Care Quality Commission

NHS England

With support from NHS Clinical Commissioners

Regulation of General Practice Programme Board

Joint framework: Commissioning and regulating together

A practical guide for staff

Contents

1. This framework

1.1 Purpose of the framework

This joint working framework was developed by the Care Quality Commission (CQC) and NHS England, with the support of NHS Clinical Commissioners (NHSCC). Its purpose is to help our organisations work more effectively together and reduce duplication in the regulation of general practice.

The framework is part of the work of the Regulation of General Practice Programme Board. The Board's collective aim is to coordinate and improve the regulation of general practice.

We developed the framework with the input of over 150 staff from clinical commissioning groups (CCGs), CQC, and NHS England at regional workshops in London, Leeds, Birmingham and Bristol held in May and June 2017. We would like to acknowledge their valuable contributions.

It gives us an opportunity to improve joint working to reduce duplication between regulation and commissioning, and to become more streamlined and targeted in our activity.

In many areas, relationships are working well and this framework is therefore intended to help provide structure, support, and examples of good practice for our organisations, partners and stakeholders, including GP practices, to share and learn from.

1.2 Who this framework is for

This framework is primarily for staff working in CQC, NHS England, and in CCGs, and is designed to work alongside each organisation's existing processes. It aims to provide transparency on our joint intention to reduce the impact of regulation and commissioning oversight on practices. The framework will evolve as we continue to work together and our relationships mature, and will reflect the changing landscape of commissioning. Over time, we will extend the framework to include other organisations with a role in the commissioning, regulation, and oversight of general practice, and it will reflect the roles of key stakeholders such as local medical committees and Healthwatch.

The scope of this framework is limited to general practice in England. It describes:

- roles and responsibilities
- when and how CQC, NHS England and CCGs will share information

- how we will respond to concerns and risk

- what a good working relationship between CQC and commissioners looks like.

1.3 The Regulation of General Practice Programme Board

The Board was established in June 2016 following the publication of the General Practice Forward View (GPFV). The GPFV aims to tackle five important areas in primary care, including practice workload.

The purpose of the Board is to:

- Coordinate and improve the overall approach to the regulation of general practice in England by bringing together the main statutory oversight and regulatory bodies and delivering a programme of work that will streamline working arrangements and minimise duplication.

- Provide a forum to enable statutory bodies to sign up to a common framework – a shared view of quality – which will be co-produced with the professions and the public.

Further information on the work of the Regulation of General Practice Programme Board can be found here.

1.4 Our principles

As organisations that deliver, commission, fund, support and regulate general practice, we are committed to following these principles in our work to help improve the quality of general practice:

1. We ensure a commitment to patient and public participation.

2. We promote quality through everything that we do.

3. We are committed to reducing unnecessary duplication in our efforts to monitor and assure quality.

4. We are committed to supporting and encouraging improvement.

1.5 Changing landscape of primary care

We recognise the changes and challenges facing the commissioning and delivery of general practice. The General Practice Forward View sets out an ambition to develop enhanced primary care with general practice at its core, and to build capacity and resilience through wider integration. The successful delivery of new and emerging models of care requires integration between community and mental health

services, the voluntary sector and social care providers. New care models are equally reliant on these services making changes to traditional ways of working. These system changes will bring challenges for providers, commissioners and regulators.

We recognise that changing models of care may bring instability, which can create periods of increased risk during this transition. Our commissioning and regulatory approach needs to be proportionate to ensure a safe transition with a focus on quality, in a way that does not create a barrier or disincentive to change.

There are opportunities for oversight bodies to provide a more targeted approach to identify and support practices that need to improve. We aim to use our commissioning and regulatory responsibilities and levers to support improvement. We therefore make reference in the framework to the GP Resilience Programme and other commissioning powers, and the roles of other key stakeholders.

2. Collaborative working arrangements

2.1 Benefits of collaboration

We share information through collaborative working in four ways:

- through routine information sharing

- at local meetings

- when it concerns emerging and urgent concerns (non-routine)

- when coordinating ongoing activities.

The benefits of collaborative working are:

For people who use services	• all agencies work well together to improve quality • the system of oversight is easier to understand
For providers	• clear and consistent expectations from oversight bodies • less duplication of requests for information
For national and local system partners	• more efficient working with less duplication • organisations share information and expertise

2.2 Routine information sharing

This is an important way to make sure that CQC, NHS England, and CCGs can fulfil their statutory functions effectively. We need to ensure that GP practices are confident that the data sharing and information governance arrangements between our organisations are appropriate and actively seek to reduce duplication.

We have already made significant steps to streamline processes and share information. The following are examples of how our organisations currently share information routinely:

- NHS England regularly shares eDec (annual GP practice electronic self-declaration) information with CQC

- CQC shares weekly inspection rating updates with NHS England

- CQC can share planned inspection schedules with commissioners

- commissioners share local information and intelligence with CQC

- CCGs keep CQC up-to-date with local quality improvement work

- commissioners engage regularly with local medical committees (LMCs)

- the General Medical Council (GMC) shares information to inform CQC inspection activity

- NHS England shares a range of metrics with GP practices, LMCs and commissioners through its Primary Care Web Tool.

Positive working relationships based on trust and a clear understanding of the roles and responsibilities of each stakeholder are critical for ensuring successful partnership working. In some areas, there are established formal mechanisms between commissioners and CQC to ensure successful collaborative working, although these should not be seen as the only means to develop those relationships. We also recognise the role of Quality Surveillance Groups (QSGs) and other local forums that have been established to share information in some areas of the country.

NHS Clinical Commissioners recognises that relationships have, and will continue to develop, on a one-to-one basis between CCGs (typically primary care leads) and their local CQC inspection contact. These will also reflect the different types of relationships and levels of interaction.

Telephoning the right person at the right organisation at the right time is often the best way to both develop those relationships and avoid duplication, wherever possible. Some teams have already recognised that it is important to take opportunities to reflect on lessons learned, including where things have been successful, for example, when supporting a practice in special measures.

One attendee at a regional workshop summarised this as:

"*Quality and trust, with a patient focus. Building on what we already have.*"

CQC has introduced maximum intervals of five years between inspections for practices rated as good or outstanding. This makes relationships with local stakeholders and the timely sharing of information even more important.

2.3 Local meetings

Staff across the country have implemented a variety of ways to support collaborative working. Some examples of the practical arrangements that work well include:

- quarterly stakeholder meetings (local authority/CCG/CQC)
- monthly updates on activity e.g. retirements/partnerships/closures (CCG/CQC)
- special measures meetings as required (practice/CCG/LMC/CQC/NHS England).

2.4 Support for improvement

This framework also aims to focus support for struggling GP practices through transparent and regular sharing of information between key partners.

Support for practices, and in some cases localities, will take various forms, including through the GP Resilience Programme and other commissioning powers such as Section 96 funding. See Appendix C for more information on the GP Resilience Programme.

2.5 Emerging and urgent concerns (non-routine)

Emerging or urgent concerns may present a risk to patient safety and need to be shared more quickly than through routine channels.

One of the aims of this framework is to provide clear lines of responsibility for considering and investigating particular concerns. Therefore the organisations that are involved have agreed the following general rules:

- NHS England should be the first contact where concerns relate to an individual professional.
- CQC should be notified where there are concerns across a practice that may affect patient care.
- The GMC's Employer Liaison Service should be notified where there are concerns about a doctor's fitness to practise or where concerns about patient safety or public confidence in the profession remain following intervention from NHS England or CQC.

NHS England Responsible Officers have a statutory role and are the main point of contact when concerns may relate to a doctor. Responsible Officers need to be able to consider emerging, recurrent and / or urgent concerns regarding a doctor's fitness to practise and that may have a bearing on their revalidation recommendations. Responsible Officers seek advice from the GMC's Employer Liaison Service when

considering fitness to practise concerns and with revalidation and routinely involve GMC Employer Liaison Advisers in early discussions about an emerging fitness to practise concern.

The NHS England Medical Director's team have a statutory responsibility to address issues regarding a GP's capacity or suitability to practise in the NHS through the performers list regulations.

2.6 Coordinating ongoing activities

Sometimes, concerns or failings may quite legitimately come under the scope of multiple organisations. In each situation, we should consider how to handle the issues, avoid over burdening the provider or practitioner, ensure that we avoid duplication where possible, and regularly review ongoing action. Communication between partner agencies and clear ownership are key.

The following are helpful pointers to achieve this:

- Identify who has the 'power' to respond to the problem by collaboratively understanding each other's remits.
- Identify the lead agency in each instance.
- Agree how to approach the problem, thinking constructively about how to reduce duplication.
- Use collective intelligence (e.g. CQC Insight, NHS England's Primary Care Web Tool and the GMC Data Tool).
- Establish a shared view of risk.
- Consider an advocate for the provider e.g. a representative of the LMC.

2.7 Next steps

This framework sets out where we have got to at this point in time. We recognise there is more for us to do to improve the effectiveness of our joint working. We must continue these efforts and share the successes we have for others to learn from.

Appendix A: Examples of good working relationships between CQC and commissioners

Case study 1

This example highlights how colleagues in the Central region have jointly developed processes for working together. This is built on efforts to understand each other's responsibilities and ways of working.

West Leicestershire CCG and CQC Lincolnshire and Leicestershire team working together	
Why we needed to develop strong information sharing with all agencies	• To ensure that all agencies have all relevant information. • To prevent duplication of any action. • To reduce the impact of regulation on providers. • To ensure that patients are protected and have good quality care and treatment. • To ensure a good use of resources.
What we did together	• Took time to understand each agency's role. • Held joint meetings. • Reached an understanding of who would do what, and when. • Attended the CCG board meeting to discuss the joint issues. • Mapped out each organisation's processes. • Developed a process to ensure consistency around our decision-making.
The impact	• The agreed process has proved helpful, especially with providers rated as inadequate by CQC and/or where enforcement has been required. • Each party has known what they needed to do at each stage to ensure that improvements were made and patients were kept safe. • The CCG board acknowledged the impact of the jointly agreed process: o all agencies are kept up to speed with ongoing risk

	o the CCG has taken swift action to support the practices in need
	o practices have turned around and improved quickly
	o decision-making for CQC has been made simpler as there is confidence in CCG's action/support to the practices.

Case study 2

This example shows how stakeholders in West Yorkshire meet to share information and improve the effectiveness of their joint working.

Wakefield CCG – Quarterly CQC engagement meeting	
Aims and objectives	To support effective information sharing, service coordination and dialogue to improve health and care services for residents, their families and carers within NHS Wakefield CCG. • Informing partner organisations of key service developments. • Reporting the outcome of recent inspections. • Sharing intelligence about providers, including complaints and concerns. • Notifying of future inspection plans. • Discussing opportunities for coordination/support. • Updating on areas of previous concern. • Viewing quality of care across provider boundaries (health and care system).

Membership	• CQC representation from (or covering) teams from:
	   o Adult social care
	   o Hospitals
	   o Primary medical services
	   o Mental health
	• Wakefield Local Authority teams:
	   o Safeguarding
	   o Care and support commissioning team
	• CCG teams:

	o Quality o Primary care o Care homes o Safeguarding • Healthwatch Wakefield.
Typical agenda by sector	• recent inspections • concerns raised by others • updates on areas of previous concern • future inspection plans • organisational service developments • opportunities for coordination/support.
The impact	• Better information sharing when planning inspections leads to reduced duplication. • By discussing risk we are able to identify areas to support improvement.

Case study 3

This details work in response to specific concerns in the South West. This work was an excellent example of organisations working together effectively to protect patients and support practices.

Bristol, North Somerset, South Gloucestershire and Somerset CCGs, NHS England and CQC working together	
What has worked well	• After a practice in Bristol was placed into special measures, a joint meeting between the CCG, NHS England, the LMC and CQC was held to share learning. • Somerset CCG shared pre-inspection information, including risks. • There was a multi-agency approach when a practice was placed in special measures, which involved sharing information, providing oversight of the exiting and incoming provider, and mitigating the impact on patients. • Each party was clear what they needed to do at each stage

	to ensure that improvements were made and patients were kept safe.
The impact	• All agencies were kept up to speed with ongoing concerns.
	• The CCG took swift action to help the practices that needed support.
	• Practices responded by improving quickly and avoiding more severe regulatory action.
	• Decision-making for CQC was made simpler as there was confidence in the CCG's action and support to the practices.
	• More information sharing, including pre QSG information and risks.
	• A Primary Care Hub has been developed.
	• Knowledge and resources are shared, including CQC Insight and NHS England's Primary Care Web Tool.

Appendix B: Illustrative agenda for local meetings

We have developed this illustrative agenda to help provide structure to meetings between local stakeholders that do not have well-established relationships.

General practice stakeholder meeting

Date:	
Location:	
Attending:	
Apologies:	

No.	Agenda item	DELETE AS APPROPRIATE BASED ON STAKEHOLDER
1	Welcome and introductions	
2	CCG / NHS England update	• Support for practices • New services / models / collaborations / pilot schemes • Cross sector issues
3	CQC update	• Feedback and trends arising from local inspections • CQC Insight • Providers in special measures
4	Developing CQC's inspection schedule	• Sharing CQC's current plans for GP and GP out-of-hours • Opportunity for stakeholder input • Performance on enhanced services • Compliance with contractual obligations • Patient experience surveys
5	Any other business	• Serious case reviews
6	Date of next meeting	

Appendix C: GP Resilience Programme

The GP Resilience Programme (GPRP) is a four-year, £40m programme designed to help GP surgeries that are facing the most difficulties and to build greater overall resilience into the system. The first £16m of this funding was allocated in 2016/17, with £8m allocated for the subsequent three years of the programme, to 2020.

It supports GP practices across the country in a range of ways based on the following 'menu of support':

- diagnostic services to quickly identify areas that need support to improve

- specialist advice and guidance, for example, human resources, information technology

- coaching, supervision and mentorship

- practice management capacity support

- rapid intervention and management support for practices at risk of closure

- coordinated support to help practices struggling with workforce issues

- change management and improvement support to individual practices or groups of practices.

This investment complements £10m of previous investment, committed in December 2015, to support practices identified as needing the greatest support (the Vulnerable Practices Programme).

Allocation of funding is coordinated by NHS England and practices can self-refer as well as being identified for support by CCGs or NHS England. Further information on the programme, and links to case studies, is available on NHS England's website.