

Framework for responding to CQC inspections of GP practices



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Executive summary

General practice, at its best, is often described as the jewel in the crown of the English NHS. We know that the vast majority of GPs do their utmost to provide the best possible care, in the face of rising demand from the public. But we also know from early visits carried out by the Care Quality Commission (CQC) that there are a very small number of practices who may be struggling to meet the standards that both patients and taxpayers alike have the right to expect.

From October 2014, the CQC will begin to roll out their new inspection regime to inspect and rate every GP practice in England by April 2016. Practices will be inspected across five key questions, considering the extent to which they are safe, effective, responsive, caring and well-led. They will be rated in one of four categories; outstanding; good; requires improvement; or inadequate.

This framework is designed to support area teams to work with the minority of practices that are rated inadequate so that there is a consistent approach to avoiding risk to patients and ensure continued patient confidence in the local NHS and primary care services.

As independent contractors, it is ultimately the practice's responsibility to address any problems identified at inspection and to ensure improvement. However, it is important that area teams - and Clinical Commissioning Groups (CCGs) when co-commissioning - ensure there are clear and transparent improvement plans in place and support appropriate interventions if services to patients are at risk.

This guidance describes how area teams:

- collaborate with CQC through ongoing monitoring and surveillance of contracts, prior to and during practice inspection to share intelligence.
- support practices rated inadequate in one of the key domains or population groups by putting in place an improvement plan and signposting to external support to ensure sustained measurable improvement.
- oversee progress against the plan and take further contractual action if there is no demonstrable improvement.

The principles described throughout this framework have been co-developed with area teams, CCGs, GP practices, CQC and experts in general practice improvement. They are based on experience of supporting practices and professionals to improve quality, safety and resilience.

The framework will be updated in due course as CQC's inspection and special measures regime is tested further and becomes embedded within the system.

Chapter 1: Ongoing monitoring and surveillance

1. Effective monitoring and surveillance of primary medical care services requires effective collaboration between CQC, NHS England and CCGs. Mature local relationships are required to ensure that information on general practice is shared and discussed in an appropriate and timely manner and that any risk is identified and managed and escalated where necessary.
2. The Quality Surveillance Groups (QSG) have become an essential forum for sharing concerns relating to primary care contractors. Critical to the success of the QSG is the commitment of senior leadership from each organisation and the opportunity to share concerns at an early stage to build a picture of the difficulties facing challenged practices. All QSGs are encouraged to ensure there is an appropriate sharing of information on risk and service delivery in primary care between the relevant agencies.
3. This chapter aims to give greater clarity on how CQC inspection teams, NHS England regional and area teams and CCGs combine their knowledge and resources. The impact of a failure to work together would significantly increase workload and reduce the effectiveness of all parties and the impact of poor coordination between area team and CQC could result in the continuation of an unsatisfactory service for longer than is necessary.
4. The introduction of a special measures regime makes it even more important that roles and responsibilities are clarified and that a consistent way of working together is established to oversee and support not just the practice, but the local clinical community, if risk to patient care is to be managed.
5. The logistics of what and how information is exchanged, when and how meetings take place, must be determined at a local level and these arrangements will be dependent upon factors such as geography, number of CCGs per area team and CCG constitutions for example. Different models of working have evolved with examples of weekly or monthly review meetings taking place between CQC inspection managers and area teams, some having all CCGs from an area represented and others meeting on a more individual basis with CCGs to discuss member practices. Regular meetings should take place where CQC and area team staff have specific discussions regarding a number of practices causing concern. It is important to agree a set of principles for joint working with CQC leads and implement a consistent system locally.
6. Principles for joint working should clearly set out:
 - Clarity of roles and responsibilities across CQC, NHS England and CCGs.
 - The personal leadership of the Area Director in setting up these arrangements and explicit involvement of Medical and Nursing Directors as well Primary Care Commissioning Leads.
 - An established on-going relationship between NHS England, CQC and CCGs outside of the inspection process to ensure there is an on-going route of communication and information sharing.

- How surveillance and ongoing monitoring is used to maintain shared risk assessments, at both practice and locality level (in recognition of the potential domino effect if an inadequate practice fails to improve).
 - A consistent approach to pre-inspection planning – particularly important to manage the post inspection work load on area teams and CCGs.
 - CQC inspections that are joined up with CCG and NHS England activities.
 - Greater transparency of meaningful information sharing (both hard and soft) about registered providers.
7. Table 1 sets out the proposed roles and responsibilities of CQC, NHS England and CCGs working collaboratively before, during and after inspections. The key elements include:
- Agreed information data set, available prior to discussions and normally discussed prior to any inspection.
 - A schedule of inspections made available in good time.
 - Targeted inspections by agreement.
 - Pre and post inspection information sharing meetings between CQC, area teams and CCGs.
 - Mechanism for immediate escalation to all parties.

Co-commissioning

8. CCGs have a statutory responsibility to support the improvement of primary care and their contribution to a Primary Care QSG is an essential element to this role. On 1 May 2014, NHS England announced plans to allow CCGs to develop new models of co-commissioning primary care. One of the stated aims of co-commissioning was:

“raising standards of quality (clinical effectiveness, patient experience and patient safety) within general practice services, reducing unwarranted variations in quality, and where appropriate, providing targeted improvement support for practices.”

9. The potential scope for co-commissioning of primary care encompasses a wide spectrum of activity, including the assessment of needs, decision making on strategic priorities with Health and Wellbeing Boards, designing and negotiating local contracts (e.g. PMS), managing financial resources, and monitoring contractual performance.
10. Three categories of interest in co-commissioning have been described.
- Greater involvement in primary care commissioning alongside NHS England area teams.
 - Joint commissioning arrangements through the creation of a joint committee or “committees in common” across NHS England and the CCG(s).
 - Delegated commissioning arrangements.
11. Whilst NHS England is able to give full delegated powers to CCGs to commission primary medical care services, NHS England is unable to delegate responsibility for the commissioning of primary care. It will be essential therefore that NHS England retains an element of oversight of primary medical care services.

12. Area teams and CCGs will need to agree within the principles for joint working the nature and extent of the CCG role through co-commissioning arrangements and ensure this is clearly articulated to CQC and to member practices.

Information and data sources

13. A range of information should be utilised throughout the processes of robust contract management and service improvement. NHS England, CCGs and the CQC should routinely aim to share all available information, in particular during pre-inspection meetings.
14. Some sources (primary care web tool) are accessible to GP practice staff, CCGs, NHS England area and regional teams and other approved stakeholder organisations including CQC. However, other information (complaints, contractual compliance, individual performance concerns and workforce information) will be held locally.
15. The following list may be helpful for pre-inspection preparations:
 - General Practice High Level Indicators (GPHLI) and General Practice Outcomes Standards (GPOS) within the primary care web tool:
 - Agreed subset of key indicators from both datasets. e.g.
 - Patient experience domain indicators.
 - Friends and family test (when available).
 - Patient safety domain indicators.
 - Patient annual turnover.
 - Practice profile.
 - Practice electronic declaration.
 - QOF data.
 - Complaints / SUI / SEA / whistleblower / performance concerns.
 - Contractual compliance.
 - CQC data packs and intelligent monitoring.
 - CCG information regarding quality / clinical effectiveness including possibly information for prescribing audit data, referral data.
 - Professional investigations.
 - Workforce information.
 - Premises information:
 - Any known issues / ongoing or proposed developments.
 - Minimum standards audit (Principles of Best Practice part 8) to be released.
 - Infection prevention control audit (Principles of Best Practice part 9) to be released.
 - Any premises 6 facet survey held by the area team

Table 1: Roles and responsibilities of area teams, CCGs and CQC before, during and after inspections

Who	Before	During	After
Area team <i>Each area team has a small senior team who lead on primary care issues. It will include the Medical Director (MD), Director of Nursing (DoN) and the Primary Care Commissioning Lead, as a minimum. It is important that this team has established lines of communication with the CQC Inspection Manager (IM) to share real time concerns. They should look to hold weekly meetings with CCGs and CQC to discuss any concerns or issues arising and agree any action required.</i>	<ul style="list-style-type: none"> Provides any relevant contextual information to CQC (e.g. enhanced services, demographics, history). Provides information about the practices being inspected (eg contractual issues, complaints, improvement plans). Advises CQC whether there are any other practices that should be inspected (this should usually be picked up in the ongoing work together but this could include where some recent concerns have been raised). 	<ul style="list-style-type: none"> Identifies a named responsible officer at director level to be accessible should any immediate risks be identified. Informs the relevant CCG lead of any concerns identified by the CQC. Manages any immediate contract issues. Appropriate professional lead in the area team manages any immediate professional issues. 	<ul style="list-style-type: none"> Senior representative to be available if risks or concerns are identified. CQC will have a specific meeting with the area team and CCG after visiting practices in a particular CCG area. Any professional issues will be managed by the appropriate professional lead in the area team. Good and outstanding practice identified will be shared with CCG and others. The area team will clarify the mechanism for doing this at local level. Thresholds for escalation for discussion at local and regional QSGs to be agreed.
CCGs <i>CCGs have a duty in relation to the quality of primary medical services provided, as described in statute Section 14S NHS Act 2006. They assist and support NHS England in discharging its duty relating to securing continuous improvement in the quality of primary medical</i>		<ul style="list-style-type: none"> Identifies a named responsible officer at director level to be accessible should any immediate risks be identified. 	<ul style="list-style-type: none"> CCG quality improvement and support may form part of any action plan to resolve concerns or risks identified by the inspection visit.

<p><i>services. CCGs monitor performance of services commissioned directly from primary care providers against agreed service standards. CCGs should share information with CQC to help prioritise where inspections may be needed.</i></p>			
<p>CQC <i>The Inspection Manager (IM) at the CQC builds and leads ongoing relationships with key relevant stakeholders, including area teams and CCGs. They share information and concerns, escalating risks in real-time, attends the local QSG as a member and facilitates informal information sharing, e.g. CQC attendance at local ‘huddles or monthly attendance at area team quality/risk meetings. The IM coordinates CQC resources across the local area to enable inspections to be prioritised and will share the risk register with area teams.</i></p>	<ul style="list-style-type: none"> • IM coordinates and chairs pre-inspection information sharing meeting with area team and CCG. • If there are significant issues the Head of Inspection supports the inspection manager at the meeting. • Clarifies and improves understanding of new approach and process with area team and CCG. • Leads discussion on providers being inspected agree any variation to the list (this is not an opportunity to add additional inspections but depending on issues/actions inspections may be paused). • IM briefs inspectors and Head of Inspection on the outcome of discussions at meeting. 	<ul style="list-style-type: none"> • Inspector feeds back to practice at the end of the inspection, including if there are any immediate concerns. • In the case of any major of immediate concerns the inspector will discuss this with their inspection manager and the Head of Inspection. Any major or immediate concerns will also need to be fed back to NHS England. IM will contact the area team on the same working day. 	<ul style="list-style-type: none"> • IM presents overview of findings/themes across practices at post-inspection meeting to area team and CCG, including good and outstanding practice. • IM will highlight where there are concerns about individual practices prior to this meeting, for example if a practice is rated inadequate. • A CQC Management review meeting will be held to decide next steps if there is a need to consider any enforcement activity.

CQC inspections and ratings

16. CQC will inspect practices and ask whether they are safe, effective, caring, responsive and well-led. The inspections focus on six key population groups (older people, people with long term conditions, working age people; families, children and young people, people living in vulnerable circumstances and people with poor mental health).

17. Following CQC inspections, each GP practice will receive ratings at four levels:

Level 1: Rate every population group for each key question.

Level 2: An aggregated rating for each population group.

Level 3: An aggregated rating for each key question.

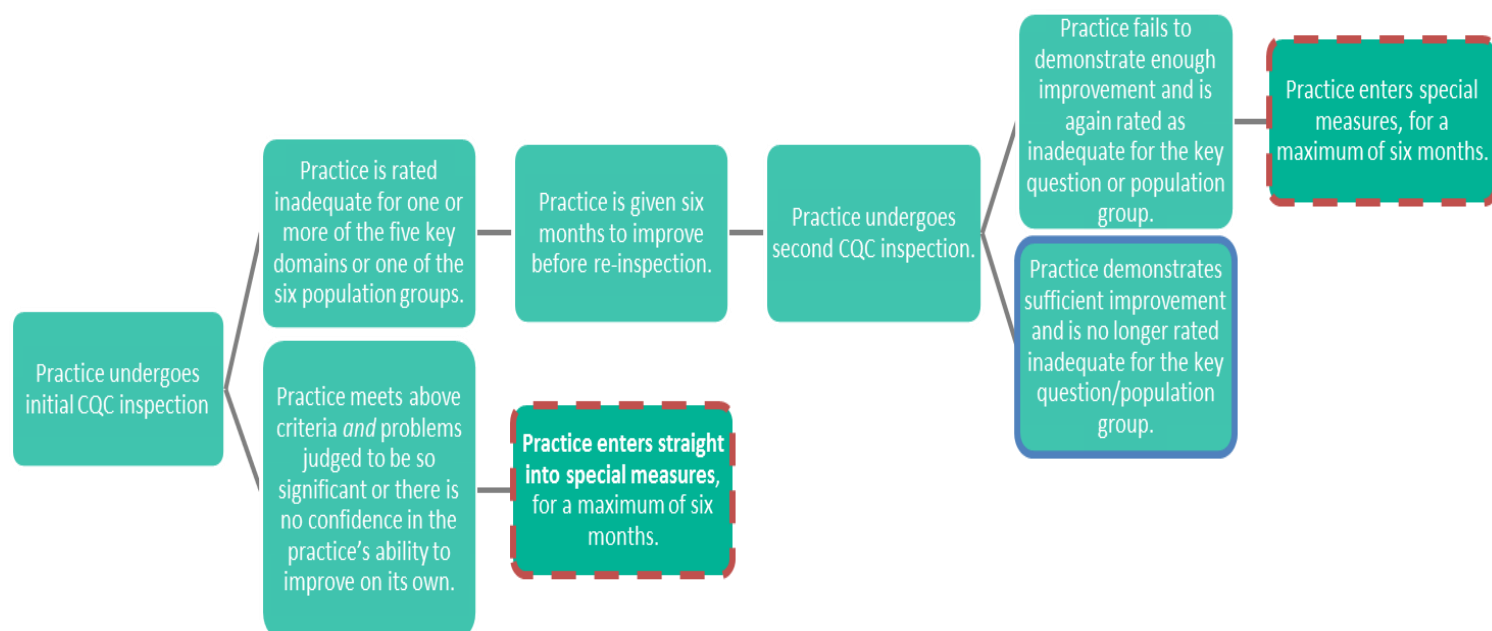
Level 4: An aggregated overall rating for the practice as a whole.

18. The following illustration shows how the four levels work together:

Level 1: Every key question for every population group		Safe	Effective	Caring	Responsive	Well-led	Level 2: Aggregated rating for every population group
	Older people	Good	Outstanding	Good	Outstanding	Good	
	People with long term conditions	Good	Inadequate	Good	Inadequate	Good	
	Families, children and young people	Good	Good	Requires improvement	Good	Requires improvement	
	Working age people (including those recently retired and students)	Good	Good	Outstanding	Good	Outstanding	
	People living in vulnerable circumstances	Good	Outstanding	Good	Requires improvement	Good	
	People with poor mental health (including people with dementia)	Good	Good	Requires improvement	Good	Requires improvement	
Level 3: Aggregated rating for every key question	Overall	*	*	*	*	*	Level 4: Overall rating for the practice

Inadequate rated practices and special measures

19. The diagram below illustrates the relationship between a practice found to be inadequate and the special measures regime.



20. Where a practice is rated inadequate for one or more of the five key questions (safe, effective, caring, responsive or well-led) or one of the six population groups, CQC will give the practice six months to improve and require the practice to set out the actions that it will take to address the findings.

21. The next chapter describes how area teams should work with practices rated inadequate for one or more of the five key questions or one of the six population groups to develop an improvement plan that can be used by the practice to respond to CQC on the actions being taken, but which also goes further in setting out how they will address the underlying root issues, aim for continual improvement and identifies relevant sources of support to draw upon. A template is enclosed at annex 2. Clearly, there may be instances where a practice receives a level one inadequate rating and the resolution is straightforward. Whilst it is just as important for the area team to work with the practice to ensure the issues are rectified ahead of any re-inspection, a lighter touch improvement plan may be developed by the area team which is more proportionate to the issues identified.

22. The practice will be re-inspected six months later and if there has been no demonstrable improvement and is again rated inadequate for the key question or population group then the practice will be placed into special measures by the CQC.

23. In some cases a practice will be rated as inadequate for one of the five key questions or one of the six population groups and the problems are either judged to be so significant that patients are at risk, or there is no confidence in the practice's ability to improve on its own that the GP practice will be placed straight

into special measures. This will usually include when a practice is judged to be 'inadequate' for the well-led domain as well as one of the other five domains or population groups.

24. In either instance (following an initial inspection or a re-inspection), once a practice is placed into special measures, this will be for a maximum period of 6 months. Being placed into special measures should be seen by the contractor and NHS England as an indication that this is the last chance for the practice to improve, and if improvements are not made, CQC will move to cancel the registration of that provider.
25. In all of these circumstances NHS England must ensure that they take the necessary, appropriate and timely contractual action, to ensure ongoing patient safety and access to services.

Support for practices placed in special measures

26. From October 2014 to October 2015, NHS England will be working with the Royal College of General Practitioners to pilot a peer support programme which will provide expert support, mentoring and coaching for practices placed in special measures. The costs will be split between NHS England and practices on a matched funding basis, each contributing half. More information about the pilot is available at annex 1 and details will be shared with area teams in due course.

Chapter 2: Improvement

27. It is the responsibility of the contract holder of the practice to improve services to patients and ensure the appropriate action is taken following any CQC inspection. Area teams and CCGs, however, can play a vital role in ensuring a positive climate of improvement in a health community, guiding and appropriately supporting a practice in the direction of improvement
28. Area teams are advised to invest in building effective working relationships with local stakeholders including Local Medical Committees (LMCs) before inspections. Other bodies can contribute a great deal in terms of helping to identify problems, providing facilitation and expertise for discussions about solutions, and providing direct assistance in implementing change.
29. Notwithstanding the potential future of co-commissioning, CCGs already have a responsibility to improve the quality and safety of primary care provision for local people and are a key partner for area teams in responding to performance concerns identified by CQC. In many cases, the CCG will already have specific knowledge of the issues concerned, as well of improvement approaches adopted by other practices. In addition to its statutory role in improving primary care, it has a leadership role among local practices by virtue of its being a membership body. Peer support between practices and networks for practice staff are well established sources of support for practices to use on improvement journeys.
30. Many CCGs have already established programmes, resources and processes to promote and support continuous quality improvement in practices. Peer support between member practices is an obvious example. This is very welcome and NHS England strongly encourages all CCGs to engage actively in supporting improvement.
31. Table 2 summarises many of the roles and abilities of different local stakeholders. It is not intended to be exhaustive or to replace contractual or other obligations already in place.

Table 2 : Responsibilities and expectations of key stakeholders

	Responsibilities	Expectations
CQC	<ul style="list-style-type: none"> Clearly identify in the inspection report and post-inspection discussions what needs to be improved/reasons for inadequate ratings. Use enforcement powers to: <ul style="list-style-type: none"> Protect people who use regulated services from harm and the risk of harm. Hold providers and individuals to account for failures in how services are provided. 	
The practice	<ul style="list-style-type: none"> The practice itself is responsible for the care it provides and for improving in response to CQC instructions. Others may be able to provide advice and practical support, but that does not lessen the responsibility on the practice. Undertake a root cause analysis to establish any underlying issues that need to be addressed within the improvement plan or that may require referral to other organisations such as NCAS or the GMC. Create a plan for improvement, agreeing key milestones and measures with the area team and submit this to CQC. Commit sufficient time to creating and implementing a plan for improvement. Provide the area team and CQC with regular updates on progress in enacting change. 	<ul style="list-style-type: none"> Collaborate openly with the area team in creating and implementing a plan for improvement. Work with others (eg CCG, LMC) to identify collaborative solutions to local needs. Incorporate learning from others, including from neighbouring practices.

Area team	<ul style="list-style-type: none"> • Support the practice to draw up an improvement plan. • Undertake monitoring against the improvement plan. • Consider any relevant contractual action. 	<ul style="list-style-type: none"> • Help the practice to identify sources of support for improvement. • Provide direct advice and support from the medical and nursing teams. • Where a practice in special measures secures support through the national Royal College of General Practitioners offer, work closely with the support team to ensure they have all relevant information about the practice and locality, including other local support resources.
Clinical Commissioning Group	<ul style="list-style-type: none"> • Support the process of improvement planning, and identification of solutions and sources of support for the practice. 	<ul style="list-style-type: none"> • Support the practice in identifying root causes of issues. • Identify ways in which new opportunities could be created as part of plans for the locality or the development of federations and mergers. • Gather and share learning which benefits all practices locally. • Consider the benefit of peer support.

Creating an improvement plan

32. Where a practice is rated inadequate for one or more of the five key questions (safe, effective, caring, responsive or well-led) or one of the six population groups, CQC will give the practice six months to improve and require the practice to set out the actions that it will take to address the findings.
33. Area teams should work with these practices to develop an 'improvement plan' which can be used by the practice to respond to CQC on the actions being taken, but which also goes further in setting out how they will address the underlying root issues, aim for continual improvement and identifies relevant sources of support to draw upon.
34. A proposed template for the improvement plan can be found **at annex 2** and a step by step guide aimed at practices to support its development is enclosed at **annex 3**.
35. The template is offered as a specimen to help area teams work with practices to record their improvement plan and track progress. It includes the recommended information to be sent to CQC, to satisfy the requirement to notify them of proposed actions.
36. Clearly, there may be instances where a practice receives a level one inadequate rating and the resolution is straightforward. Whilst it is just as important for the area team to work with the practice to ensure the issues are rectified ahead of any re-inspection, a lighter touch improvement plan may be developed by the area team which is more proportionate to the issues identified.
37. There is a strong expectation that the improvement plan will be co-developed between the area team, the CCG and practice. Where the practice is not forthcoming in sharing the information, area teams should consider whether it would be appropriate to take contractual action to require the information.
38. The process of reflection, discussion and planning which results in such a document is more significant in improvement than the document itself. The best plan will be one that is developed collaboratively and one that addresses underlying issues not only superficial symptoms, aims to achieve continual improvement, draws on relevant sources of support and forms the basis of a rigorous delivery of change.
39. **Annex 4 contains a range of case studies** of practice improvement that have worked in some areas. Area teams may find these helpful, however, it is important to note that we are not endorsing nor recommending any one type of approach locally. Ultimately, it is the practices responsibility to improve and address any concerns highlighted in the inspection and has to be at the discretion of the area team how much support is possible.
40. **Annex 5 contains a list of potential sources of support** for practices to help inform decisions about securing support to improve. Entry on the list does not constitute a recommendation or commitment to provide funding. If there are

additional suggested entries, please forward these to Dr Robert Varnam, Head of General Practice Development at NHS England (robert.varnam@nhs.net).

41. Practices may benefit from the support of a wide variety of people and organisations. In many cases, they will want to seek others' input to help compile a coherent package of support, while, in others, a more piecemeal approach will be appropriate.
42. CCGs have a significant role to play in stimulating the development of support offers to help practices innovate and improve. These may combine in-house and external resources, depending on local circumstances. Some CCGs have already contributed to the creation of locally based expert teams and systems for sharing experience between practices. Others are beginning to work with national organisations to support practices directly or build local capabilities. It is likely that every CCG will need access to both local and wider expertise to help all practices improve quality and transform services for the future, and development of the right capacity and capabilities this will need to be an area for detailed planning and investment over coming years.

Monitoring of Implementation

43. Improvement plans should include clear details of how and when progress will be assessed by the area team (ideally in partnership with the CCG). Important principles for monitoring are as follows:
 - Include an early assessment of the extent to which the practice as an effective organisation, and all relevant members of the practice team are engaging in the process of improvement and accept their responsibility. The area team should consider performance issues of GPs that may be associated with the problems found during the inspection.
 - Look for signs of any new issues emerging, or other evidence that plans may need to be amended. This is not uncommon during an improvement process, and often indicates that additional root cause analysis may be required.
 - Agree at the outset whether, when and how the area team or others will review the preparedness of the practice prior to re-inspection by the CQC.
 - Aim to minimise the burden of monitoring, to ensure the practice is able to concentrate on its improvement work.

Informing patients

44. It is important that patients are kept continually informed when issues are identified with the quality or the conformity of their services, for example when a practice is rated inadequate or is placed into special measures. Patients should be kept up to date what the rating means and, in particular, what action the practice is taking to improve.
45. Area teams should support practices to inform patients through all reasonable means, including information in the waiting room, on the practice website and NHS Choices, as well as in direct meetings with patients such as the patient participation group.

46. Area teams should also take appropriate action to ensure that the largest possible number of patients are aware of the outcomes. This could include notices via Healthwatch, area team and CCG websites, and other communications channels.
47. CQC already publish their reports and ratings to patients, and during autumn 2014, the Department of Health is consulting on whether to require providers to display their CQC ratings, including on their website and within their premises.
48. It is good practice to ensure a senior responsible person in the area team (or CCG through co-commissioning arrangements) ensures effective measures are put in place to make patients aware of the action being taken by the practice, the area team and the CCG. Patients are generally very supportive of their practice, and rightly expect to be informed about important developments. They are also often a significant source of support in improvement efforts.

Chapter 3: Performance oversight and contractual action

50. NHS England has a statutory obligation, pursuant to Section 13E of the NHS Act 2006, to exercise all its functions with a view to securing continuous improvement in the quality of services provided to individuals for, or in connection with, healthcare which would include taking contractual action, where necessary to do so, to ensure the safety of patients and compliance with contracted services.
51. This chapter sets out the framework for taking a contractual response to concerns raised by the Care Quality Commission (CQC) following a practice inspection visit and/or an 'inadequate' rating given to a GP practice.
52. In the most part it is likely that matters will be resolved through the development and implementation of improvement plans. There will be occasions, however, when area teams will need to take contractual action to resolve matters either alongside the CQC regulatory arrangements or completely independently from them.
53. This chapter aims to support area teams in consistently taking the proportionate and appropriate contractual action in response to CQC concerns and ratings, signposting to existing guidance and policies in the event of intractable problems and to ensure patient safety, continuity of services and choice are considered at all times throughout the processes.
54. Timely, effective and appropriate information sharing between CQC and area teams will be essential to minimise duplication of effort and allow NHS England to take forward its management of a contractor. However, it is relatively likely that NHS England will need to undertake some further investigation using its contractual powers where the CQC has identified concerns about a provider. In drafting the terms of reference for such an investigation, area teams should have regard to information supplied by the CQC.
55. Nothing will restrict area teams in their right to act independently of the CQC inspection and rating, in enforcing contractual compliance in line with the single operating model policies, legislation and regulations.

CQC enforcement action

56. This section summarises the approach that CQC takes in deciding when to use its enforcement powers. These are described in full in the CQC Enforcement policy which is published on the CQC website (<http://www.cqc.org.uk/content/how-we-enforce>).
57. Where CQC identifies concerns a decision will be made about what action is appropriate to take. The action taken is proportionate to the impact or risk of impact that the concern has on the people who use the service and how serious it is. Where the concern is linked to a breach in CQC registration regulations, CQC has a wide range of enforcement powers given to take action. The CQC enforcement policy describes these powers in detail and the general approach to using them.

- Enforcement action can be taken under either:
- Civil enforcement: to protect people from harm.
- Criminal law: to hold a registered provider or manager to account in court in relation to a significant failing.

58. CQC also “recommends improvements” where they have identified changes that could or should be made but where a regulation has not been breached.

59. In addition to using the enforcement powers, CQC will also work with other organisations, including other regulators and commissioners, to help ensure action is taken on concerns that have been identified. This includes placing a practice which is found to be providing inadequate care into special measures.

CQC’s urgent powers to suspend or cancel registration

60. CQC can also use their powers of conditions, suspension and cancellation through urgent procedures, which have immediate effect (providers are able to appeal after CQC’s decisions to use urgent procedures).

61. CQC decides, when it is appropriate, to impose conditions or suspend registration using urgent procedures. To cancel a registration using urgent procedures CQC must apply to a justice of the peace for a court order.

62. The CQC action taken under urgent procedures takes immediate effect though the registered person affected by these actions does have the right of a fast track appeal to an independent tribunal.

63. The CQC will alert the area team to their views within one working day of a concern being identified following inspection and will notify the area team of its intention to suspend or cancel a provider’s registration under urgent action and any other relevant information in respect of that suspension as soon as that decision has been made.

64. Where a provider’s registration is to be suspended they are suspended from providing the relevant regulated activity from all locations. If the provider is suspended from providing all regulated activities the effect of this is that the provider will be temporarily blocked from being able to deliver services under the GMS/PMS or APMS contract until such time as that suspension is lifted, the outcome of any fast track appeal hearing is known and/or the CQC cancels the registration.

65. In these circumstances the contractor must immediately engage with the area team to consider the options for ensuring the continuity of service delivery which may include consideration of sub-contracting or parachuting arrangements.

Subcontracting

67. Subcontractors that provide treatment or care services that include the provision of a regulated activity will usually need to register with CQC in their own right, although this will always depend on the nature of the subcontracting arrangement.
68. CQC's Scope of Registration provides further detail on who needs to register (http://www.cqc.org.uk/sites/default/files/documents/20130717_100001_v5_0_scope_of_registration_guidance.pdf).
69. Generally, a sub-contractor with a contract to supply part of a wider and more comprehensive service will have to be registered for any regulated activity they perform if they retain any responsibility for the delivery of the service (such as the operational policies and protocols, day-to-day operational or staff management, clinical governance or quality assurance).
70. In situations where an existing registered provider takes over the running of the services from another practice the sub contracted provider must register the practice as a new locality under their own registration.
71. The locations that a provider is registered to operate from are listed in one condition of registration and sub-contracted providers can apply to vary this condition.
72. Sub-contracted providers must have their application approved before they can start to implement the changes (ie to provide care from a new location).
73. If providers are adding a new location, or changing the location to another, they will need to provide the CQC with information about this and the CQC may need to make a visit as part of the assessment of the application.
74. The sub-contracted provider will remain responsible for the services at the new/added locality while it remains part of their registration.

Urgent cancellation of registration

75. The CQC will consider using urgent procedures to cancel a registration as a last resort where the problem cannot be resolved in any other way and where a person(s) is at serious risk to their life, health or wellbeing.
76. When using its powers to cancel a registration using urgent procedures, the CQC must apply to a justice of the peace for a court order.
77. The CQC will notify the area team of the intention to make an application to cancel a provider's registration and any other relevant information in respect of that application.
78. Action under urgent procedures takes immediate effect. Registered persons have the right of a fast track appeal to an independent tribunal.

79. It is important to note that the CQC does not have the power to close the doors of a practice, only to take action in respect of the registrations associated with that practice.
80. Cancellation of a provider's registration means that they are no longer able to provide the relevant regulated activities which has the effect of removing the ability of the contractor to deliver services under their GMS/PMS or APMS contract resulting in the necessity to close the practice doors. This would constitute a significant breach of the contract and in such circumstances an area team should take, or is very likely to have taken, the appropriate contractual action as set out in the following information.

NHS England – contractual actions

81. This section sets out the actions that area team primary medical care contract teams should follow on receiving notification from the CQC that they have concerns in respect of a practice that is likely to be reported as “inadequate”, entering special measures or moving towards CQC suspension or cancellation of registration .
82. Where the CQC have concerns about a practice, following the first inspection, they will notify the area team, within one working day of the visit providing a brief description of the concerns and any evidence available at that time.
83. In due course the CQC will provide a full report and rating, identifying any further action required by the practice in regard to their CQC registration. Area team contracting teams should not wait for this full report before assessing the risks and taking any necessary contractual action.
84. Timely, effective and appropriate information sharing between the CQC and NHS England will be essential to minimise duplication of effort and allow area teams to take forward management of a contractor. However, it is relatively likely that the area team will need to undertake some further investigation using its contractual powers where the CQC has identified concerns about a provider. In drafting the terms of reference for such an investigation, area teams should have regard to information supplied by CQC.
85. On receipt of the concern notification from the CQC, the area team should complete a risk assessment to establish whether it is necessary to undertake a contractual management visit to the practice for further investigation and/or the most appropriate contractual action, if any, to take. See flow chart at Annex 7.
86. Upon completion of the initial risk assessment and any subsequent visit and investigation, the area team may take one of the following actions:

Action 1: No contractual action

87. CQC ratings are provided against a set of criteria that do not always directly relate to contracted matters capable of a breach and therefore a concern and/or

inadequate rating may not always result in the issue of a contractual remedial/breach notice.

88. Following the risk assessment and any necessary contractual practice visit and investigation, the area team may consider that no further contractual action is either necessary or appropriate and will inform all interested parties in writing accordingly.
89. Practices that are notified that no contractual action is to be taken must have regard to the remaining requirements of the CQC registration and must use all best endeavours to improve their compliance with the standards over the period specified by CQC. Template letter provided at Annex 8.

Action 2: Remedial/Breach notices

90. Where, following the risk assessment and any necessary contractual practice visit and further investigation, an area team consider that the concern/inadequate rating also constitutes a contractual failure which is capable of remedy, the area team should issue the contractor with a remedial notice under the terms of the contract/agreement.
91. This notice should be issued in accordance with the policy for *Managing contract breaches, sanctions and termination for primary medical services contracts* and must relate to the contracted terms that have been breached, rather than the CQC concern/inadequate rating.
92. The notice must set out the actions that the contractor must take in order to remedy the breach and this may include the development of an improvement plan to be monitored by the area team over an agreed period of time, for the contractor to demonstrate their compliance with the contracted obligations.
93. Where the breach is not capable of remedy, and/or where the contractor has failed to satisfy the terms of any previous remedial notice, the area team may issue a breach notice in accordance with the policy for *Managing contract breaches, sanctions and termination for primary medical services contracts*.
94. Practices that are both notified of an inadequate CQC rating, or are breaching the CQC registration requirements and are issued with a contractual remedial/breach notice, must be made aware that they are required to satisfy both the CQC registration and area team regulatory requirements within the individually specified time scales. For example, CQC may allow the practice a six month period for improvement where the area team remedial/breach notice may require more rapid action to be taken to ensure contractual compliance and patient safety matters are resolved more quickly, usually within 28 days.
95. Where possible, CQC and area teams should coordinate their responses to contractual and CQC regulatory requirements in order to align timescales for achieving both sets of required actions.

96. Failure to comply with a contractual notice may result in the termination of the contract regardless of how long may be left in respect of any agreed CQC improvement period. Area teams must make this clear to contractors when issuing a notice that is in parallel to CQC actions being taken. Template letters provided at Annex 9(a) and (b).

Action 3: Sanctions/Terminations

97. Where the practice has been placed into special measures, or following a failure to comply with earlier contractual notices area teams must urgently assess the risk to patients and the NHS of allowing the contract to continue.
98. Following the risk assessment, a contractual practice visit and further full investigation, where the area team consider that the contractors breach is substantial enough to represent a significant risk to patient safety it may issue a notice of termination to the contractor in accordance with the policy for, *Managing contract breaches, sanctions and termination for primary medical services contracts*.
99. The area team will not have established a right to terminate purely on the outcome of a CQC inspection, concern notification or rating. It is therefore essential that the correct procedures are followed, the full supporting evidence gathered and considered and the appropriate legal advice sought prior to issuing a notice of termination.
100. Where the right to terminate has been established, the area team may instead choose to apply a contractual sanction in accordance with the contract regulations and single operating model policy.

Investigation

101. A right for NHS England and its area teams to take contractual action cannot be established by CQC ratings alone. In the vast majority of cases, where the CQC reports adverse findings or concerns are raised, it will be necessary for area teams to carry out their own investigation before they are able to consider taking formal contractual action.
102. This section provides the general principles for assessing the necessary level of further investigation whilst ensuring the most suitable use of resource is deployed in each case.
103. The level of investigation required will vary from case to case but should fall into one of the following three categories:
1. Minor level.
 2. Moderate level.
 3. Major level.
104. In addition, consideration needs to be given whether any concerns identified during an investigation, raises concerns regarding professional performance of individual GPs (or other clinicians).

105. NHS England has a responsibility under the National Health Service (Performers list) regulations (2013) to ensure that practitioners on the national performers list are 'fit for purpose' - potential performance concerns will need to be addressed through the NHS England framework for managing performance concerns.

Minor level – Assurance

106. A minor level investigation would be required to assure the area team of the contract compliance and quality of service provision. Depending on the seriousness and nature of the findings against the contractor, a first step in some circumstance may be to seek information from the contractor and/or assurances as to the provision of services.
107. The area team may write to a contractor setting out the issues identified and remind them of their contractual obligations and any formal action which the area team may be able to take in the event that contractual breaches are identified.
108. The letter should request either information or written assurance from the contractor in relation to their compliance with the contract, continuity and quality of service provision. An example of a risk that might be satisfied through minor investigation is where the concern is that the contractor may not hold adequate liability insurance.
109. It may be that no further contractual action will be required once assurances are obtained.
110. If the contractor is not able to provide the information or assurance required, the area team should reassess the level of risk and may then feel it appropriate to escalate the matter and complete more thorough investigations.

Moderate level – practice visit

111. If the failings are more serious or widespread and it is felt that a practice visit will be necessary, or satisfactory assurances cannot be obtained under a minor level investigation, the area team should arrange an investigative visit to the practice at the earliest opportunity.
112. This should comprise of a meeting with the contractor and their team, including CCG representation and aim to address the specific concerns raised. The visiting team should collate any information or evidence necessary to satisfy the area team that the concerns are capable of remedy and that appropriate action is being taken by the contractor to satisfy the terms of the contract.
113. Under the terms of the contract, area teams must provide sufficient notice to the practice of the visit and may wish to make a formal request for further information in accordance with the regulations.

114. If the contractor is not able to provide the evidence or refuses to engage with the visit, the area team should reassess the level of risk and may then feel it appropriate to escalate the matter for more immediate action either in terms of contractual notices or through a major investigation.

Major level – detailed investigation

115. Where the failings are of a serious and widespread nature, the area team will need to schedule full practice audit, including (but not limited to) a premises inspection, clinical governance audit, information security review, patient records review, and interviews with individual staff members. An audit should target the areas of concern identified as well as core areas of general medical practice and must result in a detailed audit report identifying areas of concerns, the contractual terms that are being breached and any action (with timescales) that must be taken by the contractor.
116. A multidisciplinary approach will be required. The outcome of the audit will inform the area team's next steps in terms of contractual management and may include referral of an individual performer which should be managed in accordance with the Framework for managing performer concerns: NHS (performers lists) (England) Regulations 2013.
117. The terms of reference for the audit will be central to achieving the required outcomes of the audit and should be directly linked to the practice's contractual obligations.
118. Obtaining and accurately recording all evidence, including but not limited to witness statements, such as practice staff and patients, is essential to support any necessary contractual action that an area team may need to take.
119. This guidance does not intend to set out the detailed instructions in respect of completing a full practice visit and audit but does direct that where statements are being taken, the area team must obtain consent from witnesses for the information contained in their statements to be used by it in exercising its right to act under the regulations and to the information's disclosure for use in any GMC proceedings, to the doctors legal representative and the parties' experts and advisors and, depending on the facts of the case, the police and/or NHS protect.

GMS/PMS/APMS - alternative arrangements for service provision

120. Where a contract holder/CQC registered provider is aware that they are likely to either have their registration suspended or cancelled they must immediately engage with the area team to consider the options available for ensuring continuity of services.
121. One possible option would be for the contractor to sub-contract services, in accordance with the regulations. The contractor must in all cases, have taken reasonable steps to satisfy itself that it is reasonable in all the circumstances

and that the sub-contractor is qualified and competent to provide the service, including being fully registered with the CQC and that registration includes the contractors practice as a locality.

122. No sub-contracted service can be delivered at that locality until such time as the full variation to a sub-contractors registration with the CQC takes effect, to include the practice premises.
123. There should be no gap in service provision between the time when an existing provider's registration is suspended or cancelled and the sub-contracting service provision commences. It is also important that patients are kept informed and involved in the decision making if alternative arrangements are being put in place. NHS England has a duty to engage with the public under section 13 of the Act in relation to changes to services.
124. The contractor must have notified the area team in writing of its intention to sub-contract as soon as reasonably practicable before the date on which the proposed sub-contract is intended to come into force and in accordance with the terms of their contract.
125. The area team may request further information relating to the proposed sub-contract and the contractor shall not proceed with the sub-contract or, if it has already taken effect, shall take steps to terminate it, where, within 28 days of the contractors notice, the area team has served a notice of objection to the sub-contract on the grounds that:
 - (a) the sub-contract would:
 - (i) put at serious risk the safety of the Contractor's patients.
 - (ii) put the Commissioning Board (NHS England) at risk of material financial loss.
 - (b) the sub-contractor would be unable to meet the Contractor's obligations under the Contract.
126. Where the area team does not object to the sub-contracting arrangement, this will be deemed as a contract variation and the sub-contractor will be held accountable for the delivery of the regulated activity carried out at the practice premises in accordance with their CQC registration. The contract holder remains accountable and liable for the overall delivery of the primary medical care contract and for the actions of their sub-contractor. Any sub-contracting arrangement has no bearing on the area team's right to act and to take appropriate contractual action against the contract holder.
127. The area team may instead propose to contract with a parachute provider for the suspension period to ensure the safe and efficient delivery of essential services to the registered population.
128. Each case of suspension should be individually considered with regard to all possible options for ensuring the delivery of services to the registered population including the availability of alternative provider services, any proposal to sub-contract by the contractor and all other local matters relevant to the case.

Termination of Contract

129. In the event of termination of the contract area teams would undertake all expected steps with regard to procurement for new permanent contract arrangements, merger or dispersal of patient lists. This is not specifically covered by this guidance but due process and consultation must be followed. Any timing on termination must be taken so services to patients are maintained and timed to be consistent with any actions necessary by the CQC.

Resilience - capacity and capability

130. Whilst CQC estimate that the numbers of practices receiving an inadequate overall is likely to be fairly low at any one time, consideration will need to be given regionally about the potential impact on an area team's capacity to deliver timely and proportionate support across a number of GP providers who may be assessed as inadequate through CQC inspection in a locality.
131. Contract management, particularly putting in place urgent measures to secure primary care provision is extremely resource intensive. Area teams should explore with regional teams options to explore how resources can be mobilised across the system to support an area team where there is risk of multiple practices being identified with concern, or risk of systemic failures in primary care resilience being identified through the CQC inspection regime.
132. Area teams, working with regional teams, should undertake some rapid contingency planning to assure local system resilience. NHS England's central team will be working with regions to explore how to support area teams in taking consistent and well advised action.

Annex 1: Pilot support programme for practices placed in special measures

The Department of Health and NHS England have commissioned the Royal College of General Practitioners (RCGP) to provide a pilot programme offering expert peer advice and support for GP practices that enter special measures following inspection by the Care Quality Commission (CQC).

Purpose of the programme

The programme is intended to support practices needing to make significant changes to improve their services. It will provide a package of expert professional advice, support and peer mentoring from senior GPs, practice managers and nurse practitioners with specialist expertise in quality improvement coordinated by the RCGP. The programme will draw on insight and support from other local practices and professional leaders, including the LMC and CCG.

The RCGP support team will draw up a tailored plan for each practice in the programme. The duration and sequencing will be agreed at the outset, although reasonable efforts will be made to ensure the support adapts to changing circumstances in the practice. The focus is likely to include work to:

- help the practice understand the problems identified by the CQC
- support the practice to develop an improvement plan (or refine their existing plan) to address issues underlying the problems identified by the CQC
- provide direct advice and mentoring to GPs, practice managers and other staff as they work on improvements
- draw on insight and support from other local professional leaders, including the LMC, area team and CCG

The practice is at liberty to engage other support in addition to this programme.

This pilot programme ends in October 2015. The RCGP will therefore work with practices to plan a programme of mentoring and development that fits within this time frame and the timetable for improvements set by CQC.

Eligibility and cost

Any practice placed into special measures between 1 October 2014 and 30 June 2015, where NHS England does not enact contractual action, will be eligible to apply for this support.

NHS England will provide up to £5,000 of funding directly to the RCGP for each practice entering the programme, providing the practice matches that 1:1.

Agreement

When agreeing to participate in the programme, the practice will sign an agreement jointly with the area team and the RCGP. The key terms of this will be as follows:

- **Standards.** The RCGP undertakes to operate to the very highest professional standards in their work. It is understood that practices receiving support will

often be in a very difficult situation. The team will work supportively and non-judgementally. They will adopt a coaching, mentoring and advisory approach to help the practice gain insight into the problems identified by the CQC and from other local feedback, and develop solutions in partnership with the Practice. They will respect the confidentiality of the practice and the individuals within it, except where they have a duty to report back to the NHS England or raise concerns regarding matters such as serious professional misconduct or fraud.

- **Participation.** The practice team will undertake to participate fully in this programme of support. This will require GPs, the practice manager and other staff as needed to commit to regular meetings together with the support team. A high level of commitment is essential for success. Where all relevant senior staff do not engage consistently and appropriately, the RCGP team may terminate their involvement.
- **Evaluation.** The practice will be required to provide anonymised feedback about the support programme as part of the national evaluation of the pilot. The workload impact of this will be minimal.
- **Payment.** The practice will be required to arrange payment to the RCGP prior to support commencing. The NHS England area team will match fund the practice payment. If the practice or the RCGP terminates the support agreement prior to completion of the initially agreed package of support, determination will be made by the RCGP of whether a partial refund is appropriate, on the basis of the staff time spent thus far.
- **Liability.** The practice retains full responsibility for all aspects of their contractual and ethical obligations regarding the provision of services to their patients. Neither the RCGP nor NHS England assumes any responsibility for the quality of the practice's services nor any actions the practice takes to improve them.
- **Other support.** Where a practice engages in other support, it is expected they will liaise with the RCGP team to ensure the value of all support is maximised, and duplication avoided.

A mock template for the agreement is enclosed below.

RCGP Special Measures Support Programme

Agreement

Between

The Royal College of General Practitioners (RCGP)

and

[Enter name] (Area team)

and

[Enter name] (Practice)

This Agreement sets out the terms and understanding agreed between the RCGP, [enter name] area team and [enter name] practice for the support programme for the Practice to address the problems which led to it being placed in special measures.

Background

The Department of Health and NHS England have commissioned the Royal College of General Practitioners (RCGP) to provide a programme offering expert peer advice and support for GP practices that enter special measures following inspection by the Care Quality Commission (CQC).

The programme is intended to support practices that need to make significant changes to improve their services. It will provide a package of expert professional advice, support and peer mentoring from senior GPs, practice managers and nurse practitioners with specialist expertise in quality improvement, coordinated by the RCGP. The programme will draw on insight and support from other local practices and professional leaders, including the LMC and CCG.

The RCGP will support the Practice in drawing up, or refining their existing improvement plan, to be agreed with the NHS England area team, which is tailored to the specific needs identified by the CQC. The duration and sequencing will be agreed at the outset and will be designed to fit within the timetable for improvements set by CQC, although reasonable efforts will be made to ensure the support adapts to changing circumstances in the Practice. The focus is likely to include work to:

- help GPs understand the problems identified by CQC;
- support the Practice to develop an improvement plan to address issues underlying the problems identified by CQC and any additional issues identified by the RCGP (including those highlighted by local contacts) (the Improvement Plan);
- provide direct advice and mentoring to GPs, practice managers and other staff as they work on the improvements agreed in the Improvement Plan;
- draw on insight and support from other local practices and professional leaders, including the LMC and CCG.

The Practice is at liberty to engage other support in addition to this programme.

The RCGP will oversee an evaluation of the support programme, including external input, in October 2015.

Purpose

This Agreement sets out the roles and responsibilities of the Practice, area team and the RCGP in respect to the Special Measures support programme.

RCGP Responsibilities

1. The RCGP undertake to operate to the very highest professional standards in their work. It is understood that the Practice may be in a very difficult situation. The RCGP will work supportively and non-judgmentally. They will adopt a coaching, mentoring and advisory approach to help the Practice gain insight into the problems identified by CQC and from other local feedback, and will develop solutions in partnership with the Practice.
2. The RCGP will respect the confidentiality of the Practice and the individuals within it, except where they have a duty to report back to NHS England or raise concerns regarding matters such as serious professional misconduct or fraud.
3. The RCGP will make initial contact with the Practice within one week of receiving a request for support. The Practice will be invited to have an initial discussion with the RCGP before a formal request for support is made.
4. Upon return of a signed agreement, the RCGP will arrange a meeting with key persons within the Practice, to be attended by an RCGP adviser or small team of advisers. The RCGP will help the Practice develop an Improvement Plan that is tailored to the practice's needs and achievable within the limits of funding available, timescales and other logistical considerations.
5. Once an Improvement Plan is agreed by relevant parties, the RCGP will coordinate a local "Turnaround Team" that will include appropriate expert input, whose purpose will be to offer advice and peer support in order to help the Practice meet the objectives of the Improvement Plan.
6. The Turnaround Team will provide support for the practice, in accordance with the terms agreed in the Improvement Plan and subject to sufficient funding, for a period up to 6 months when it is envisaged that CQC will make their reassessment. The progress of the Turnaround Team will be monitored by the RCGP.
7. The RCGP will seek anonymised feedback from the Practice, its patients and other relevant stakeholders during and following its period of support to the Practice to inform the evaluation of the first phase of the programme.
8. The RCGP will not provide support to the Practice beyond the scope or period of support agreed in the Improvement Plan.
9. The RCGP will provide peer support, advice and mentorship to the Practice, but is not responsible for the Practice's success or failure in its CQC re-assessment.
10. It is acknowledged and agreed that the nature of the work being carried out under this Agreement is such that specific results cannot be guaranteed and that all work is done without any express or implied warranties, representations or undertakings. Save as set out in 1 above, RCGP makes no warranty, express or implied, and shall not be held responsible for any consequence arising out of any work performed under this Agreement. The liability of RCGP shall be limited to the aggregate amount of any payments received from the Practice in respect of this Agreement.

Practice responsibilities

1. The Practice will request support through the RCGP's administrative team, which will also manage any subsequent issues relating to the RCGP's agreed package of support.
2. The Practice team will participate fully in this programme of support and specifically in implementing and co-operating with the Improvement Plan. This will require GPs, the practice manager and other staff as needed to commit to meetings with the RCGP. A high level of commitment is essential for success. Where all relevant senior staff do not engage consistently and appropriately, the RCGP's administrative team will notify the Practice of the RCGP's concerns and if these are not resolved to RCGP's satisfaction, RCGP reserves the right to terminate their involvement.
3. The RCGP welcomes the engagement of additional support but where a practice engages in other support, they must liaise with the RCGP to ensure the value of all support is maximised and duplication avoided.
4. The Practice will share all information that is relevant to the development and implementation of an Improvement Plan with the RCGP.
5. The Practice will be required to provide anonymised feedback as part of the national evaluation of the programme. The Practice will also facilitate a suitable mechanism to enable the RCGP to gather feedback from patients during and following the RCGP's period of support to the practice to inform evaluation.
6. The Practice will agree a plan of payment with the RCGP for costs associated with the RCGP's work in supporting the development and implementation of an Improvement Plan prior to the commencement of an intervention. If the Practice or the RCGP terminates the agreement prior to completion of the initially agreed package of support, determination will be made by the RCGP of whether a partial refund is appropriate, on the basis of the staff time spent and direct and third party costs incurred thus far. The RCGP will not refund the Practice in any way based simply upon the Practice deeming the College's intervention to be ineffective, unless it is agreed that there has been an area of insufficient engagement in exceptional circumstances.
7. The practice retains full responsibility for all aspects of their contractual and ethical obligations regarding the provision of services to their patients. Neither the RCGP nor NHS England assumes any responsibility for the quality of the Practice's services nor any actions the Practice takes to improve them after the support provided.
8. The Practice will not spread negative publicity about the RCGP based on the service provided.

NHS area team responsibilities

1. The area team will share any relevant information with the RCGP that may inform its intervention.
2. The area team will agree an Improvement Plan with the Practice, CQC and the RCGP in a timely fashion.
3. The area team will support the programme by providing relevant expertise if requested by the RCGP.

Duration

This Agreement shall become effective upon signature by the authorised officials from the following organisations. .

Practice

Practice name
Practice representative
Position
Address
Telephone
Fax
E-mail

_____ Date:
(Signature)

area team

area team name
area team representative
Position
Address
Telephone
Fax
E-mail

_____ Date:
(Signature)

RCGP

RCGP representative
Position
Address
Telephone
Fax
E-mail

_____ Date:
(Signature)

Annex 2: Example improvement plan template

This template is offered as a specimen, to help area teams work with practices to record their improvement plan and track progress. It includes the recommended information to be sent to CQC, to satisfy the requirement to notify them of proposed actions.



Report on actions you plan to take to meet CQC essential standards.

Please see the covering letter for the date by which you must send your report to the Care Quality Commission and where to send it. Failure to send a report may lead to enforcement action.

CQC registration details

Account number	<Provider ID>
Our reference	<Inspection ID>
Location name	<Organisation name>

It is recommended to update the document regularly, to allow you to track and report on progress over time. Remember to update the date in the box below each time.

Completed by: (please print names (s) in full)	
Position(s):	
Date:	

Please use a new page for each regulation where action is required. Where multiple underlying issues are identified for a single problem, you may wish to use a new page for each issue and related action plan (ie resulting in a number of pages for a single problem).

Regulated activity(ies)	Regulation
<Regulated activity(ies)>	<Regulation number and description> < Regulation heading
	How the regulation was not being met:
	<Copy from the How the regulation was not being met section within the inspection report>

<p>Underlying issue(s) identified</p> <p>Record root causes here, or note if further work is planned to identify them.</p>	
<p>Action(s) planned</p> <p>Are these S.M.A.R.T.? (Specific, Measurable, Achievable, Relevant, Time bound)</p>	
<p>Lead person</p>	
<p>Resources required</p>	
<p>Sources of support</p>	

<p>Eventual goal</p> <p>How will you know when this problem and any underlying issues have been resolved?</p>	
<p>Planned completion</p>	
<p>Milestones</p> <p>For complex or lengthy actions, how will you know you are making progress towards the eventual goal?</p>	
<p>Progress to date</p> <p>Use this as a log of work completed so far and your assessment of its impact.</p>	

<p>Next steps to take</p> <p>For complex or lengthy plans, what will you do next?</p>	
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Annex 3: Step by step guide for creating an improvement plan

Step	Goal	Common pitfalls	You may want to....
Review your CQC report Does everything make sense? Are there any surprises?	Clarify the goals of your improvement plan.	Overlook some problems.	Liaise with your area team or the CQC to ensure there is a common understanding of the problems to be addressed.
Identify underlying issues For any problem cited, do you know why the practice is not doing well in that area?	Find root causes	Develop plans which address symptoms of issues, rather than underlying root causes. This often results in only superficial or short-term improvements. New problems are likely to continue appearing until root causes are dealt with.	Look for common themes among problems. For any one problem, ask “Why is it like this?”. Continue asking why until no new answers arise. It is often found that “five whys” are needed in order to get at pervasive underlying issues. [more at bit.ly/1uCdrUr] Use external help to facilitate discussions about underlying issues, especially where relationships are involved.
Draft improvement ideas As a team, list every idea for improving the problems identified.	Generate ideas and build the team’s shared commitment to improving.	Overlook potentially useful ideas from members of the team. Fail to secure team commitment to the goal of improving patient care and the improvement process. This will make implementation of change much harder.	Hold team meetings to discuss the problems and potential solutions. Run a brainstorming session for all staff to contribute suggestions. Refer to Annex 6 on improvement frameworks. Use external help to facilitate the process of identifying possible solutions.

<p>Agree actions Ensure you are using every relevant idea for improvement.</p>	<p>Produce a list of actions which is comprehensive and practical, addresses root causes and makes best use of existing sources of support.</p>	<p>Overlook potentially useful ideas from other practices' experience. Fail to make best use of existing sources of support.</p>	<p>Ask senior peers to review your improvement ideas. Read examples of other practices' improvement ideas, eg provided by your LMC or CCG.</p>
<p>Identify resources and sources of support Who is going to help you gain a good understanding of your issues, develop a comprehensive plan and implement change?</p>	<p>Increase your chance of success.</p>	<p>Fail to make improvements in the right areas in the right timescale.</p>	<p>Liaise as soon as possible with the area team and CCG.</p>
<p>Put actions into a plan Agree on a sequence of actions (with SMART objectives), and milestones at which you will check on progress.</p>	<p>Develop a rigorous plan for implementing changes.</p>	<p>Fail to make improvements because of a lack of clear planning and robust management of the process. Underestimate the time commitment required. Fail to break complex or lengthy changes into smaller actions.</p>	<p>Use the SMART checklist to review each action proposed in the plan. Aim to specify a series of manageable tasks, rather than a single complex one. Ask peers to review your plan, including assumptions about timescales.</p>
<p>Submit & continuously update the plan Forward your plan to the CQC and the area team, to notify them of your intended actions. Update the plan document as actions are updated or other progress is made.</p>	<p>Ensure the CQC and your commissioners are kept up-to-date on your progress.</p>	<p>Fail to report intentions or progress within specified timescales.</p>	<p>Where a lot of work is required, it may be helpful to use calendar reminders as a prompt to complete actions or provide updates within specified timescales.</p>

Standards for improvement plans

They should be action-oriented. Plans should contain practical actions with SMART objectives (rather than areas for discussion or exploration):

- **Specific** – does the plan identify the details of what the issue is, and what action needs to be taken? Does it explicitly say what they want to achieve and who is going to make these changes?
- **Measurable** – does it say how they are going to ensure that changes have been made? What measures are they going to put in place? Who will do this?
- **Achievable** – are the measures they are going to put in place achievable, attainable and sustainable? Has the provider described the resources needed to implement the changes? Are these in place?
- **Relevant** – is it clear that proposed actions will address the problems identified by CQC, as well as any underlying issues? Will the actions help to create lasting change as part of a process of ongoing improvement?
- **Time bound** – is there an appropriate date by which the changes will have been made? How will this date affect people who use services? How will the practice demonstrate that progress is being made, throughout the process of enacting change (many plans will take months to complete, but progress should be demonstrable early)?
- They should address underlying issues rather than superficial symptoms wherever possible.
- They should ensure that problems presenting the most immediate threat to patients should be addressed as a matter of urgency. If necessary, this will involve the application of interim solutions which reduce risk to patients while permanent improvements are made.
- The goal should be to deliver excellent care for patients, not merely to become adequate. Effective plans should have a clear focus on significantly improved care. They will therefore often need to describe a journey of improvement which is longer and has higher ambitions than that required to meet essential regulatory or contractual standards.
- They should take account of local strategic plans for primary care. For example, where there are moves to establish greater inter-practice collaboration or new approaches to integrating with other providers, improvement plans should align with the ambitions and plans for the locality. This will often create potential benefits for the index practice and the wider health economy. For example:
 - o new solutions to premises problems might be identified as part of plans to establish new organisational forms for inter-practice collaboration (eg federations or mergers), or by exploring co-location with other agencies such as community services, pharmacies, social care providers or third sector.

staffing challenges might be addressed through pooling of staff among local practices in the course of federating.

- They should make the most of assets in the local economy. In most cases, plans should include input from a range of people and organisations – suggestions are included in '*Sources of support*'. Where external support is used, it will be important to draw up a clear memorandum of understanding, and to agree what resources (time, financial and other) will be necessary.

Annex 4: Case studies of improvement

These are stories of real approaches to supporting practice improvement. They illustrate the application of the above principles. Some details have been amended to preserve anonymity. It is important to stress that there is no mandatory requirement on area teams to provide specified support. No one approach will work in every locality; there are different demands facing different areas and as such commissioners must have flexibility to decide on potential solutions that respond to the needs of their health community.

Solutions-finding for GP recruitment

The problem: A practice was measuring falling patient satisfaction and receiving a growing number of complaints from patients unable to obtain an appointment. On discussion with the partners, the area team identified significant problems in recruiting and retaining clinicians.

Improvement plan: The area team medical directorate, supported by the LMC, supported the partners in reviewing their approach to recruitment and skill mix. The area team contacted local practices to identify urgent clinical cover. The LMC provided examples of successful recruitment approaches and partnership agreements. They supported the practice in considering how to apply for the retainer scheme.

Outcome: The immediate capacity problem was resolved. The practice reviewed their approach to recruitment and is now applying for a GP through the retainer scheme.

Rapid financial governance review

The problem: A practice expressed concerns to the area team about their financial governance following the unexpected departure of the practice manager.

Improvement plan: The finance and primary care teams of the area team helped the practice investigate their position and processes. The LMC identified another local practice manager to mentor the interim practice manager through the creation of new processes.

The Shropshire and Staffordshire 'SWAT team'

The area team, in collaboration with local CCGs and LMCs, has established a multi-professional team to provide practice appraisal and improvement support. The team is made up of GPs, very experienced practice nurse, practice manager, an administrator and their own analyst.

The time-limited support provided by the team is intended to help the practice identify and understand issues, find new opportunities to improve and begin the process of improvement. They see their role as building the practice's own capability for improvement, rather than doing the work for the practice team.

Practical inputs provided by the team vary according to need, but can include mentoring, advice and practical help with service redesign, and locum assistance – doctor or nurse. The team work entirely independently of the area team's primary care commissioning functions.

Local peer intervention

The problem: A practice identified multiple areas of non-compliance with CQC requirements, covering almost every domain. An improvement plan was agreed between the practice and area team. However, this resulted in very little improvement. Subsequently the CCG took the lead in driving the improvement planning, resulting in more detailed plans which drew on the support of a range of stakeholders in the local health community.

Improvement plan: The CCG acted as broker and coordinator of inputs from others, including CCG staff and local practice peers. Public Health informatics created a balanced scorecard to help understand quality in the practice, looking particularly at preventive care. The CCG and area team collaborated to broker new premises plans with the NHS Property Services, and to help the practice develop transition plans. The LMC provided pastoral support and mentorship to the partners during the improvement process. The area team advised on matters of appraisal and CPD.

Outcome: At re-inspection, the practice was compliant with all but one domain.

A CCG-led proactive support system

Following positive experiences of collaborative peer-led improvement approaches, Trafford CCG have established a proactive support system available to all member practices. Quarterly practice education events provide specific training on quality improvement. A member website contains a one stop CQC resource containing a self-assessment checklist developed by the CCG, case studies and best practice examples drawing on learning from other practices. The CCG's primary care team offers "mock" CQC visits to give additional insight and confidence for practices, and peer support between practices is facilitated for both clinical and managerial staff. Action planning for specific practice improvements is now led by the CCG with support from other stakeholders who can contribute to solutions. The learning practices generate is then fed back to neighbours through the member website.

Multi-agency response to multiple problems

The problem: Concerns regarding safeguarding were raised by CQC. The practice also raised concern about their ability to recruit and retain, with high turnover of GPs and Practice Nurses. During the same period, the Practice Manager had unplanned long-term sick leave. The Area Team received increased complaints relating to access. The remaining partners were isolated from other local colleagues.

Improvement plan: The area team Safeguarding lead worked with the practice to review systems and processes and agree an action plan to address areas of concern: practical examples provided, along with advice on actions being taken. Engagement Team worked with the practice to ensure appropriate management of complaints. Communication Team helped the practice with communication to patients and managing press enquiries. Primary Care Team contacted local practice to request details of part-time GPs, Practice Nurses or Practice Managers who could support the practice. Finance Team provided financial breakdown for PMS to GMS and reviewed payments made. Primary Care Team then briefed the deputy Practice Manager about key payment issues coming up. The LMC provided a Practice Manager mentor, to support the deputy practice manager. We met with the practice and neighbouring practice separately, to discuss opportunities for working together to resolve staffing and physical capacity issues. The LMC facilitated a subsequent joint meeting of both practices. Medical Directorate colleagues provided support to one of the remaining partners, linking in to other professional support mechanisms.

Outcome: Recruitment has improved and is not now critical, but they are still below GP capacity. CQC reviewed and approved the actions taken on Safeguarding/Engagement. The practice administrative team has remained stable, with the deputy practice manager acting up. Financial stability has been retained and the practice has decided to return to GMS. Relationships with the neighbouring practice have improved, with on-going contact between the two.

Brokerage of shared premises discussion

The problem: Four practices within the same town were receiving rising rates of complaints relating to access, and falling patient experience measures. Partners were expressing concern about their workload and an inability to continue operating at that level. Existing premises had limited scope for expansion. Forthcoming housing developments would swell the local population.

Improvement plan: The area team supported the four practices to begin discussions about short and longer term premises solutions, based on a sharing of the space.

Outcome: The practices continue to actively explore options, including greater organisational collaboration to provide more resilient services from shared premises.

Multi-skilled consultancy team

The problem: Complaints had been made to the CCG and GMC regarding standards of care at a practice. The CCG commissioned an external consultancy to undertake a review and make recommendations for improvement. The consultancy involved staff with experience covering clinical quality, professional performance, practice management, contracting, project management, conflict resolution and negotiation.

Improvement plan: The consultancy team was able to uncover problems and root causes which had not come to light previously. Problems were uncovered with a range of factors including referral rates, the quality of referral communications, prescribing decisions and levels, use of a new clinical system and clinical record keeping. The team judged that underlying these were relationship breakdown between GPs, under-developed demand management systems and a lack of IT confidence. Their improvement plan combined team-building, the creation of a new partnership agreement based on an agreed vision, training in redesigning demand management and support to create new systems for referrals and audit.

Annex 5: Potential sources of support

This list is intended to help inform decisions about securing support to improve. Entry on the list does not constitute a recommendation or commitment to provide funding. Please forward suggestions for additional entries to Dr Robert Varnam, Head of General Practice Development at NHS England (robert.varnam@nhs.net).

Practices may benefit from the support of a wide variety of people and organisations. In many cases, they will want to seek others' input to help compile a coherent package of support, while, in others, a more piecemeal approach will be appropriate. CCGs have a significant role to play in stimulating the development of support offers to help practices innovate and improve. These may combine in-house and external resources, depending on local circumstances. Some CCGs have already contributed to the creation of locally based expert teams and systems for sharing experience between practices. Others are beginning to work with national organisations to support practices directly or build local capabilities. It is likely that every CCG will need access to both local and wider expertise to help all practices improve quality and transform services for the future, and development of the right capacity and capabilities this will need to be an area for detailed planning and investment over coming years.

Local sources of support

Organisation	Expectations
Local Medical Committee	Provide professional leadership, promoting the identification of solutions which put the needs of local patients first. Support the identification of solutions and sources of support for the practice. Provide support and mentoring to leaders of the practice. Offer brokerage of discussions between local practices about solutions involving collaborations.
Other local practices, including networks or federations where relevant	Identify how they can support the practice, working with the AT/CCG - for example by sharing practice management, practice nurse or other expertise. Seek to build collaboration in the best interests of local patients.

Organisation	Expectations
Health Education England	Offer personal mentoring schemes to support quality improvement.
RCGP Faculty	Offer personal mentoring schemes to support quality improvement.
Health and Wellbeing Board	Potentially contribute to discussions about the future of local community based health services, where practice performance issues raise these. Contribute to discussions about new premises solutions.
Local authority	Provide advice and support to improve services they have commissioned from the practice, where relevant.
Patients and the public	Can contribute ideas and practical support, and are often very keen to champion their practice.

National & commercial sources of support (listed alphabetically)

Organisation/company	What they can help with	Further details
CHEC	Practice development support, for example root cause analysis, improvement development plans, education and training, mentoring, and facilitated away days.	www.chec.org.uk
GP Access	Redesigning GP access using the Stour Access model	www.gpaccess.uk
Health and Social Care Information Centre	A suite of resources and guidance about effective governance and systems, especially around records.	www.hscic.gov.uk/standards
Third sector organisations	A number of third sector organisations offer resources such as best practice guidance and staff training on specific issues.	
Medical indemnity providers	The indemnity providers are able to provide a range of services, including advice on best practice and staff training.	
NHS Employers	Resources to support workforce planning and best practice in HR.	www.nhsemployers.org

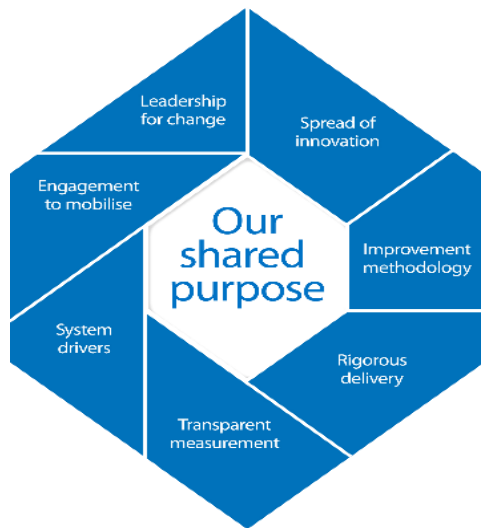
Organisation/company	What they can help with	Further details
National Association of Patient Participation	Support for PPGs which could contribute to improvement plan and deliver perspective on performance	www.napp.org.uk
National Care Forum	Providing links to various organisations that can provide toolkits for working with patients (hard to reach/marginalised groups etc.)	www.nationalcareforum.org.uk
NCAS	Expert advice and support, clinical assessment and training for staff who give cause for concern.	www.ncas.nhs.uk
NHS Improving Quality	Productive General Practice. A guided practice development programme focusing on teamwork and service redesign using Lean principles.	www.nhsiq.nhs.uk
Personal Strengths Ltd	Team development, conflict resolution, leadership development	www.personalstrengthsuk.com
PCC	Access to interim practice management/business management. Facilitation for planning and direct support. Free best practice resources. Training workshops, events and e-learning.	www.pcc-cic.org.uk

Organisation/company	What they can help with	Further details
Practice Management Network	A national community run by practice managers for practice managers. The Network offers support and opportunities to share, develop and influence.	www.practicemanagement.org.uk
Primary Care Foundation	Support to measure and understand urgent workload.	www.primarycarefoundation.co.uk
Productive Primary Care	Redesigning GP access using the Stour Access model ('Doctor First' programme)	www.productiveprimarycare.co.uk

Annex 6: Frameworks for improvement planning

When drawing up plans for improvement, it is often helpful to refer to an established framework for organisational development and change planning. Two commonly used frameworks are listed below. Suggestions are made for how they can be used to develop a solutions-focused understanding and a comprehensive set of improvement plans.

The NHS Change Model



The [NHS Change Model](http://www.changemodel.nhs.uk) can help to move a practice team's focus from problems to solutions. It ensures a comprehensive range of improvement areas are considered, and that alignment among them is achieved.

• www.changemodel.nhs.uk

While the Change Model primarily indicates how to effect change, it also points to areas of organisational capacity and capability required for successful change and high performance. Just as success will often depend on alignment between all the components of change, building capabilities in them will often present opportunities to address several (or all) at once. This is attractive in general practice, where change leadership skills and systems are less well developed, and where a practical approach to personal and organisational development is generally preferred.

NHS Change Model Component	Description	Implications for diagnosis & understanding	Implications for planning improvements
<p>Our shared purpose</p> <p>Links:</p> <ul style="list-style-type: none"> • Change Model resources, <u>shared purpose</u> • Leading with purpose, video 	<p>Evidence confirms that the most powerful commitment comes from the “heart”, not just the “head”, and in the NHS, we know that what drives most people, most strongly, is their common vocational motivation.</p> <p>So, a good shared purpose will be about serving patients rather than simply surviving as an organisation. It will be truly shared by all the staff, and all decisions and activities will be clearly aligned behind it. It will be evident to patients and others outside the practice, both through the team culture and the quality of care.</p>	<p>A lack of focus is very common cause of poor organisational performance. This is often because a ‘higher’ purpose such as providing excellent care becomes supplanted by a ‘de facto’ purpose such as maintaining profitability. De facto purposes are not necessarily wrong, but they are best kept in check behind higher priorities.</p> <ul style="list-style-type: none"> • Does the practice have a statement of purpose, vision or objectives? • Is excellent patient care the chief priority? • Have staff contributed to its production? • Do staff have the chance to review and revise it periodically? • Is it clear that all decisions and activity in the practice are aligned behind this purpose? • What proportion of 	<ul style="list-style-type: none"> • Having a clear, shared purpose for change is essential if improvements are to occur rapidly and sustainably. It also acts to ensure coherence where multiple changes are being implemented, increasing the effectiveness of each and reducing duplication or gaps. • Engaging all staff in discussing the practice’s purpose, its vision for the future and the means of achieving that is a powerful means of building teamwork, creating a culture for quality and identifying high impact actions to improve. • It can be helpful to produce a ‘vision for the future’ in visual form, ideally involving all staff in the process. This vision can be used to generate the words that will form the shared

		decisions or activities detract from or conflict with the shared purpose?	<p>purpose.</p> <ul style="list-style-type: none">• Keeping the shared purpose at the heart of the changes required, (a visual representation in the practice and / or frequent references to it in meetings) would be a recommended way for the practice to achieve its improvement goals.
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<p>Engagement to mobilise</p> <p>Links:</p> <ul style="list-style-type: none"> • Change Model resources, <u>engagement to mobilise</u> 	<p>People are more likely to be committed to something if they are involved in both its development and delivery. Engagement also unearths views that need to be managed, whether they are supportive or not. This is about the way in which all those who make care good are engaged and empowered to play their part. This engagement determines the extent to which people are inspired to commit to the practice's purpose.</p>	<p>Much poor performance stems from limited engagement of patients and staff in strategic decisions or operational improvement.</p> <ul style="list-style-type: none"> • What are the rates and trends of staff efficiency, sickness absence, recruiting and retention. • Is there evidence of a learning and improvement culture? What are the rates and trends of Patient satisfaction and complaints? • Is there evidence that the practice promotes self-care and changes in help seeking behaviour? 	<ul style="list-style-type: none"> • Creating multiple opportunities for staff to shape their work and the improvement plan, for example through facilitated meetings. • Follow through on opportunities to make it easier to do the right thing via an improvement plan. • Help patients to feel a sense of ownership in the practice, making it easy and attractive to provide ideas for improvement and play their own part in achieving it. Methods could include a social media strategy, feedback boards, action planning at PPG meetings and patient champion roles. • Feedback rapidly and clearly with proposed action from complaints.
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<p>Leadership for change</p> <p>Links:</p> <ul style="list-style-type: none"> Change Model resources, <u>leadership for change</u> 	<p>Teams need to be led, not just managed. In times of change, the need for skilled and inspiring leadership is particularly prominent. An effective change leader will unleash others' commitment, and support them through transitions.</p>	<ul style="list-style-type: none"> Is it clear who leads the practice team? Is there a practice organogram or list of roles and responsibilities? Do they lead in a way that inspires loyalty, unleashes commitment, releases potential and supports the team through change? Is there evidence of distributed leadership? Are staff encouraged to take responsibility for solving problems? 	<ul style="list-style-type: none"> Leaders need to be clear about their role, and given the support to do it. Specific training in leadership for change, particularly in generating commitment (rather than expecting compliance) is beneficial for many leaders. Feedback, coaching and peer support are also helpful, particularly at times of stress.
<p>Spread of innovation</p> <p>Links:</p> <ul style="list-style-type: none"> Change Model resources, <u>spread of innovation</u> 	<p>Innovations, big and small, are generally slow to spread in the NHS. Someone else often has a potential solution to a problem you face. Adoption of innovation requires knowledge of it, as well as evidence of and belief in its benefits and applicability. Staying up to date with best practice requires a deliberate commitment, supported by a systematic and persistent approach to implementation. Just as importantly, once an innovation is identified for adoption a plan for this needs to be agreed including a member of</p>	<ul style="list-style-type: none"> How does the practice identify, evaluate and implement new and improved ways of working, including best evidence clinical practice? Is priority given to this? Is there a systematic, efficient and reliable approach to it? Are all relevant staff engaged in the assimilation of new knowledge and ways of 	<ul style="list-style-type: none"> Review current systems, practices and performance against best evidence guidance. Assess and focus on the learning culture of the practice with regular educational activities and time to share ideas and experiences. Focus particularly on areas where the practice is known to perform poorly, which have not been reviewed recently or for

	<p>staff to act as its champion, staff training, measurement of progress and regular sharing of successes / troubleshooting.</p>	<p>working?</p> <ul style="list-style-type: none"> • Are new changes sustained over time? 	<p>which there is no 'champion' within the practice.</p> <ul style="list-style-type: none"> • The area team, CCG and LMC may be able to provide examples of high potential innovations. • Try involving the multidisciplinary team, +/- colleagues in other practices and from other providers. • Agree a systematic approach for implementing a care innovation, and try it out on a specimen topic.
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<p>Improvement methodology</p> <p>Links:</p> <ul style="list-style-type: none"> Change Model resources, <u>improvement methodology</u> 	<p>Although they have often developed organically over time in established GP surgeries, intuitive or ad hoc approaches to improving systems or processes are often inefficient or ineffective. They frequently achieve change through staff working harder. Improvement methodologies facilitate change through working smarter. They are a group of tools and methods underpinned by an assertion of the value of systematic, measurable approaches which strive for excellence and which allow all staff to contribute. Through small scale, rapid change they make it easier to test and refine change ideas, adapt innovations for local use and make continuous improvement possible. They also drive the development of a practice-wide learning culture.</p>	<p>Does the practice use a recognised improvement methodology (such as the Model for Improvement or Lean)? Are ideas for new or improved ways of working tested and refined at small scale before wholesale implementation? Are data and patient feedback used to ensure change results in improvement? Are staff expected and empowered to improve their own work?</p>	<ul style="list-style-type: none"> Planning an improvement in the practice can use one of many improvement methods, for example, identify opportunities to reduce waste using the 5S method or finding unnecessary work using value stream mapping. Test out solutions using rapid Plan-Do-Study-Act cycles. Try measuring the change daily using SPC charts rather than periodic averages to judge if it is working or not.
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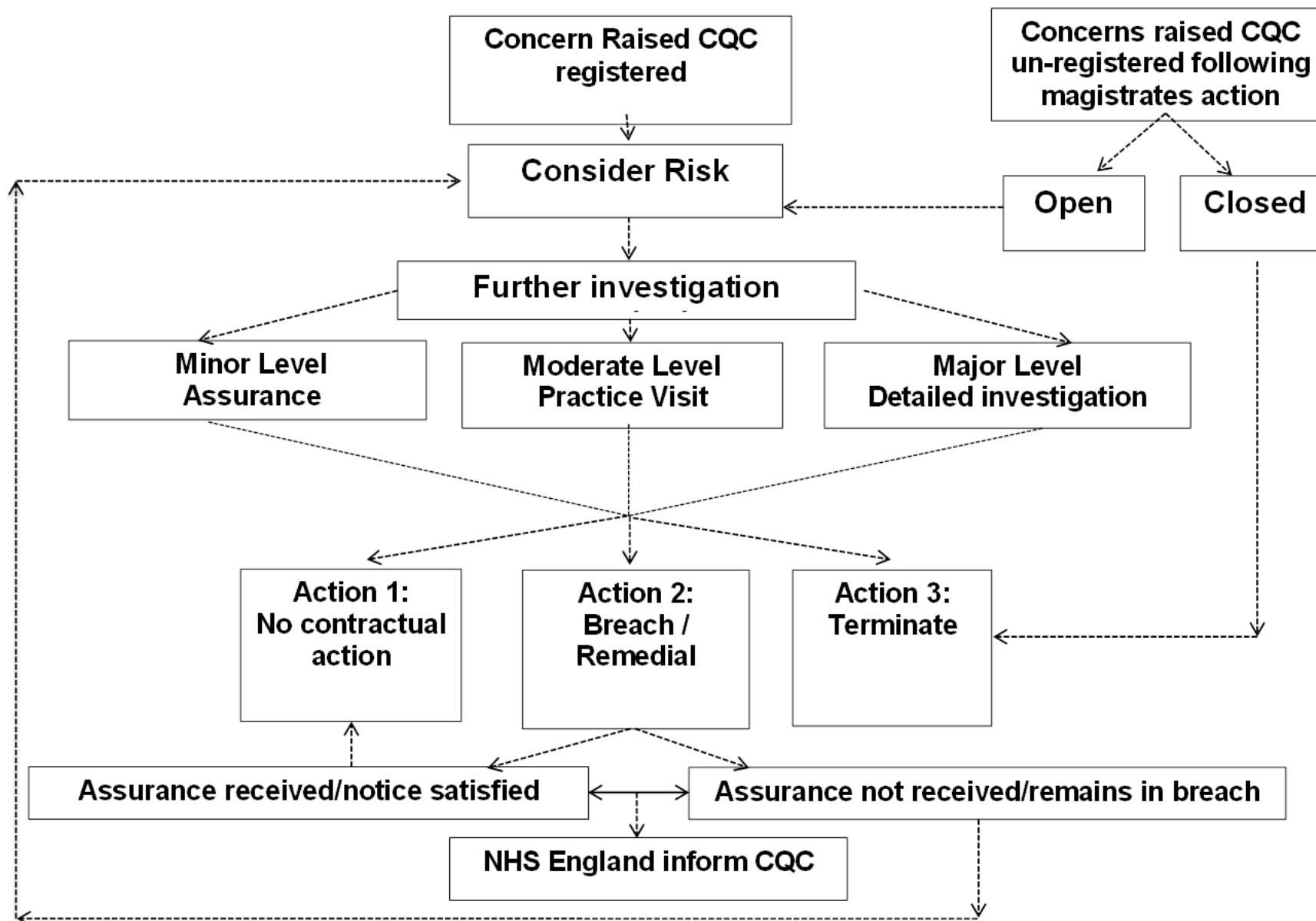
<p>Rigorous delivery</p> <p>Links:</p> <ul style="list-style-type: none"> Change Model resources, <u>rigorous delivery</u> 	<p>A systematic approach is needed to ensuring that good ideas and intentions are translated into sustainable change. Many changes are not seen through to completion, often meaning that much or all of the initial effort is wasted.</p> <p>Setting clear goals and managing the work required to achieve them is an essential skill for a practice. There are several well established project management tools that are extensively used in the NHS. Just as important, system leaders need to identify those individuals with the right personality and skill set to persistently drive an improvement plan.</p>	<p>Do you have a rigorous approach to planning and implementing change? Does everyone know about it and regard themselves as accountable to it? Are SMART objectives always set? Are they translated to individual requirements in a way staff understand and can comply with? Is an effective approach taken to incentivising compliance? Are effective sanctions used when appropriate? Does this apply to doctors as well as other members of the team?</p>	<ul style="list-style-type: none"> Use a guide or eLearning package to introduce the key principles, tools and practices of project management to everyone in the team responsible for managing change. Pick an improvement to be made and apply a rigorous project management approach to it. Write plans down. Develop measurable objectives for every element of the project. Collect the data you have specified. Use lists, diaries and reminders to monitor progress and drive continued action. As you move forward, celebrate success and help staff feel encouraged that progress is being made.
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<p>Transparent measurement</p> <p>Links:</p> <ul style="list-style-type: none"> Change Model resources, <u>transparent measurement</u> 	<p>Credible, relevant, timely and accessible data is a very powerful tool in informing, initiating and sustaining change. However, many practices have a culture of using opinion and intuition more than data to inform decisions. Success relies more on hard work and good luck.</p> <p>Putting data (qualitative and quantitative) at the heart of the practice can engage staff, stimulate curiosity and grow commitment. It will result in better plans, more rapid change and improved accountability. Knowledge of continuous improvement as a concept and tools such as run charts can introduce a real-time element to a change and allow rapid cycles of change and a much more effective end result.</p>	<p>How much does data (in the form of measurement or patient stories) inform your decisions and change processes? Are priorities set on the basis of evidence or opinion? Are decisions about change led by agreed measures or force of personality? Is data gathered in a way that answers the team's questions? Does it allow successful or unsuccessful changes to be identified and improved quickly? Is it presented in a way which is engaging and understandable for everyone who needs to be influenced by it?</p>	<ul style="list-style-type: none"> Choose a planned change and engage the team in designing key measures for it. Seek to include measures which cover activity, outcomes and unintended consequences. Aim to choose a few simple measures rather than a lot of complicated ones; those that are already collected or that can be pulled from the IT system automatically are most likely to embed. Test out with staff how relevant, timely and understandable they are. Ask how well the data links to the daily work done by the people you want to be influenced by it. In the early stages of the change, collect data as frequently as possible and publish it for all relevant people to see, in an interesting and accessible way. Actively seek opinions about what the data are showing and what should
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			be done next.
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<p>System drivers</p> <p>Links:</p> <ul style="list-style-type: none"> Change Model resources, <u>system drivers</u> 	<p>Good ideas, commitment and hard work are necessary for successful change but usually not sufficient for it to be successful and sustained. Deliberately aligning key aspects of the working environment behind the shared purpose for change is an important task for leaders. Key aspects include incentives and sanctions, workforce skills, availability of equipment and information.</p> <p>System drivers are also relevant looking outside the practice – are all incentive schemes being tackled in a systematic way to maximise funding for example?</p>	<p>Are all the key influences on your staff aligned behind your shared purpose for change? Do you have incentives and sanctions which support the change you desire? Do you have processes, premises, equipment and information systems which make it easier for people to work in the way you want? Do any of these things actively inhibit the change you want?</p>	<ul style="list-style-type: none"> Working with staff, identify any ways in which current systems, incentives, skills or infrastructure make it hard to deliver the shared purpose. Seek to quantify them and rate the ease with which they can be improved. Agree priority issues to address, based on this assessment. Establish systems to routinely hear from staff about things which make it hard or unattractive to do the right thing. Create a habit of responding. Find new non-monetary ways of incentivising desired behaviours, for example through public recognition, greater autonomy or opportunities for development.
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Annex 7: Simple flow diagram – NHS England process for contractual action



Annex 8: Example letter to practice – no contractual action

This annex is provided as an example only and area teams should ensure that they have sought appropriate advice and support, in line with NHS England protocols, prior to issuing such a letter.

Dr (other).....

Practice Address:

Date:

Dear Dr (Other).....,

Re: GMS/PMS/APMS contract dated.....

Following a recent Care Quality Commission inspection at your practice, NHS England were advised of [a] concern[s] identified in respect of compliance with your CQC registration.

The concerns raised were [include details from the CQC notification]:

[Following request for evidence/assurance] NHS England has reviewed your compliance with your contract in respect of the CQC concerns raised and have requested submission of (please include details) to provide us with assurance of your contractual compliance and the safety of your registered patients.

Following submission of the evidence requested, we are now assured of your compliance and [**]

[No further evidence or assurance sought] NHS England has reviewed the concerns identified by the CQC and considers that you are not currently in breach of your contracted terms [**].

[**]NHS England advises that we will be taking no further contractual action in this matter at present but would refer you to the requirements as set out in the full report of your CQC inspection and any outstanding action that is required of you in order to satisfy the terms of your continued CQC registration.

Yours.....

Annex 9(a): Example remedial notice:

This annex is provided as an example only and area teams should ensure that they have sought appropriate advice and support, in line with NHS England protocols, prior to issuing such a notice.

Remedial notice

Following our recent communications and discussion on the [insert date(s)], we hereby serve notice that NHS England considers you are in breach of your (GMS/PMS/APMS)*delete as appropriate contract/agreement dated [insert start date of contract] on the following grounds:

*[Insert bullet points setting out the breach details and referencing clause numbers from contract]
[Insert details of any evidence relied upon in reaching this decision]*

In accordance with schedule 6 part 8, regulation 115 of the NHS (GMS contract) regulations 2004, (schedule 5, regulation 107 of the PMS Agreement Regulations 2004)*delete where appropriate NHS England requires you to remedy this breach by taking the following steps:

[Insert details of action required]

In order to remedy this breach this action must be completed to the satisfaction of NHS England on or before [insert date]

[The notice period shall be no less than 28 days from the date of this notice, unless NHS England is satisfied that a shorter period is necessary to:

- *protect the safety of the contractor's patients; or*
- *protect itself from material financial loss]*

Your progress in taking the required action will be reviewed at a further meeting on the [insert date] to be held at [insert venue details]

If you fail to comply with this notice, repeat this breach or otherwise breach the contract resulting in further breach notices being issued, NHS England may take steps to terminate your contract or consider the imposition of a contract sanction.

Should you wish to appeal against this decision, you must do so in writing to [insert details of appeal contact address] within a maximum of 28 days from the date of service of this notice and you do, of course, retain the right to seek support from your Local Medical Committee.

NHS England would advise that this notice does not relate to the requirements of your registration with the Care Quality Commission. You must satisfy both the terms of your contract held with NHS England **and** the terms of your CQC registration and fulfil all requirements to satisfy **both**.

Taking the remedial action required under this notice does not, and will not, in any way relinquish you of the obligation to satisfy any requirements made by the CQC in respect of your registration.

Annex 9(b): Example breach notice

This annex is provided as an example only and area teams should ensure that they have sought appropriate advice and support, in line with NHS England protocols, prior to issuing such a notice.

Breach notice

Following our recent communications and discussion on the *[insert date(s)]*, we hereby serve notice that the NHS England considers you are in breach of your (GMS/PMS/APMS)*delete as appropriate contract dated *[insert start date of contract]* on the following grounds:

[Insert bullet points setting out the breach details and referencing clause numbers from contract]
[Insert details of any evidence relied upon in reaching this decision]

In accordance with schedule 6 part 8, regulation 115 of the NHS (GMS contract) regulations 2004, (schedule 5, regulation 107 of the PMS Agreement Regulations 2004)*delete where appropriate NHS England requires that you do not repeat this breach.

If you fail to comply with this notice in that you repeat this breach or otherwise breach the contract resulting in a remedial notice or a further breach notice being issued, NHS England may take steps to terminate your contract or consider the imposition of a contract sanction.

Should you wish to appeal against this decision, you must do so in writing to *[insert details of appeal contact address]* within a **maximum of 28 days** from the date of service of this notice and you do, of course, retain the right to seek support from your Local Medical Committee.

NHS England would advise that this notice does not relate to the requirements of your registration with the Care Quality Commission. You must satisfy both the terms of your contract held with NHS England **and** the terms of your CQC registration and fulfil all requirements to satisfy **both**.

Satisfying the terms of this notice does not, and will not, in any way relinquish you of the obligation to satisfy any requirements made by the CQC in respect of your registration.

Yours sincerely,

Annex 10: Relevant legislation, regulations and guidance

This is by no means an exhaustive list and is likely to be subject to future changes. Area teams should ensure they seek appropriate legal advice when considering the interpretation of any applicable legal requirements.

- The National Health Service Act 2006 as amended by the Health and Social Care Act 2012
- The National Health Service (Performers Lists) Regulations 2004
- The National Health Service (Performers Lists) Amendment Regulations 2005
- The National Health Service (Performers Lists) Amendment and Transitional Provisions Regulations 2008
- The National Health Service (Performers Lists) Direction 2010
- The National Health Service (General Medical Services Contracts) Regulations 2004
- The National Health Service (Personal Medical Services Agreements Regulations 2004
- The National Health Service (Primary Medical Services) (Miscellaneous Amendments) Regulations 2004
- The National Health Service (Primary Medical Services) (Miscellaneous Amendments) Regulations 2005
- The National Health Service (Primary Medical Services) (Miscellaneous Amendments) (No 2) Regulations 2005
- The National Health Service (Primary Medical Services and Pharmaceutical Services) (Miscellaneous Amendments) Regulations 2006
- The National Health Service (Primary Medical Services) (Miscellaneous Amendments) Regulations 2007
- Public Contracts Regulations 2006, as amended
- The Alternative Provider Medical Services Directions 2010, as amended

Guidance

- Procurement guide for commissioners of NHS-funded services, 30 July 2010.
- Principles and rules for cooperation and competition, 30 July 2010.
- Records Management: NHS code of practice, 5 April 2006 and
NHS information governance – guidance on legal and professional obligations, 17 October 2007.