time to time). These are based on national agreement between the Department of Health (or bodies acting on behalf of the Department of Health) and the British Medical Association and are underpinned by nationally agreed payment arrangements as set out in the Statement of Financial Entitlements (SFE).

Personal medical services (PMS) arrangements are an alternative to GMS, in which the contract (the “PMS agreement”) is agreed locally between the contractor and the commissioning organisation. The mandatory contract terms are set out in the PMS Regulations (SI No.2004/627, as amended from time to time) but still allow local flexibility for negotiation and there are some distinct differences in the way in which GMS and PMS contracts must be managed.

Importantly there is no requirement to follow the nationally agreed pay structure for GMS, i.e. the Statement of Financial Entitlements does not apply to PMS agreements. Commissioners and PMS contractors are therefore free to negotiate entirely separate payment arrangements, although common elements are often found in both contract types eg Quality and Outcome Framework (QOF), but this also needs to be taken into consideration for the purposes of considering breaches across the differing routes.

The mandatory requirements that apply to Alternative provider medical services (APMS) contracts are set out in the Alternative Provider Medical Services Directions 2010 (as amended). These Directions place minimum requirements on APMS contractors which broadly reflect those for PMS contractors but otherwise enable the remainder of the contract to be negotiated between the commissioner and the contractor or, more commonly, stipulated by the commissioner during the course of a tender process.

Unlike GMS and PMS arrangements, which place significant restrictions on the organisational structure of the contractor, there are fewer such restrictions for APMS contractors.

All contractors who have a list of registered patients must provide essential services. However, unlike GMS Regulations, PMS Regulations do not require provision of essential services and therefore a list of registered patients is not required. Those PMS agreements that take advantage of this flexibility and do not include the full range of essential services are known as Specialist PMS (SPMS**)** arrangements and are again locally agreed contracts.

2. CCG and NHSCB/AT Relationship – Description

Whilst contractual management is the sole responsibility of ATs, unlike primary dental, optometric and pharmacy services, delivery of effective, safe and high quality primary medical services will require CCGs to play an active role in supporting the AT in exercising its statutory responsibilities for member practices within its area. CCGs will have a statutory duty to assist the NHS CB in the quality improvement of PMC. The NHS CB is responsible for direct commissioning of primary medical services, therefore CCGs will not commission or decommission national services; this function will remain an exclusive role of the NHS CB as the commissioner and contract holder. CCG will however be responsible and accountable for services commissioned locally through the standard NHS contract.

Through transparent measurement across practices within a CCG and CCGs within an AT, the practice-AT relationship (supported by CCGs) provides a forum for collaborative and engaging discussions regarding national and local implementation of this policy. Such engagement and collaboration recognises the contribution that each practice can make to both the quality of services to their registered patients and the wider impact to service delivery across the whole CCG population.

The AT will not only be concerned with the procurement of new services or of contract compliance of poorly performing practices, but will also be involved in ensuring unwarranted variation is reducing and quality is improving, as it is with safeguarding patient safety etc. As such, the model described here is one which embraces open, collaborative and engaging relationships/partnerships between practices, CCG and the PMC team within the AT with whom they are aligned. This ensures that GPs remain at the heart of delivering the quality improvement agenda. The basis of the partnership is one of excellent service provision, recognising that all parties have different levers and influences.

What this means is that practices will contribute, with the CCG leads and the AT to work out together, drawing from factual intelligence and other sources of internal and external information what a practice quality improvement plan will include, what the development needs may be and how practices can be best supported to make those improvements. This could include programme objectives, interventions, sharing best practice, milestones, supporting information/evidence, funding estimates (if appropriate), cost-sharing arrangements and actions to be taken if progress exceeds or falls short of expectations at specified review points. In many cases where practices are performing well, plans may be minimal, and the primary relationship will be between the practice and the CCG, allowing the CCG to share such best practice amongst its members, to support the CCG wide quality improvement statutory obligations.

Whilst it is recognised that there is excellence in general practice, in a small number of others there may be greater concerns bordering on contractual failure requiring a more formal conversation led by the AT, but the process and focus will be the same for all Practices; one of support to improve, with market exit as a last resort.

Crucially, whilst the AT remains accountable for contract management, a co-ordinated practice/CCG/AT/LMC relationship provides an opportunity for an engaging and collaborative discussion that covers each practice's quality and achievement across a range of agreed standards, be that in respect of the service provided by a practice or a practices use of for example, secondary care services. By way of an example and to provide clarity, a CCG may have a conversation with a member practice, which from an initial view, appears to have a disproportionate number of emergency admissions for conditions usually managed in primary care. This in itself may not necessarily indicate a problem, but allows the CCG to understand the implications in the wider commissioning arrangements.

For the 'commissioner' of PMC services this represents a significant departure from focusing solely on the *contract* to focusing on *contract **and** quality improvement / health outcomes*. This tilts the AT PMC manager's role away from activities that verify income, to those that assure excellent service provision whether or not it is enforceable with the current contractual levers. Contract sanctions and variations should only be considered as a last resort having explored all other support and improvement mechanisms. (Please see the *Policy for managing breaches, sanctions and terminations for primary medical service contracts*).

Within this new environment the NHSCB will retain the responsibility for monitoring and managing fraud, the arrangements for which are currently under discussion.

It is not for the AT to determine *how* CCG leads should discharge their quality improvement activity with their practices as they will ultimately be measured on their clinical outcomes, but the AT will need to oversee progress in order to discharge its own responsibilities as contract manager.

An AT PMC manager will be aligned to a number of CCGs with whom they will develop a relationship regarding the development of PMC. Recognising that data alone is not an indication of poor service provision, the AT PMC managers will use a collection of information including national data (clinical indicators, quality outcome standards, appraisals, complaints etc.) and local intelligence (including conferring with stakeholders) in order to assess and mitigate any potential risk to service provision and patient safety within a practice. They will be expected to take the necessary steps to assure themselves that adequate and effective support is being provided to reduce the risk, identify areas for improvement and be able to demonstrate and measure that improvement. This role therefore is expected to operate with a high degree of autonomy and personal discretion informed by the organisations core principles and culture. The AT will also have a senior medical practitioner who will be the lead clinical commissioner and Responsible Officer (RO) – in the clinically-led new order it will be the relationship between this individual and the PMC manager, working with CCG clinical leads and GP leads in individual practices that will be key to continuously improving service provision in primary medical care.

3. Data and intelligence to support the NHS CB assessment

The NHSCB made a commitment to provide area teams with a centrally available set of pre-analysed data which it could use to begin to assess unwarranted variation in the provision of primary medical services. This information has been developed and made available through a web interface accessible to all NHSBC regional hubs, CBATs, CCGs and at the same time accessible by practices. The web interface is available through a restricted access log-in at www.primarycare.nhs.uk

As highlighted previously, unlike PCTs, the ATs will be operating across a greater footprint, working with a greater number of practices and with fewer staff. This means the AT will not have the same degree of personal relationship, insight or knowledge of every practice that exists currently between PCTs and practices. Again recognising the AT retains contractual accountability, the Practice/CCG/AT/LMC relationship, supported by a centrally provided, transparent and consistent suite of measures, in conjunction with robust, fair and consistent guidance for the management of service and performance improvement, will ensure risks to quality and patient safety are addressed in a timely and proportionate manner.

The model described talks about the AT engaging with CCGs regarding the quality of each practice: The standards set by the Care Quality Commission (CQC) describe the characteristics of ‘good’ quality primary medical care.

http://www.cqc.org.uk/organisations-we-regulate/gps-and-primary-medical-services

Other definitions of Good General Practice which may also provide the starting point for discussions between practices and the AT (supported by the CCG and LMC) are as follows:

- That aspect of health services that assures person focussed care over time to a defined population, accessibility to facilitate receipt of care when it is first needed, comprehensiveness of care in the sense that only rare or unusual manifestations of ill health are referred elsewhere, and coordination of care such that all facets of care (wherever received) are integrated." Starfield, B. J Epidemiology and Community Health 2001; 55:452-4.

- The well-known but underappreciated secret of the value of primary care is its person and population, rather than disease, focus. (Starfield, 2009,).

- The general practitioner is a specialist trained to work in the front line of a healthcare system and to take the initial steps to provide care for any health problem(s) that patients may have. The general practitioner takes care of individuals in a society, irrespective of the patient's type of disease or other personal and social characteristics, and organises the resources available in the healthcare system to the best advantage of the patients. The general practitioner engages with autonomous individuals across the fields of prevention, diagnosis, cure, care, and palliation, using and integrating the sciences of biomedicine, medical psychology, and medical sociology. (Olsen et al. BMJ 2000; 320:354-7).

As excellent service provision cannot be discerned from a single set of measures or indicators it is proposed that along with local knowledge there will be three key sources of data and intelligence to assist the AT in assessing risk to service provision and patient safety with a practice;

1. An annual electronically held profile which describes the characteristics of each practice; the demography of the population served etc. This information is unlikely to change significantly but may contain specific information which may have a bearing on their achievement of certain standards eg student practices.

    - A practice profile is attached as annex 2

2. An electronically held and annually updated practice self-declaration including for example, operating policies, opening times and assurance of good workforce planning etc. This information will link with contractual requirements and CQC essential standards, as well as providing relevant additional information for use by NHS CB staff if required.

    - A practice declaration is attached as annex 3

3. A suite of clinical indicators and outcome standards (shared transparently with practices)

This indicator set will apply to all practices and ATs nationally in order to allow for comparisons to be made, within a CCG, within AT, by Association of Public Health Observatories (APHO) grouping, by practices of other similar characteristics, student practices, dispensing practices etc. The indicators are designed to face in two directions; as far as possible they link back to the NHS Outcomes Framework and the Commissioning Outcomes Framework (COF), which will be used to measure CCG performance and they also tie back to the current contract regulations.

- A set of clinical indicators is attached as annex 4

It is acknowledged that these indicators and outcomes standards do not capture the full range of services provided by general practice, they are however an important starting point in helping individual practices, CCG leads and the AT to have an objective and rounded view of performance with a focus on service improvement and outcomes.

It is also accepted that there are very few circumstances where data alone would determine AT intervention; therefore, this data will be represented such that attention is paid to those practices whose service provision may be a cause for concern. However to avoid standard 'clipboard' management, the AT PMC managers will be required to make a judgement regarding risk to quality and patient safety and discern whether a practice requires support to improve or intervention. If there is a concern that, despite appropriate and adequate support, a practice is unable to demonstrate improvement, the AT PMC manager will undertake to establish whether there is an actual cause for concern. This will include the scrutiny of any other relevant sources of intelligence or data for example;

- Additional and detailed practice data (PCCA tool)
- CQC reports (relationship with CQC being explored)
- Performer performance/concerns (if appropriate)
- CCG engagement and relationship
- LMC intelligence
- Practice phone call or visit

In the few circumstances where there is a practice failure the AT PMC manager will investigate all opportunities to help the practice to improve their service provision liaising with the CCG and LMC (as appropriate). As a last resort, the AT may need to use contractual levers, breaches and sanctions and ultimately issue a termination notice if risks to quality and patient safety are not addressed. (Please see policy on *Managing breaches, sanctions and terminations for primary medical service contracts*).

Whilst the performance framework is risk rather than rules based it is expected that ATs will conduct random quality assurance visits in place of QOF visits to ensure the robustness of data, to assure the NHS CB of practice performance, and to ensure that AT staff gain a wide perspective of quality in primary care provision. It is advised however that until the NHSCB counter fraud arrangements are agreed that ATs include some QoF checks as part of the random QA visits and guidance regarding the areas that ATs may wish to focus and be found at http://bit.ly/YLV66w and http://bit.ly/Xk1mq1

Data alone is not a panacea and at a practice level needs to be understood in the context of wider determining factors (eg social deprivation, health needs, population profile, resourcing, to name but a few). There are numerous examples of data being used inappropriately and the outcomes being contradictory to the intention; one such non healthcare related example is provided below.

- The Bhoomi Project, an ambitious effort by the southern Indian state of Karnataka to digitize some 20 million land titles, making them more accessible. It was supposed to be a shining example of governance and open data that would benefit everyone and bring new efficiencies to the world's largest democracy. Instead, the portal proved a boon to corporations and the wealthy, who hired lawyers and predatory land agents to challenge titles, hunt for errors in documentation, exploit gaps in records, identify targets for bribery, and snap up property. An initiative that was intended to level the playing field for small landholders ended up penalising them and bribery costs and processing time actually increased.

A level playing field doesn't mean much if you don't know the rules, or have the right sporting equipment, so key to the successful delivery of the commitments in securing excellence will be in applying this policy consistently, but proportionately and being in possession of multiple sources of factual information and intelligence to support decision making.

4. Relationship with performer assurance

Whilst this policy is concerned with practice or *team* performance there is a relationship between this and the policy for the *Identification, management and support of primary care practitioners whose performance gives cause for concern*. The data and intelligence required to support that function will be different but both sources of intelligence will provide for the overall assessment of both GP and practice performance. Again, the relationship between the AT PMC manager and lead medical commissioner/RO together with the medical lead in the CCG and the individual GP is of central importance in securing the best outcome for patients and the professionals involved.

Annex 1: Abbreviations and acronyms

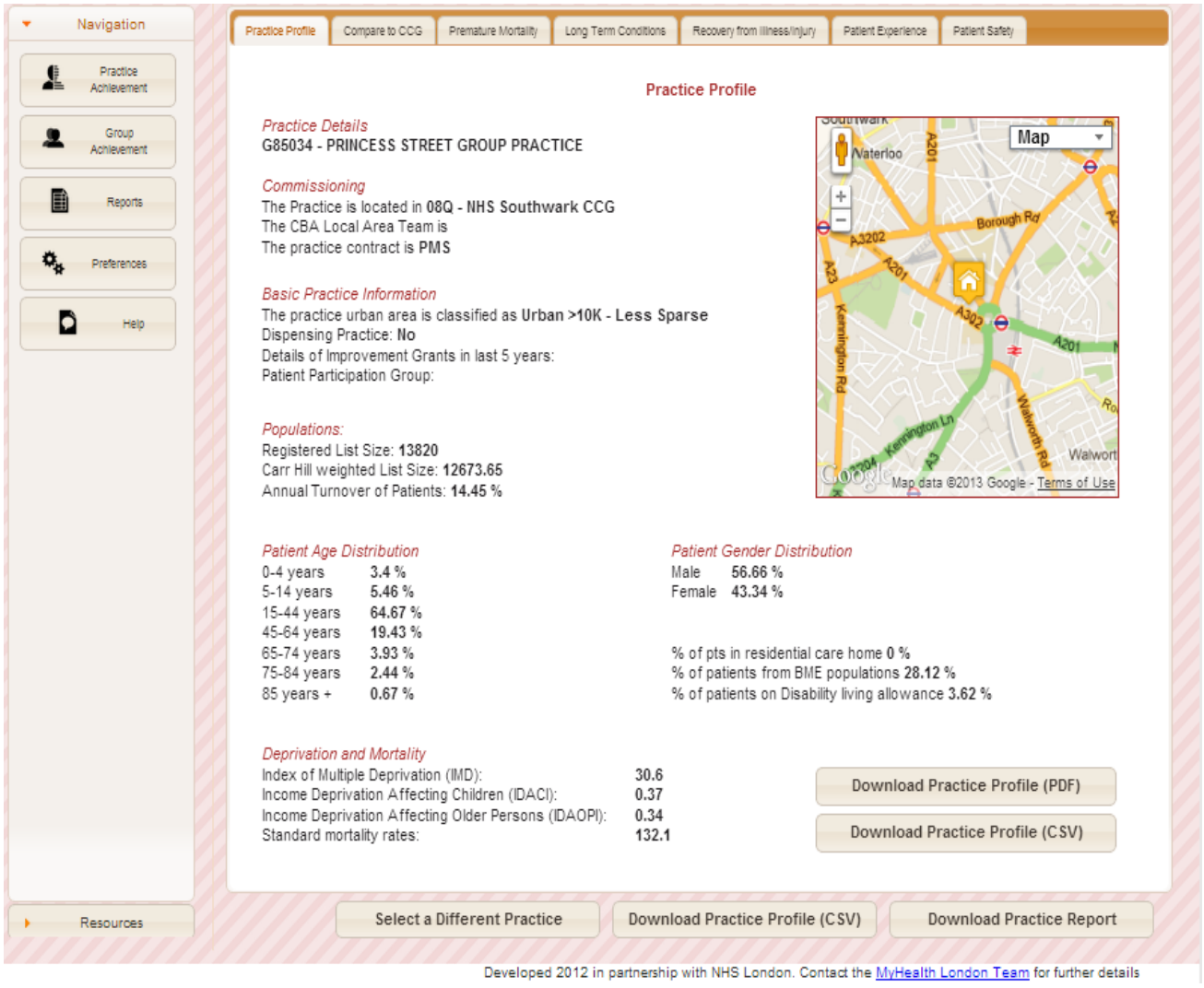
A&E	accident and emergency
APHO	Association of Public Health Observatories (now known as the Network of Public Health Observatories)
APMS	Alternative Provider Medical Services
AT	area team (of the NHS Commissioning Board)
AUR	appliance use reviews
BDA	British Dental Association
BMA	British Medical Association
CCG	clinical commissioning group
CD	controlled drug
CDAO	controlled drug accountable officer
CGST	NHS Clinical Governance Support Team
CIC	community interest company
CMO	chief medical officer
COT	course of treatment
CPAF	community pharmacy assurance framework
CQC	Care Quality Commission
CQRS	Calculating Quality Reporting Service (replacement for QMAS)
DAC	dispensing appliance contractor
Days	calendar days unless working days is specifically stated
DBS	Disclosure and Barring Service
DDA	Disability Discrimination Act
DES	directed enhanced service
DH	Department of Health
EEA	European Economic Area
ePACT	electronic prescribing analysis and costs
ESPLPS	essential small pharmacy local pharmaceutical services
EU	European Union
FHS	family health services
FHS AU	family health services appeals unit
FHSS	family health shared services
FPC	family practitioner committee
FTA	failed to attend
FTT	first-tier tribunal
GDP	general dental practitioner
GDS	General Dental Services
GMC	General Medical Council
GMS	General Medical Services
GP	general practitioner

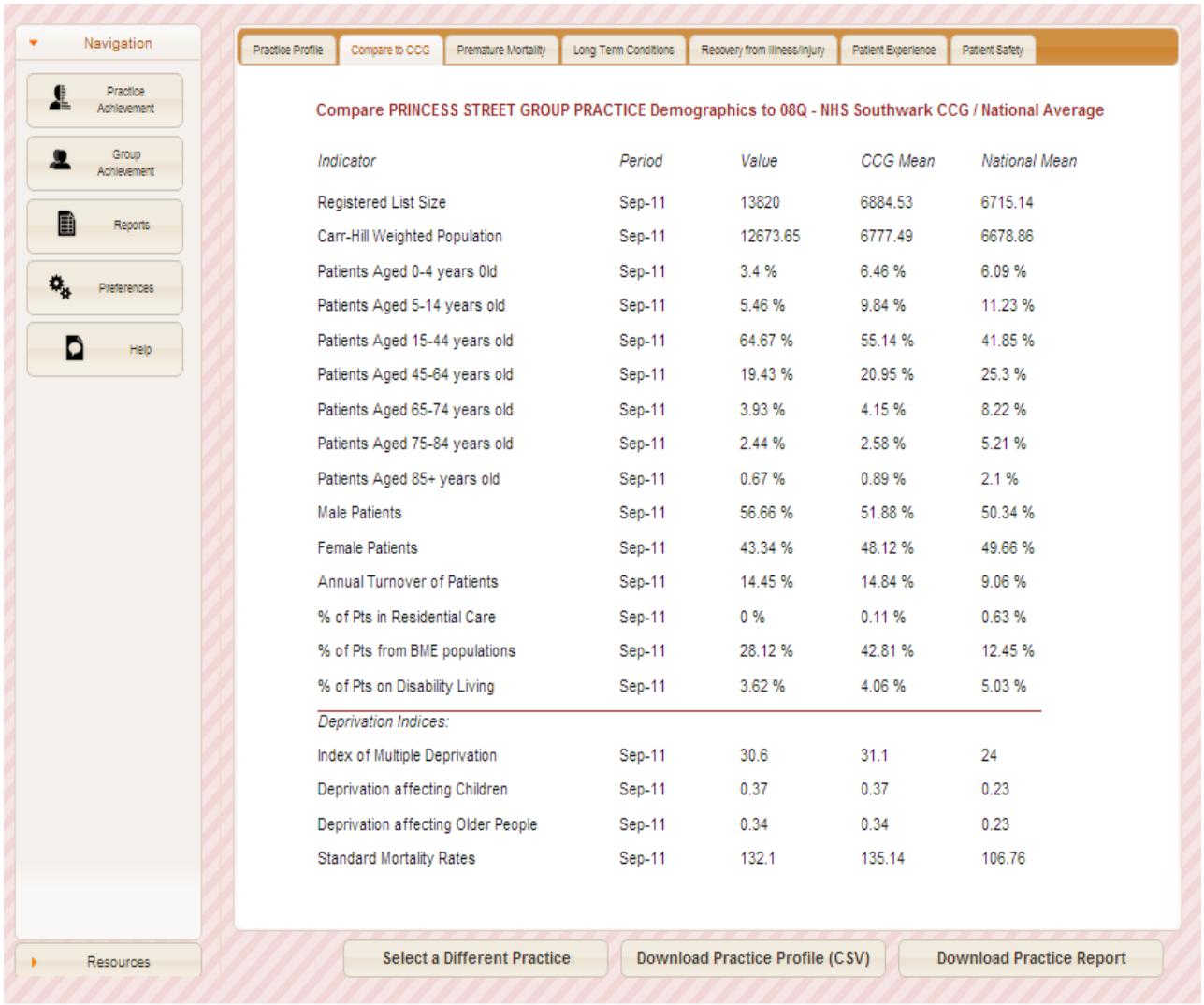
GPES	GP Extraction Service
GPhC	General Pharmaceutical Council
GSMP	global sum monthly payment
HR	human resources
HSE	Health and Safety Executive
HWB	health and wellbeing board
IC	NHS Information Centre
IELTS	International English Language Testing System
KPIs	key performance indicators
LA	local authority
LDC	local dental committee
LETB	local education and training board
LIN	local intelligence network
LLP	limited liability partnership
LMC	local medical committee
LOC	local optical committee
LPC	local pharmaceutical committee
LPN	local professional network
LPS	local pharmaceutical services
LRC	local representative committee
MDO	medical defence organisation
MHRA	Medicines and Healthcare Products Regulatory Agency
MIS	management information system
MPIG	minimum practice income guarantee
MUR	medicines use review and prescription intervention services
NACV	negotiated annual contract value
NCAS	National Clinical Assessment Service
NDRI	National Duplicate Registration Initiative
NHAIS	National Health Authority Information System (also known as Exeter)
NHS Act	National Health Service Act 2006
NHS BSA	NHS Business Services Authority
NHS CB	NHS Commissioning Board
NHS CfH	NHS Connecting for Health
NHS DS	NHS Dental Services
NHS LA	NHS Litigation Authority
NMS	new medicine service
NPE	net pensionable earnings
NPSA	National Patient Safety Agency
OJEU	Official Journal of the European Union
OMP	ophthalmic medical practitioner
ONS	Office of National Statistics
OOH	out of hours
PAF	postcode address file
PALS	patient advice and liaison service

PAM	professions allied to medicine
PCC	Primary Care Commissioning
PCT	primary care trust
PDS	personal dental services
PDS NBO	Personal Demographic Service National Back Office
PGD	patient group direction
PHE	Public Health England
PLDP	performers' list decision panel
PMC	primary medical contract
PMS	Personal Medical Services
PNA	pharmaceutical needs assessment
POL	payments online
PPD	prescription pricing division (part of NHS BSA)
PSG	performance screening group
PSNC	Pharmaceutical Services Negotiating Committee
QOF	quality and outcomes framework
RCGP	Royal College of General Practitioners
RO	responsible officer
SEO	social enterprise organisation
SFE	statement of financial entitlements
SI	statutory instrument
SMART	specific, measurable, achievable, realistic, timely
SOA	super output area
SOP	standard operating procedure
SPMS	Specialist Personal Medical Services
SUI	serious untoward incident
UDA	unit of dental activity
UOA	unit of orthodontic activity

Annex 2: Practice Profile

Web Based




Navigation
Practice Achievement
Group Achievement
Reports
Preferences
Help
Resources
Practice Profile
Compare to CCG
Premature Mortality
Long Term Conditions
Recovery from Illness/Injury
Patient Experience
Patient Safety
Compare PRINCESS STREET GROUP PRACTICE Demographics to 08Q - NHS Southwark CCG / National Average
Indicator | Period | Value | CCG Mean | National Mean
Registered List Size | Sep-11 | 13820 | 6884.53 | 6715.14
Carr-Hill Weighted Population | Sep-11 | 12673.65 | 6777.49 | 6678.86
Patients Aged 0-4 years Old | Sep-11 | 3.4 % | 6.46 % | 6.09 %
Patients Aged 5-14 years old | Sep-11 | 5.46 % | 9.84 % | 11.23 %
Patients Aged 15-44 years old | Sep-11 | 64.67 % | 55.14 % | 41.85 %
Patients Aged 45-64 years old | Sep-11 | 19.43 % | 20.95 % | 25.3 %
Patients Aged 65-74 years old | Sep-11 | 3.93 % | 4.15 % | 8.22 %
Patients Aged 75-84 years old | Sep-11 | 2.44 % | 2.58 % | 5.21 %
Patients Aged 85+ years old | Sep-11 | 0.67 % | 0.89 % | 2.1 %
Male Patients | Sep-11 | 56.66 % | 51.88 % | 50.34 %
Female Patients | Sep-11 | 43.34 % | 48.12 % | 49.66 %
Annual Turnover of Patients | Sep-11 | 14.45 % | 14.84 % | 9.06 %
% of Pts in Residential Care | Sep-11 | 0 % | 0.11 % | 0.63 %
% of Pts from BME populations | Sep-11 | 28.12 % | 42.81 % | 12.45 %
% of Pts on Disability Living | Sep-11 | 3.62 % | 4.06 % | 5.03 %
Deprivation Indices:
Index of Multiple Deprivation | Sep-11 | 30.6 | 31.1 | 24
Deprivation affecting Children | Sep-11 | 0.37 | 0.37 | 0.23
Deprivation affecting Older People | Sep-11 | 0.34 | 0.34 | 0.23
Standard Mortality Rates | Sep-11 | 132.1 | 135.14 | 106.76
Select a Different Practice
Download Practice Profile (CSV)
Download Practice Report
Developed 2012 in partnership with NHS London. Contact the MyHealth London Team for further details

Annex 3: Practice Declaration

Web based

Annual Practice Declaration

The practice

Practice code	
Practice name	
Practice area	
Practice contract type (GMS/PMS/APMS/other)	
Organisation type (Social Enterprise/NHS body/Non NHS body)	
Contract start date/ end date (where applicable)	
Practice telephone number (for patients)	
Practice telephone number (other, if different)	

1. Practice staff

CQC Essential Standard 13

At all times there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. *Regulation 22 of Health & Social Care Act 2008 (Reg Activities) Regulations 2010.*

For the purpose of this Practice Declaration the contractor is assumed to have sufficient staff, suitably qualified, skilled and experienced to provide a level of service sufficient to meet the reasonable needs of its patients. The practice should amend the declaration to 'NO' if it is not able to demonstrate this.

1A. The practice can evidence and make available the needs analysis and risk assessment it has used for deciding sufficient staff levels. Recognising the need to have the right knowledge, experience, qualifications and skills for the purpose of providing services in the practice and demonstrating capacity to respond to unexpected service changes.	Yes/No

CQC Essential Standard 12

Includes the requirements that, in relation to recruitment, staff and practitioners are not discriminated against during the application and recruitment process.

CQC Essential Standard 14

Requires that there are suitable arrangements in place to ensure that staffs are appropriately supported in relation to their responsibilities so that they can deliver them safely and to an appropriate standard, this includes receiving appropriate training, professional development, supervision and appraisal.

2. **Suitability**

1B. All Doctors and Nurses employed in the practice have annual appraisals *(GMS Schedule 6 part 4)*	Yes/No
1C. The Practice provides its staff with reasonable opportunities to undertake training to maintain their competence (*GMS Schedule 6 part 4)*	Yes/No
1D. Practice staff have written terms and conditions of employment conforming to or exceeding the statutory minimum (*relevant employment law and GMS Schedule 6 Part 9)*	Yes/No
1E. The Practice can demonstrate that it is compliant with Equal Opportunities legislation on employment and discrimination. *(Equality Act 2010 and GMS Schedule 6 Part 9)*	Yes/No
1F. Doctors and Staffs employed by the practice can demonstrate compliance with national and local child protection guidance (W*orking together and safeguarding children part one 2010*) including where relevant that they have undertaken the appropriate level of child protection training.	Yes/No
1G. The practice confirms that it has adequate insurance against liability arising from negligent performance of clinical services under the contract (*GMS Schedule 6 part 9)* And, that all Doctors working in the practice have adequate insurance or professional indemnity cover for any part of the practice not covered by an employer's indemnity scheme. *(Good Medical Practice places a professional duty on doctors to have such arrangements in place. Paragraph 34 of GMP)*	Yes/No

CQC Essential Standard 12

Includes the requirement to ensure that persons employed are registered with the relevant professional body where such registration is required and have been subject to the necessary checks so that the provider is assured that the worker is suitable for their role.

Practice Declaration

2A. All employed health care professionals employed by the practice are registered with the relevant professional body , and upon employment this together with satisfactory references are checked, and, for GPs, inclusion on the performer list is checked *(GMS schedule 6 part 4)*	Yes/No
2B. All relevant staffs have been subject to the necessary checks including appropriate level CRB.	Yes/No

3. Practice premises and equipment

CQC Essential Standard 10

Includes the requirement that practice premises must be suitable in design and layout, they must be subject of adequate security measures and adequately maintained.

Also requires that the practice meets the requirements of the Health & Safety at Work Act 1974 and other associated and relevant legislation.

CQC Essential Standard 8

Includes the requirement that, so far as is reasonably practicable, the practice must ensure maintenance of appropriate standards of cleanliness and hygiene in relation to premises, equipment and reusable medical devices.

CQC Essential Standard 11

Includes the requirement that equipment must be adequately maintained, suitable for its purpose and used correctly.

Practice Declaration

3A. The premises used for the provision of services under the contract are suitable for the delivery of those services and sufficient to meet the reasonable needs of the practice's patients. *(GMS Schedule 6 part 1)* and must meet Minimum Standards as defined in Schedule 1 of the Premises Costs Directions (2013)	Yes/No
3B The premises used for the provision of services under the contract are subject to a plan that has been formally agreed with the PCT under Regulation 18 (3) if rectification actions are	Yes/No

required; or in order to comply with Minimum Standards as defined in Schedule 1 of the Premises Costs Directions (2013),	
3C. The practice is able to demonstrate that it complies with arrangements for infection control and decontamination in accordance with the Health & Social Care Act 2008 code of practice on the prevention and control of infections and related guidance, appendix D: examples of interpretation for primary medical care, including carrying out annual audits as set out in the code. *(GMS Schedule 6 Part 1)*	Yes/No
3D. The practice can demonstrate that it meets the requirements of the Health & Safety at Work Act 1974 [this might include for example evidence of regular review or audit of any policies or procedures adopted by the practice]. *(Health & Safety at Work Act, and GMS Schedule 6 Part 9)*	Yes/No

4. Access to and availability of practice services

Opening Hours (reception and phone lines open)	Details of opening hours for reception	Details of opening hours for phone lines
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		
Phone Access	Where not a geographical number, the practice is assured it complies with 084 guidance requirements	Yes/No
	Where applicable the practice can demonstrate it has a plan and timescale in order to achieve compliance	Yes/No

Extended Opening Hours – where the practice is funded to provide outside of core contract hours		
Hours per week (not within 08:00-18:30 Mon-Fri)	Funding mechanism (ie ES, Incentive Scheme, PMS growth, other)	Contract/agreement end date

In case of Emergency	
The practice can evidence that during core contract hours (08:00 – 18:30 Monday to Friday) there are sufficient arrangements in place for its patients to access essential services if the practice is not open.	Yes/No

Out of Hours	
The practice is responsible for care in the OOH period	Yes/No (opted out)
If 'Yes' and the practice sub-contracts the provision of out of hours care, please provide name of accredited provider.	
If 'Yes' the practice can evidence that it has in place arrangements to monitor its contract with its OOH provider, including frequency of meetings with the provider, and any action it has taken against its provider through non-compliance or complaints.	Yes/No

5. Information about the practice and its procedures

CQC (Non-Essential) Standard 15

The Practice has a statement of purpose that describes the aims and objectives of the service provider, the kinds of services provided and the range of service users' needs they are intended to meet. The full name of the provider and any registered manager together with their business address and telephone number, legal status and locations at which services are provided. *Regulation 12 and Schedule 3 of the CQC (Registration) Regulations 2009.*

CQC Essential Standard 17

Includes the requirement that the practice must have an effective system in place for identifying, receiving, handling and responding appropriately to complaints and comments made by service users or persons acting on their behalf.

Practice Declaration

5A. The practice produces a leaflet that includes all of the requirements set out in its contract (*GMS Schedule 10*)	Yes/No
5B. The practice reviews and updates its leaflet at least once every 12 months. *(GMS Schedule 6 part 5)*	Yes/No
5C. The practice leaflet is made available for patients/prospective patients *(GMS Schedule 6 part 5)*	Yes/No
5D. The practice has a complaints policy which complies with the NHS complaints procedure and it is advertised to patients *(GMS Schedule 6 part 6)*	Yes/No
5E. The practice can demonstrate reasonable grounds where it has refused an application to register and keeps a written record of refusals and the reasons for them *(GMS Schedule 6 part 2)*	Yes/No
5F. When removing patients from its list the practice can demonstrate that it does so in accordance with contractual requirements and provides the required notice, including providing an explanation of the reasons in writing to the patient. *(GMS Schedule 6 part 2)*	Yes/No

CQC Essential Standard 9

Includes the requirement that the practice must make appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity, including controlled drugs.

The National Health Service (Pharmaceutical Services) Regulations 2012 Chapter 16 and Schedule 6 Terms of service for dispensing doctors

Practice Declaration

5G. The practice has a written policy and procedures in line with the requirements of the Medicines Act (GMS Schedule 6 part 3) which will be made available if requested.	Yes/No
5H. Practice stores vaccines in accordance with the manufacturer's instructions *(GMS Schedule 6 para 1)*	Yes/No
5I. The practice has a procedure to ensure all batch numbers and expiry dates are recorded for all vaccines administered and that all immunisations, vaccinations and consent to immunisations are recorded in the patient record *(GMS Schedule 2 para 4)*	Yes/No

5J. The Practice stores its Vaccines in fridges which have a max and min thermometer and can demonstrate, if asked, that readings are taken on all working days.	Yes/No
5K. All staff involved in administering vaccines are trained in the recognition of anaphylaxis and able to administer appropriate first line treatment when it occurs *(GMS Schedule 2 para 4)*	Yes/No
5L. The practice can demonstrate it has clear procedures, that are followed in practice, monitored and reviewed, for controlled drugs, unless they are taken by the person themselves in their own home, including: investigations about adverse events, incidents, errors and near misses; sharing concerns about mishandling.	Yes/No
5M. Systems in place to ensure they comply with the requirements of the Safer Management of Controlled Drugs Regulations 2006, relevant health technical memoranda and professional guidance from the Royal Pharmaceutical Society of Great Britain and other relevant professional bodies and agencies.	Yes/No
5N. The practice declares it complies with the terms of service of dispensing doctors outlined in schedule 6 of The National Health Service (Pharmaceutical Services) Regulations 2012 and; The practice can demonstrate that for all patients which it dispenses to it is satisfied that they would have serious difficulty in obtaining any necessary drugs or appliances from an NHS pharmacist by reason of distance or inadequacy of means of communication (colloquially known as the “serious difficulty” test which can apply anywhere in the country); or A patient is resident in an area which is rural in character, known as a controlled locality, at a distance of more than one mile1 (1.6 km) from pharmacy premises (excluding any distance selling premises). The pharmacy premises do not have to be in a controlled locality.	Yes/No

CQC Essential Standard 2

Includes the requirement that the practice must have suitable arrangements in place for obtaining, and acting in accordance with, the consent of the service users in relation to the care and treatment provided for them. *Regulation 18 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010*

Practice Declaration

5O. The practice has a policy for consent to the treatment of children that conforms to the current Children Act 2004.	Yes/No
5P. The practice records patients' consent for minor surgery including curettage and cautery and, in relation to warts, verrucae and other skin lesions, cryocautery *(GMS Schedule 2 Para 8)*	Yes/No

6. Governance

CQC Essential Standard 21

Includes the requirement to ensure that patients are protected against risk of unsafe or inappropriate care and treatment arising from lack of proper information about them, by mean of maintenance of accurate patient records that include appropriate information and documents in relation to their care and treatment.

Includes the requirement that patients can be confident that their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.

Practice Declaration

6A. The practice has a protocol to allow patients access to their records on request in accordance with current legislation *(Data Protection Act 1998 and GMS Schedule 6 Part 9)*	Yes/No
6B. The practice has a designated individual responsible for confidentiality of personal data held by it (GMS Schedule 6 Part 5)	Yes/No
6C. The practice has a nominated person who has responsibility for ensuring the effective operation of the system of clinical governance. *(GMS Schedule 6 part 9)*	Yes/No
6D. The practice is registered under the Data Protection Act *(GMS Schedule 9 Part 9)*	Yes/No
6E. The practice has a procedure for electronic transmission of patient data in line with national policy *(Data protection act 1998 and GMS Schedule 6 Part 9)* including mechanisms to ensure that computerised medical records/data are transferred to a new practice when a patient leaves. .	Yes/No

7. Compliance with CQC

7A. Has the practice registered and declared compliance with CQC Essential Standards	Yes/No
7B. Has the practice created an action plan for any of the CQC Essential Standards	Yes/No

Annex 4: Clinical and Quality Indicators

	Indicator Short Name	Indicator Full Description
1	Emergency Cancer Admissions	Emergency Cancer admissions per 100 on Cancer Disease Register
2	Early diagnosis of Cancer	Early diagnosis of Cancer
3	DM31 - % patients where last BP is 140/80 or less	DM 31: The percentage of patients with diabetes in whom the last blood pressure is 140/80 or less
4	AF03 - % AF patients on Anticoagulation	AF 3: The percentage of patients with atrial fibrillation who are currently treated with anti-coagulation drug therapy or an anti-platelet therapy
5	CS01 - % patients with record of cervical smear	CS01: The percentage of patients aged from 25 to 64 whose notes record that a cervical smear has been performed in the last five years (including exceptions)
6	Health checks for people with serious mental illness	Under Development
7	Flu Vaccinations - Over 65 Coverage	Uptake Rates of GP Patients aged 65 years and older of Seasonal Flu Vaccine
8	Flu Vaccinations - At risk coverage	Seasonal Flu vaccine uptake in those aged 6 months to under 65 years in clinical risk groups
9	AF Prevalence ratio	AF Prevalence ratio
10	CHD Prevalence ratio	CHD Prevalence ratio
11	COPD Prevalence ratio	COPD Prevalence ratio
12	Asthma Prevalence ratio	Asthma Prevalence ratio
13	Diabetes Prevalence ratio	Diabetes Prevalence ratio
14	Emergency Admissions	Emergency Admissions per 1,000 population
15	A&E attendances	A&E attendances per 1,000 population

16	Emergency CHD Admissions	Emergency CHD admissions per 100 patients on disease register
17	Emergency Asthma Admissions	Emergency Asthma admissions per 100 patients on disease register
18	Emergency Diabetes Admissions	Emergency Diabetes admissions per 100 patients on disease register
19	Emergency COPD Admissions	Emergency COPD admissions per 100 patients on disease register
20	Emergency Dementia Admissions	Emergency Admissions for Dementia per 100 patients on disease register
21	DM17 - % of patients with cholesterol of 5 or less	DM 17: The percentage of patients with diabetes whose last measured total cholesterol within the previous 15 months is 5mmol/l or less
22	DM27 - % of patients with IFCC-HbA1c is 64 mmol/mol or less	DM27: The percentage of patients with diabetes in whom the last IFCC-HbA1c is 64 mmol/mol (equivalent to HbA1c of 8% in DCCT values) or less (or equivalent test/reference range depending on local laboratory) in the preceding 15 months
23	CHD08 - Patients with CHD with Cholesterol level of <5	CHD 8: The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the previous 15 months) is 5mmol/l or less

24	COPD15 - Spirometry Achievement	COPD 15: The percentage of all patients with COPD diagnosed after 1st April 2011 in whom the diagnosis has been confirmed by post bronchodilator spirometry
25	ASTHMA08 - % patients with measures of variability and reversibility	ASTHMA 8: The percentage of patients aged eight and over diagnosed as having asthma from 1 April 2006 with measures of
		variability or reversibility
26	Overall Exception Rate	Overall Exception Rate
27	Antidepressants ADQ/Star Pu	Antidepressants ADQ/Star Pu
28	Long/Intermediate Insulin Analogues	Long/Intermediate Insulin Analogues
29	Ezetimibe as a proportion of all Lipid modifying drugs	Ezetimibe as a proportion of all Lipid modifying drugs
30	Improving Access to Psychological Therapies	Improving Access to Psychological Therapies
31	Emergency ACS Admissions	Emergency Admissions for 19 ACS Conditions per 1,000 population
32	DM 21 - % patients with diabetes with a record of retinal screening	DM 21: The percentage of patients with diabetes who have a record of retinal screening in the previous 15 months
33	Antibacterial Items/Star Pu	Antibacterial Items/Star Pu
34	Overall experience of GP surgery	Overall experience of GP surgery
35	Ease of getting through to someone at GP surgery on the phone	Ease of getting through to someone at GP surgery on the phone
36	Overall experience of making an appointment	Overall experience of making an appointment
37	Cephalosporins & Quinolones % Items	Cephalosporins & Quinolones % Items
38	Hypnotics ADQ/Star Pu	Hypnotics ADQ/Star Pu
39	NSAIDs Ibuprofen & Naproxen % Items	NSAIDs Ibuprofen & Naproxen % Items

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