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For the attention of:
NHS England Directors of Commissioning Operations

Clinical Leaders and Accountable Officers, NHS Clinical Commissioning Groups

Copy:
NHS England Regional Directors

NHS England
Quarry House
Quarry Hill
Leeds
LS2 7UE

0113 254 0000
england.primarycareops@nhs.net

7 December 2015

Dear colleagues

SUPPORT FOR VULNERABLE GP PRACTICES: PILOT PROGRAMME

In June this year the Secretary of State for Health announced[1] NHS England would work to develop a £10m programme of support for practices identified in difficulty.

Today we are setting out how this programme will be delivered and will test how best to identify and support the most vulnerable GP practices. We have considered a range of options, working with NHS Clinical Commissioners and other key stakeholders. Local NHS England teams will be responsible for leading delivery and implementation working in very close collaboration with CCGs.

We want to secure improvements in vulnerable GP practices to help build resilience in primary care and to support delivery of new models of care. This will provide support to practices under pressure ensuring patients have continued access to high quality care.

The attached annex confirms the arrangements for:

a) the selection of eligible practices - national criteria to identify and prioritise vulnerable GP practices for support. In summary those rated by CQC as 'inadequate', those rated as 'requiring improvement' where there is greatest concern; and, those assessed by local commissioners in need of support in view of local intelligence.
b) the nature of the support offer and how this will be secured – we are working to extend the RCGP peer support programme for practices in special measures and local teams will otherwise secure additional facilitated support for other identified vulnerable practices.
c) the funding arrangements – NHS England is committed to investing at least £10 million to support vulnerable GP practices over the next 12 months. Central programme funds in 2015/16 are being transferred to Local NHS

[1] https://www.gov.uk/government/speeches/new-deal-for-general-practice

England teams to fund support as detailed in the table below. Practices will be required to match fund.

d) monitoring and evaluation - to identify what works and refine the programme in light of experience.

Table. Allocations for local NHS England teams

North Regional team		
Cheshire and Merseyside	£	399,524
Cumbria and North East	£	463,718
Lancashire and Greater Manchester	£	826,024
Yorkshire and the Humber	£	916,375
Midlands & East Regional team		
Central Midlands	£	814,509
East	£	745,752
North Midlands	£	695,219
West Midlands	£	562,018
London Regional team		
North East London	£	612,238
North West London	£	339,077
South London	£	572,863
South Regional Team		
South Central	£	664,193
South East	£	1,049,299
South West	£	273,007
Wessex	£	391,182

This initiative won't be without workload implications for already stretched local NHS England teams and CCGs, but it is aimed at helping those practices that are already likely to be on your radar, giving local commissioners some much needed resource to address practices that are already vulnerable.

In addition to this pilot programme, I thought it would be helpful to set out how we are working to ensure we support the health and well-being of GPs and their staff, which can clearly be impacted when practices find themselves vulnerable and in difficulty.

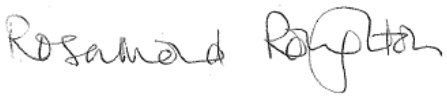
We will shortly be publishing a new national specification for GP practice occupational health services for use by local NHS England teams. This will ensure that over time we move to a position where all performers in England have access to a consistent occupation health service offer, providing enhanced occupational health assessments in relation to their duties or to support their health, safety and wellbeing at work.

You may also be aware Simon Stevens announced in September 2015 that NHS England would go further and look to develop additional services to Improve GPs' Access to Mental Health Support including combatting issues like stress and burnout. We are currently working closely with our partners to scope out what such a

service would be, with a view to putting in place a nationally available service in 2016.

If you or your teams have questions about the pilot programme which you would like to raise and are not answered by the attached information and FAQs please send an email to: england.primarycareops@nhs.net

Yours sincerely,



Rosamond Roughton
Director of NHS Commissioning
Medical Directorate
NHS England

Annex

Support for vulnerable GP practices – pilot programme

Selection of eligible practices - identifying vulnerable GP practices

1. Local NHS England teams will identify vulnerable GP practices eligible for support under this pilot programme using the criteria detailed in this paper. The methodology uses CQC ratings but importantly goes beyond these to identify vulnerable GP practices.

2. In summary vulnerable GP practices are identified as those rated by CQC as 'inadequate', those rated as 'requiring improvement' where there is greatest concern; and, those assessed by local commissioners in need of support in view of local intelligence (e.g. concerns in lieu of CQC inspection taking place or recognising even good or outstanding rated practices can quickly fall into difficulty) [2].

3. This approach acknowledges the challenges in identifying vulnerable GP practices and places primacy on local commissioners being best placed to identify and prioritise practices for support while ensuring there is a consistent approach across England.

4. Local NHS England teams and CCGs will need to agree on a prioritised list of practices to support based on their assessment of practices using the national criteria. A process for engaging with all CCGs will need to be established if a suitable one does not already exist locally. Prioritisation should be agreed at the level of the units of planning CCGs agreed in 2014/15. Prioritisation should be made on the basis of local intelligence and judgement as to where the greatest impact can be achieved from the available funding this year.

5. **Local NHS England teams will need to be able to confirm by 28 January 2016 details of those GP practices they have agreed to support**. Further details will follow on the reporting arrangements.

Support for vulnerable GP practices

6. GP practices rated inadequate by CQC will continue to be offered support through the RCGP peer support programme which is being extended to cover completion of the first wave of CQC inspections. All practices are currently expected to have been inspected by October 2016.

[2] If during this process an urgent need for a CQC inspection (or re-inspection) is highlighted CQC should be advised immediately accordingly. It is expected this need would though ordinarily be picked up through the ongoing work of Quality Surveillance Groups. Likewise individual practitioner issues can be raised through the usual channels.

7. Local NHS England teams will be responsible for securing the support offer for all other identified vulnerable GP practices through the provision of externally facilitated provider support.

8. This support is in addition to, not instead of, commissioners existing flexibilities under Section 96 of the 2006 NHS Act to provide assistance (including financial assistance) and support to contractors. The aims of this additional external support is to assess (as needed) and treat the causes of vulnerability, securing practice improvement and building longer term resilience rather than deliver short term quick fixes.

9. NHS England's national support centre will work to simplify the procurement process for local NHS England teams by securing a dedicated provider call-off framework for the programme. The framework will enable the efficient appointment of providers who can deliver tailored support, including peer support, to meet the needs of local practices by providing access to:

    - Diagnostic services if required where areas for improvement need to be identified and understood
    - Specialist advice and guidance – e.g. HR, IT, Management , Finance
    - Coaching / Supervision / Mentorship as appropriate to identified needs
    - Practice management capacity support

10. This call-off framework needs to be put in place which will take approximately 3-6 months. Until then, and in order to speed up our ability to secure support for identified practices, local NHS England teams will be responsible for putting in place local solutions to securing[3] externally facilitated support.

11. The support offer to identified practices under this pilot is conditional on:

    a) Matched funding commitment – identified vulnerable GP practices will be expected to contribute matched funding on 50:50 basis as a measure of their commitment to improvement.

    b) Movement towards sustainable models of care – funding must not be used to support unsustainable models of care or practices that fail to engage with local CCG plans for primary care (where these are in place). Again to highlight this support is in addition to, not a replacement for, Section 96 flexibilities.

Funding

12. NHS England is committed to investing at least £10 million to support vulnerable GP practices over the next 12 months. The funding available to secure support in

[3] In line with Standing Financial Instructions (https://www.england.nhs.uk/wp-content/uploads/2013/11/fin-0001-v4.pdf)

this financial year is being allocated from the central programme budget to local NHS England teams via RTF process in two phases; one third in December 2015, and the remaining two thirds in April 2016 (subject to expenditure accounts which will be reviewed in February 2015).

13. The table below confirms the allocations for each local NHS England team. These have been calculated on registered population fair shares. A small amount is being retained centrally to support RCGP pilot extension, secure CSU support for developing the call-off framework and to support evaluation. We will confirm funding allocations for next financial year following the current business planning round.

Table. Allocations to local NHS England teams

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14. During our scoping work we considered carefully allocating the funding at a CCG level. It was decided allocation at the larger local regional team footprint would allow a more targeted approach to identifying and supporting vulnerable GP practices in greatest need.

Monitoring and evaluation

15. Local NHS England teams will report on the practices they have identified with CCGs to support, and for each provide details of that support and assessment of turnaround progress. There will be a low burden evaluation after the first 6

months of operation so that successes and learning are identified, shared across regions and built on in this programme. We will discuss and develop these arrangements working with local NHS England teams and CCGs over the coming weeks.

Criteria to identify vulnerable GP practices

16. Identifying General Practice that is running into difficulties and in need of support for recovery is challenging. There are elements of any assessment which are subjective and deciding on the severity or weight of issues facing individual practices is even more problematic to measure. These criteria seek to chart a middle route between those aspects that are measurable and those less tangible issues which can have a significant impact of the operation of a practice. The nature of the issues facing a practice can be grouped generally as follows; demand, capacity and internal issues.

17. A range of criteria have been identified below that can be used as a screening tool by local commissioners. Local NHS England teams should utilise the criteria to guide their assessment with CCGs as to whether any practices of concern (whether known to the commissioner or practices self-declaring) should access the support available in order to secure local provision for patients and support local strategic plans.

18. Based on this assessment Local NHS England teams and CCGs should then use a standard risk matrix (effectively rating the likelihood and impact of vulnerability). This can be used to guide the relative ranking of vulnerable practices within a given geographical area (units of planning) to target support to those practices that are most likely to benefit from it.

19. It is suggested that local NHS England teams and CCGs will utilise their judgement when completing the assessment working with local partners, for example, the LMC. It should be noted that the criteria overlap in some cases, for example a practice with a high vacancy level may also seek to close their list to new registrations.

<u>Considerations</u>

20. When undertaking the assessment it may become evident that there are significant risks that need to be escalated rather than relying on this support to address issues. Therefore commissioners should be alert to the possibility that a practice may need to be referred to the CQC or for individual practitioner issues to be addressed through the usual channels.

Criteria

Domain	Criteria	Description and rationale for inclusion
Safety		
1.	CQC rating – inadequate	A practice rated as inadequate by the CQC is already directed to the RCGP scheme which is analogous to the proposed approach. It is not proposed that this is changed but is included within the criteria for the sake of completeness.
2.	CQC rating - requires improvement	A practice rated as requiring improvement where there is greatest concern (e.g. just short of inadequate) should be offered support. *FAQs provide further guidance*. Issues will be more intractable or have significant impact on the operation of the practice. This also applies to any patient safety issues identified as requiring improvement.
3.	Individual professional performance issues	This reflects that sometimes practices where a professional is having performance issues can have an impact on the overall performance of the practice.
Workforce		
4.	Number of patients per WTE GP	This criteria is to reflect the significant workload facing a practice in this situation, which of itself is not an indicator of a vulnerable practice as this may be ameliorated by a significant number of practice nurses or nurse practitioners.
5.	Percentage of GP sessions not routinely filled (include long term illness)	This is a key indicator of a practice that is vulnerable.
Efficiency		
6.	QOF % achievement	This is often used as a short hand measure of how well a practice is operated. The vast majority of practices score well above 90% with average 94% achievement. Just 500 practices score under 80% achievement, 100 practices score under 65% achievement. 21 practices achieve a score which is half of England average achievement (47%).
7.	Referral or prescribing performance compared to CCG average	It is proposed that this is flagged as a risk where a practice is in the upper quartile for aggregate prescribing performance compared to the CCG average and the same measure for GP referrals.

Patient Experience/ access		
8.	List closure (including application to close list)	This criteria is akin to the practice self-declaring that they have a problem. It is a crude 'measure' however in that the practice may be struggling to meet an increase in demand or it may be a struggling practice unable to managing its current demand. It will be important to consider the reasons for list closure.
9.	GP Patient Survey - Would you recommend your GP surgery to someone who has just moved to your local area? (% no).	This is one of a set of patient experience criteria that could be usefully included. Patient advocacy is known to correlate with good quality care.
10.	GP Patient Survey – ease of getting through by phone (% not at all easy).	Could be usefully included in that it provides an early indication where problems with matching capacity and demand are starting to be reflected in the results.
Organisational Issues		
11.	Practice leadership issues (partner relationships)	This is a key criteria but difficult to define so will be for local commissioners to reflect a risk rating against this and provide justification.
12.	Significant practice changes	It is self-evident that this increases the vulnerability of the practice where a practice is splitting, less so for a practice merging which may be to for positive reasons and may make local practices stronger and more resilient.
13.	Professional isolation	This is a self-evident criteria, but there are many resilient single handed practices that continue to operate successfully. However by definition a single handed practice has less resilience than a larger practice. Again it would be for local commissioners to reflect a risk rating against this.
External perspective		
14.	Other external perspectives not covered in the above criteria, for example significant concerns from LMC, CCG or NHS England	This is a key criteria. The risk score increases dependent upon how many local external bodies have significant concerns.
15.	Primary Care Web Tool – negative	Using this tool and in particular those practices that trigger 5/6 or more

	triggers	negative indicators provides an indication of some issues in a practice.

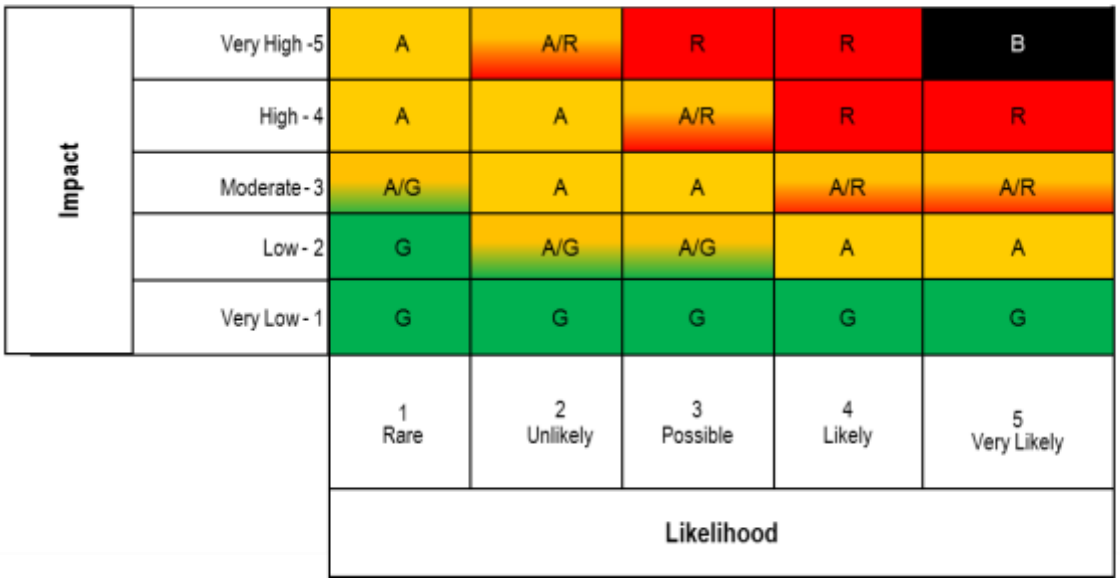
Vulnerability Risk Matrix

21. Following an assessment of the criteria above local NHS England teams should agree with CCGs where individual practices should be placed on the risk matrix below.

22. Placement should be scored between 1-5 for both likelihood of vulnerability and impact of vulnerability. Descriptions of likelihood and impact scoring are also provided also.

23. Local NHS England teams will need to ensure there is a record justifying placement based on their assessment of the criteria and demonstrating a consistent approach to the assessment of practices.

Risk matrix



Description: likelihood scoring

Category	**Likelihood Scoring**				
Likelihood score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Very Likely
Frequency / What is the likelihood of the practice falling in significant difficulties?	This probably will never happen/recur	Do not expect it to happen/recur, but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur, but is not a persisting issue or circumstance	Very likely to happen/recur; possibly frequently.

Description: impact scoring

Category	**Impact Scoring**				
Impact score	1	2	3	4	5
Descriptor	Very low	Low	Moderate	High	Very high
How serious are the practice difficulties?	• Minor difficulties • No or minimal effect for patients • No or minimal effect for staff	• Single difficulty • Low effect for a small number of patients if unresolved • Low effect on practice and staff	• Repeated difficulties • Moderate effect for multiple patients if unresolved • Moderate effect for practice and staff if unresolved	• Ongoing serious difficulties • Significant effect for numerous patients if unresolved • Significant effect for practice and staff if unresolved	• Difficulties leading to failure to meet national standards with unacceptable levels of quality of treatment or service • Very significant effect for a large number of patients if unresolved • Very significant effect for practice and staff if unresolved

Frequently Asked Questions

1) Do we need to assess all GP practices using the criteria?

No, all practices do not need to be assessed. There will be practices already on local commissioners' radar who you will want to assess and prioritise for support under this programme. In addition, the availability of support may trigger some practices to come forward to self-declare their vulnerability and who may not be on your radar currently, and who you will want to assess.

2) Can we devolve funding to CCGs with delegated commissioning responsibilities?

This is an NHS England initiative to be delivered by local teams. CCGs will need to be closely involved in the identification and prioritisation of support. This prioritisation will be at a footprint higher than individual CCG level, using the units of planning CCGs agreed. CCGs can continue to invest locally in primary care in addition to this programme.

3) Which practices rated as Requires Improvement are of greatest concern?

GP practices rated as Requires Improvement overall, with one Inadequate rating for a key question or population group. CQC inspect these practices within six months of the initial inspection report being published. If they are rated inadequate for any question or population group they will be placed into special measures. Particularly in need of support within this group, and potentially higher risk, are those with a rating of Inadequate for well-led.

GP practices rated as Requires Improvement overall, with four or five key question rated as Requires improvement (no Inadequate ratings for population groups). Particularly in need of support within this group, and potentially higher risk are those with a rating of Requires Improvement for well-led.

4) Prioritisation of vulnerable GP practices requires us to operate at a level wider than the local NHS England team given the units of planning CCGs agreed. Is there facility to transfer resources across local NHS England teams?

The respective Directors of Finance and Directors of Commissioning for Public Health and Primary Care from the local NHS England teams may jointly agree the transfer of any resources, with oversight and approval from their region(s).

5) Is there a financial limit on the external support we should offer vulnerable GP practices?

The value of the support offer is for local NHS England teams to decide on working

with CCGs to deliver the greatest impact from the available funding. It will be important to take account of the differing needs of identified vulnerable GP practices and the matched funding commitment. Local NHS England teams should always assess if agreed solutions offer good value for money.

6) How long should support last?

This is for local NHS England teams to decide on taking account of the identified needs of vulnerable GP practices that are seeking to be addressed.
Practices rated inadequate and placed in special measures by CQC are re-inspected after six months for improvement. This can offer a useful frame of reference although it is recognised the emphasis there is on securing urgent improvements.
The local offer could be intensive support delivered over a short term or more developmental delivered over a longer term, within the timescales of this pilot programme.
The local support offer should make clear the duration of support available.

7) How will I know what support vulnerable practices need?

The problems impacting on vulnerable practices may be clear from the local intelligence which supported their prioritisation (e.g. former risk assessment or practice visit, CQC inspection report etc.). If this is not the case or a fuller understanding of the issues is required a practice diagnostic may be offered as a first step to developing an effective package of support.

8) Can we set aside the practice requirement to match fund support?

Local NHS England teams are free to set the terms on how and when GP practices match fund but do not have the flexibility to set aside the requirement for practices to match fund.
It is recognised practice funding and cash flow can present a barrier to some practices match funding and taking up the offer of support. However this needs to be balanced with the need to ensure wise investment in additional support has the full commitment of a practice to achieve these improvements.
Local NHS England teams are reminded that this funded support is in addition to, and not a replacement for, flexibilities under Section 96 of the 2006 NHS Act to provide assistance (including financial assistance) and support to contractors.

9) Can practices in special measures only access the RCGP support scheme or can we offer other externally facilitated support instead of - or in addition - to this?

RCGP's peer support programme is the principle means of support to practices placed in special measures by CQC.
Other externally facilitated support should ordinarily only be offered to practices who have exited special measures but remain prioritised for support.

10) Can NHS England's £5k contribution to match-fund the costs of RCGP peer support programme for individual practices, be funded from the £10m pilot support programme allocations to regions?

Yes.

11) Who can provide support?

The importance of peer support for general practice improvement is widely understood, particularly if problems underlying a practices' vulnerability are not widely recognised or acknowledged in the practice.
Prospective providers could therefore include good local practices, GP Federations, Local Medical Committees or wider primary care organisations who are able to organise and deliver a peer support offer. In some instances more specialist advice and support might be able to be delivered by a range of different types of providers,

12) How can we secure services locally in the absence of a call-off framework?

Local NHS England teams will have previous experience of securing support for practices. Until we are able to put in place the call-off Framework, which we aim to have in 3-6 months, we recommend local regions use existing mechanisms to engage with potential suppliers for each of their requirements.
NHS England is required to follow Standing Financial Instructions (SFIs) when procuring services; Section 13.24 Requirement to Tender or Obtain Quotes. To support these processes the following mechanisms may be used in the interim period:

A. 13.24.9 For procurements that are not subject to European Union or UK law requirements, and for which a contract does not already exist, with regards to tendering the following quotation requirements apply:

   - For Procurements with a full life expenditure of over £50,000 at least five written quotes should be requested.
   - For procurements with a full life expenditure of over £10,000 up to and including £50,000 at least three written quotes should be requested.
   - For procurements with a full life expectancy of up to and including £10,000 one written quote may be obtained, where it is unlikely that three quotes would generate a substantially better price (and therefore the cost of obtaining quotes is likely to exceed any saving achieved), otherwise at least three written quotes should be obtained."

B. 13.25.1.1 Where the supply is proposed under a contract or framework negotiated by the Department of Health or another body, that NHS England is able to take advantage of, in which event the said contract or framework must be

complied with, including any requirement to tender amongst parties to a framework agreement. Where a multi-supplier framework is silent on tendering requirements, or offers the ability to either run a mini competition or appoint without running a mini competition, the requirement to obtain quotes detailed in SFI 13.24.9 apply;

- Possible appropriate Framework: https://www.england.nhs.uk/lpf/

Regional teams are to use their own judgement on the most appropriate method of procurement.

13) Do I need to submit a business case for each requirement / procurement?

The Central Primary Care Commissioning team has submitted a business case for the £10m fund; therefore local NHS England teams will not need to submit their own business case.