A Report on the Collaboration between [redacted] CCG and the RCGP Primary Care Development Team

A success story

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Executive Summary

[redacted] Clinical Commissioning Group ([redacted] CCG) is forward thinking and proactive in engaging with key stakeholders to support practices to prevent them failing, future-proof them and optimise performance. One of these stakeholders is the Royal College of General Practitioners (RCGP) through their Primary Care Development department. Collaboration between [redacted] CCG and RCGP has allowed effective support to be given through 36 completed contracts to 33 different practices over the past six years, and aligns with the work of the Care Quality Commission so that in mid-2020 [redacted] became the first CCG with no practices in special measures.

Background [1] [2] [3] [4]

NHS England currently states that general practice is 'meeting the challenges of a growing and ageing population with the next generation of pro-active, preventive health care, education, advice and treatment. We want to give patients earlier diagnoses and more life-long control over staying well, their way.'

General practice has undergone many challenges and changes since the establishment of the NHS. Before the onset of the current covid-19 pandemic, practices were struggling due to a rising and increasingly complex workload, difficulties in recruiting and retaining GPs and the higher expectations of patients. Although more GPs are entering training, overall full-time equivalent numbers are falling due to retirement or reduced hours, often due to the stress of the workload. This means that patients find it harder to access appointments and although overall satisfaction remains high, this is driving declining patient satisfaction as evidenced by the GP Patient Survey.

After some years of decline, real-term financial investment in general practice has been increasing since 2013/14 and further investment was promised in the NHS Long Term Plan published in January 2019.

The General Practice Forward View was published in April 2016, and as part of that, £500 million was invested by NHS England in a national sustainability and transformation package to support GP practices, with additional funds from local clinical commissioning groups. This included help for struggling practices, plans to reduce workload, expansion of a wider workforce, investment in technology and estates and a national development programme to speed up transformation of services. There was a commitment to an increase in investment to support general practice over the following five years.

In January 2019 a new GP Contract was introduced and this channels money directly to general practice. This contract is a five-year framework intended to stabilise general practice and act as a key vehicle to deliver the commitments of the Long Term Plan and provide a wider range of services to patients. The contract also stated a commitment to the GP

partnership model. A voluntary extension to the contract led to practices coming together to form primary care networks (PCNs).

Practices are now coming together at scale and new roles are being introduced. The development of effective teams is fundamental to the future of general practice.

NHS [redacted] Clinical Commissioning Group ([redacted] CCG) [5]

Clinical Commissioning Groups (CCGs) are the bodies responsible for commissioning most of the hospital and community services in the local area for which they are responsible, and are assured by NHS England which retains responsibility for commissioning primary care services such as GP and dental services. However, following the publication of the Five Year Forward View in October 2014, primary care co-commissioning was introduced, giving CCGs the opportunity to take on greater responsibility for general practice commissioning. BSol CCG opted for delegated commissioning, meaning they now have fully delegated responsibility for commissioning general practice services.

[redacted] CCG was created on [redacted] with NHS England approval from a merger between [redacted]. It became the largest clinically led commissioning organisation in England, responsible for 1.3 million people. They also work with [redacted] CCG to commission health services for people living in [redacted], ensuring a single commissioning voice across the city.

[redacted] has 164 member practices which, with branch surgeries, cover 216 sites over six localities. They have long been proactive in supporting both individual GPs and practices.

- They have had a GP Peer Support Team for some years which launched a refreshed model in 2020 and is available to all member practices. The team is recognised locally and nationally as an exemplary model.
- They support GP trainees and new GPs in their first five years in the 'First 5 Network'. Here they have access to experienced GP mentors and locality peer support networks. This is in collaboration with the RCGP [redacted] Faculty and the RCGP First 5 Committee.
- They have recruited highly experienced GPs to their Late Career GP Mentorship Scheme, who support practices or GP providers with extra clinical support and mentorship, to develop performance, effectiveness and efficiency.
- Since it launched in January 2020, they have had 43 recruits to the New to Practice Programme of two-year fellowships[6], which support newly-qualified GPs and nurses working in primary care.
- They are also supporting practices to improve screening uptake through the Cancer Screening and Early Diagnosis Group.

Since 2015 they have also had a close relationship with the RCGP peer support team, starting with support for practices in special measures.

Care Quality Commission (CQC) [7]

The Care Quality Commission (CQC) is an executive non-departmental public body of the Department of Health and Social Care, established in 2009 to regulate and inspect health and social care services in England. Its role, which is independent, is to register care providers, monitor, inspect and rate services and take action to protect service users. Their

aim is to ensure that services meet fundamental standards, below which care must never fall.

When GP practices are inspected inspectors are seeking answers to the following five questions:

- Are they **safe**? - patients are protected from abuse and avoidable harm.
- Are they **effective**? - care, treatment and support achieve good outcomes, help maintain life quality and is based on best available evidence.
- Are they **caring**? - staff involve and treat patients with compassion, kindness, dignity and respect.
- Are they **responsive** to people's needs? - services are organised to meet patient needs.
- Are they **well-led**? - leadership, management and governance of the practice make sure it is providing high-quality care that is based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

Since 2014, following inspection, practices are rated in one of four bands:

- **Outstanding**, where the practice is performing exceptionally well
- **Good**, where the practice is performing well and meeting expectations
- **Requires improvement (RI)**, where the practice is not performing as well as it should, and the service is told how it should improve
- **Inadequate**, where the practice is performing badly and action is taken against the person or organisation running it.

Currently those practices rated inadequate are placed in special measures (SM), which leads to reinspection within six months, when failure to demonstrate significant improvement could lead to cancellation of registration. Most inspections are announced to minimise disruption, but unannounced inspections may take place in response to particular issues or concerns.

CQC works closely with CCGs and with NHS England. Under the Regulation of General Practice Programme Board (now the Primary Care Quality Board), as part of a joint working framework published in January 2018, the bodies responsible for the regulation and oversight of general practice in England, were brought together. The aims were to coordinate and improve the overall approach to regulation and deliver a programme of work that would streamline working arrangements and minimise duplication. Information continues to be shared both routinely and urgently when concerns emerge, and ongoing activities are coordinated.

The RCGP programme has proved to be of benefit in monitoring practices who have caused concern. With the involvement of the RCGP, practices are able to demonstrate engagement, with external agencies in order to evaluate and improve the service they provide. Although there is no obligation for practices to share RCGP advisers' findings (normally presented as a diagnostic report and forward plan), it is beneficial when they do and many comply, often using the FP to give assurance of progress. Following an inspection CQC may request an action plan from the provider. Practices have used the FP to meet this request as it can be seen as a constructive tool with defined areas needing action identified and clear actions to mitigate. The plan can be used at reinspection to support achievement. CQC recognises the benefit to practices receiving support and guidance which the RCGP.is able to provide, enabling the practice to work constructively towards good governance.

NHS England (NHSE) [8] [9]

The National Health Service England is the publicly funded healthcare system in England. This is led by NHS England and NHS Improvement, which have worked together as a single organisation from April 2019. The single operating model has been designed to support delivery of the NHS Long Term Plan.

Where there are concerns about an individual professional, NHS England should be the first point of contact. From April 2013, NHSE was given the responsible officer (RO) roles that previously sat with Strategic Health Authorities and Primary Care Trusts. Consequently, the responsible officers for the majority of doctors in England now have a proscribed connection to NHSE. The Responsible Officer Regulations give specified senior doctors (responsible officers) in certain organisations (designated bodies: in this case NHS England ([redacted]): [redacted]) responsibility for oversight in the context of revalidation and encompasses, regulation, revalidation and clinical governance. They have a statutory duty to evaluate doctor's fitness to practice and advise the GMC by making revalidation recommendations.

NHSE has statutory responsibility for managing the England Performers List for GPs through the regulatory framework of the National Health Service (Performers Lists) (England) Regulations 2013 (performer list Regulations). To meet these obligations, they have established a framework for managing performer concerns, encompassing:

- the process for considering applications and decision making for inclusion, inclusion with conditions and refusals to be undertaken by NHSE's local offices;
- the process by which the team identify, manage and support primary care performers where concerns arise; and
- the application of NHSE's powers to manage suspension, imposition of conditions and removal from performers lists.

This supports the RO with a governance structure with members undertaking some RO duties as '*persons with appropriately delegated responsibility*', and the framework process is that:

- the Performance Advisory Group (PAG) reviews all new and ongoing cases
- the Performers list Decision Panel (PLDP) considers cases of a serious/or urgent nature (referred to it by the PAG)

Although the RCGP Practice Development Team has not worked directly with the RO or the PAG in [redacted], they are aware of circumstances when performer issues and the response of the PAG, can have a material effect on practice function.

Local Medical Committee (LMC) [10]

A local medical committee is an independent statutory body in the UK, representing individual NHS GPs and GP practices, to the primary care organisation. Their statutory role was first enshrined in law in 1911 and since 1999 their role has been extended to represent all GPs regardless of contractual status. Their independent status enables them to be effective in standing up for and supporting GPs to whom they are accountable. They represent local GP's views nationally through the General Practitioners Committee of the British Medical Association.

[redacted] LMC is made up of democratically elected GP members elected from among their peers. The electoral term is four years. They undertake a wide range of pastoral care and support functions determined by the need of GPs and their practices, including:

- Support and guidance on practice resilience and sustainability
- Advice on all areas of CCG membership and engagement
- CQC registration and compliance: advice and support following practice inspections and ratings
- GP Performers list and all other professional performance issues

[redacted] LMC liaises closely with local CCGs, including [redacted], as well as the local authority and all other relevant bodies. It has also been very supportive of and complementary to the RCGP Practice Development work.

Royal College of General Practitioners (RCGP)

The Royal College of General Practitioners is the professional body for general practitioners (GPs) in the United Kingdom and it represents and supports GPs at all stages of their careers on issues including licensing, education, training, research and clinical standards. Its stated purpose is to encourage, foster and maintain the highest possible standards in general medical practice.

One department of the college is Primary Care Development (PCD), which arose from a National Peer Support Service commissioned by the Department of Health and NHS England from 2014-17 to support practices that entered special measures. 87% of practices that received RCGP support improved their CQC rating and 80% exited special measures.

The RCGP continues to support practices placed in special measures, but in addition it now provides a bespoke service supporting development and transformation, working with individuals, practices, PCNs, at-scale organisations, and CCGs. There is an experienced advisory team, including GPs, practice managers, practice nurses and clinical pharmacists who can be deployed across the whole of the UK. As independent, critical friends who understand at first hand the challenges faced, they are uniquely placed to facilitate the progress to better and sustainable patient care.

Outline of processes when a practice causes concern (appendix 1)

When a practice has concerns it can seek advice and support from a range of bodies, including their Federation (if it belongs to one), CCG, LMC, RCGP, British Medical Association, Defence Body and GMC as well as other specialist sources.

Practices are however not always aware that there are issues causing concern and these may be picked up through the regular monitoring of the CCG, CQC and NHSE, who work closely together and share intelligence. Concerns may also be raised through patient complaint or staff whistleblowing.

Action taken depends on the particular concern raised and its severity. Practice based problems may only need support from the CCG while significant risk may lead to an early CQC inspection. Significant concerns about an individual practitioner could lead to investigation by NHSE.

[redacted] CCG is unusually proactive and at an early stage is now commissioning the RCGP to support practices both directly and by enabling the CCG to provide optimum support.

[redacted] Demographics[11]

[redacted][12]

2017 mid-year estimates (ONS) show that approximately 1,137,150 people lived in [redacted]. Of these 49.5% are male and 50.5% are female. It is a young population with 72% aged under 45 years old. The 2011 census estimated that 42% of the population came from Black, Asian and Ethnic Minority groups compared with 15% nationally.

During 2013 to 2017 [redacted] saw just over 102,000 migrants register with GPs across the city.

As a whole, [redacted] has high levels of deprivation with 40% of the population living in the most deprived decile. Average male life expectancy is 77.2 years and female life expectancy is 81.9 years which compares poorly with the England figures of 79.5 years for males and 83.1 years for females. Even more marked, in the city centre the figures may be as low as 74 years for males and 79 years for females, while in the least deprived areas on the city outskirts, the figure rises to 84 years for males and 87 years for females.

The disease prevalence for diabetes mellitus is 8.73%, almost 20% higher than the England average of 7.08%.

[redacted]

The Public Health England profile 2016 gives the population as approximately 212,000. It has a different demographic to [redacted] with lower than England rates of deprivation, and 40% of the population living in the least deprived quintile. The distribution of age is closer to the England averages although with smaller numbers of working age people and at 21%, a slightly larger percentage of people aged 65 and over, compared with the England figure of 17.9%. Only 8.6% are from the Black, Asian and Ethnic Minority groups.

Average life expectancy is above the England average at 80.4 years for males and 84.2 years for females (2014 - 16), although life expectancy is 12.8 years lower for males and 11.1 years lower for females in the most deprived areas compared with the least deprived.

Development of the relationship between [redacted] and the RCGP PCD

RCGP were first commissioned in 2016 to support practices who had been placed in special measures (SM). Over 2016, four practices in [redacted] CCG were supported and two of them subsequently achieving good ratings. A third, who started with very challenging problems, got out of SM, achieving RI. The fourth, which had been run by a post retirement age single handed practitioner, closed when the GP was supported to retire.

All of these practices had been in a precarious position and the CCG, while pleased with the results achieved, were keen to find ways to support practices before they became inadequate. With the SM programme being time limited, the RCGP also wanted to explore

other ways to be involved in working directly to support practices. In late 2016 the RCGP was commissioned by [redacted] CCGs for a pilot project to support Vulnerable Practices. This project would involve working with practices with a Requires Improvement (RI) rating following CQC inspection. The intention was to support practices:

- To understand the problems identified by CQC with a diagnostic report (DR)
- To develop a practice action plan (AP) to address issues underlying the problems identified by CQC and any additional issues identified by the RCGP (including those identified by local contacts)

It was intended that the programme would draw on insight and support from other local practices and professional leaders, including Local Medical Committees (LMCs) and CQCs.

Ongoing support was not to be provided by RCGP but after dissemination of the DR and AP and liaison with both the practice and the CCG, the best sources of support to enable delivery of the AP would be identified.

Eleven practices were proposed and RCGP worked with four within the pilot. Six practices declined the offer to join the pilot and one practice which had been expected to achieve RI was finally placed in special measures and was supported under the SM programme. All five supported practices subsequently achieved a good rating, whereas for those practices who declined support, five achieved a good rating but one remained RI. Following the pilot, the AP was renamed Forward Plan (FP) as this was felt to be more positive.

Through this period, the CCGs were developing their Peer Support Team and although limited, the pilot was felt to have been successful with the reports enabling effective local support. The pilot was used as the blueprint for giving optimal support to all practices either below a good rating or with other identified vulnerabilities.

Overview of process

Although there are a number of common underlying problems, every practice is different and there is therefore a need to address every practice as an individual. This is very much the ethos of the work done by the RCGP advisers, who seek to review all the issues affecting each individual practice so that ongoing support can be tailored to the practice need.

Normally, once the Primary Care Development team (PCD) is commissioned, one of the Deputy Leads is appointed to lead the contract. The Deputy Leads are all experienced advisers, and are clinicians, either a GP, practice nurse or practice manager. The Deputy Lead will speak to the practice lead to get an idea of the issues the practice is facing, and is then responsible for recruiting an appropriate adviser team from the pool of advisers working with the Primary Care Development team. The lead also supports the adviser team throughout and is responsible for quality assessing the work.

[redacted] has had a different relationship with the RCGP than most CCGs. With the VP pilot, a close working relationship was established between the CCG Lead [redacted] and one of the Deputy Leads, Jayne Dewhurst, with whom regular meetings were established, both to review ongoing work and to arrange new contracts. When Jayne Dewhurst retired, Morag King (who had previously been involved in supporting a number of BSol practices) took over the role, continuing a close working relationship with [redacted]. This has enabled a profound understanding of how the CCG is able to support practices and allows for constructive dialogue at all levels.

Once the adviser team is in place, they review all available documentation for the practice and then arrange to undertake scoping. Prior to the current pandemic, this would entail a whole day visit to the practice, to talk in detail to key individuals, usually the lead GP and Practice Manager, but also to meet as many staff as possible. The advisers have structured questionnaires, but may also talk more widely as needed. All conversations are confidential (with the caveat that any information relating to safety, safeguarding or fraud cannot be), but permission to share is sought if possible. For large practices or split sites where it may be difficult to speak to everyone, the advisers can use a confidential staff questionnaire. Originally this was a paper document which they collected when visiting, but is now available to share on Survey Monkey. Due to the emergence of covid-19, all scoping work has had to be conducted remotely.

Once this work is complete, the advisers produce a detailed Diagnostic Report (DR) which describes the practice in detail, including its history, personnel, day to day function, practice demographics and benchmarks. Staff opinion is included along with any available patient opinion. Findings are summarised, conclusions drawn and recommendations are provided. As well as highlighting areas for improvement, the report will also applaud areas of good practice, as often practices who are in distress lose sight of those things they do well. Along with this a detailed Forward Plan (FP) is drawn up covering all actions which the team feel are required for the practice to be CQC compliant and/or to enable the practice to address any issues which threaten viability or resilience. The FP is RAG (red-amber-green) rated, to show the level the action has reached towards completion, and also contains appropriate time scales. This enables the practice to prioritise work within a realistic time frame, and they can update the RAG rating as they proceed. The FP also ensures that the practice understand who is responsible for actioning work and who is accountable, as well as outlining the evidence needed.

The practice is asked to review the DR for any factual inaccuracies, and then asked for permission to share both documents with the CCG. If this permission is not given, then the documents cannot be shared. It is very much in the best interests of the practice to do so, and usually this permission is forthcoming. This then allows a review meeting between the advisers, the practice and the CCG, so that a support plan can be agreed, and the advisers can then share an updated FP with both the practice and the CCG. In most cases at this point the RCGP involvement ends and ongoing support is provided by the CCG Peer Support Team, but in some cases they have proved to be the best option for providing some additional specific support and/or facilitating discussions between the practice and the CCG.

Although this process has been undertaken for the majority of practices, it has not been appropriate for all, and in some cases the Primary Care Development team has undertaken an isolated team building Away Day with a practice.

Experience gained from work with practices

It has been found that there are a number of common underlying problems. The majority of those practices which have been supported are situated in the areas of the greatest deprivation with high disease prevalence (notably diabetes mellitus) and the additional challenge of language and cultural issues. Part of the income in primary care is related to achievement of targets and the underlying demographics can make this achievement difficult, as well as presenting a high workload. Many of these practices have low incomes compared with the England average. The result is that practices find it difficult to recruit and

retain, particularly clinical staff, and this compounds the stress engendered by working to meet patient expectations.

General practice has changed profoundly over the last thirty years, from an insular, GP led service to the establishment of large multidisciplinary teams providing primary care services in a variety of ways. The recent development of Primary Care Networks is also leading to the development of new ways of team working. Unfortunately, the experience of advisers is that many practices have remained insular, retaining outdated ways of working, with partners failing to embrace team working while at the same time underestimating their own governance responsibilities.

The vast majority of practices have welcomed RCGP support and have been pleased to accept the ongoing CCG support, with subsequent improvement of both performance and viability. In particular practices have welcomed the opportunity to talk freely with colleagues who understand the problems but have no vested interest. Advisers have been constantly impressed by the openness and honesty of interviewees. For some partners in particular the chance to 'get things off their chest' has been the most positive feature of the experience.

Unfortunately, there have been exceptions, where practices have viewed the intervention with suspicion and have blocked adequate contact or have resented any criticism even when presented constructively. In these circumstances, it is impossible to help a practice, however much effort is made.

The current covid-19 pandemic has increased the challenge of working closely with a practice. Much is lost by remote interviewing, particularly the wealth of information that can be gleaned by walking into and around a practice. Some practice members have blocked video meetings and contact with the wider team has been limited. Despite this, several practices have been successfully supported through this period.

Overview of RCGP Support (appendix 2)

Special Measures

Eight practices have been supported. One single-handed GP was enabled to retire and the practice closed. One practice has changed management twice and has not undergone re-inspection. All the other practices came out of SM, three achieving good ratings. For those that achieved RI, in all cases this was a significant improvement.

One practice which had both an unusual demographic and management organisation was a particular concern as it lacked many of the basic structures needed for adequate governance: but despite this produced some excellent clinical work. RCGP organised a meeting with all the relevant stakeholders, from which a workable plan was agreed. This included RCGP providing an experienced Practice Manager who worked in the practice for two weeks, providing intensive support and enabling the practice to achieve an RI rating when CQC revisited. Since there had been insufficient time for changes to become embedded, it would have been unrealistic to hope for any more. Subsequently, the management structure altered to become more compatible with standard primary care and RCGP was asked to provide a further DR and FP to the new managers, which was done by the original adviser team. Although some of the original issues had not yet been fully resolved, it was a pleasure for the advisers to see how far the practice had improved. A repeat CQC visit is awaited.

A second practice which had struggled for a number of years has also been supported twice, both times after being rated RI. The first time, they subsequently achieved a good rating but then failed to sustain their improvement and returned to RI. After the second episode of RCGP support, the practice developed some additional personnel issues and sadly ended in SM. However, the rest of the team were inspired to undertake the necessary actions and were able to use the FP to drive improvement, going straight to a good rating when CQC returned. The practice is now under new management.

Requires Improvement

Diagnostic Reports and Forward Plans were produced for twenty-three practices, including those in the pilot. Fourteen subsequently achieved good ratings. Seven practices have not yet been revisited by CQC. One single-handed practice with underlying complex issues remained RI, although the report stated that there had been significant improvements in areas of concern. A second practice which was initially offered support following an RI rating, and then again after remaining RI on a second visit, proved very unwilling to accept support. On the first occasion they repeatedly cancelled visits which led the RCGP to withdraw and on the second where all discussion had to done remotely due to the covid-19 pandemic, their participation was extremely reluctant, contact with the wider team was blocked and they were unwilling to accept any suggestion of critical comment. They remain RI, but nevertheless we believe that they have improved in a number of the areas where we recommended action.

One practice, which improved to Good, had had particular issues with governance. It had historically been run on the previously common system of top down management by a senior Partner. This structure is no longer compatible with running a multi-partner practice and the partners needed support to take over joint responsibility when the senior Partner stepped down. Not only did they have the RCGP reports but the partners all benefited from the opportunity to discuss issues, both as individuals and a group, with the advisers. They have also had excellent support from a late-career GP peer mentor, provided by the CCG. It is clear that all the partners have been able to develop their roles considerably since then and they believe that their effective management of Covid-19 has been helped by the changes that RCGP helped them to achieve.

Other vulnerability

One practice that had an RI rating was known to have particular issues within the wider team, so rather than produce a DR & FP, the RCGP was asked to support a whole team Away Day, focused on team building. This was remarkably successful and enjoyed by all. They left with much better understanding of roles and responsibilities, both their own and those of others. By the afternoon the mood and participation had become noticeably more positive and the day culminated in a brainstorming session to address repeat prescribing, where there was longstanding inefficiency and a constant source of irritation. Within an hour, and with the contribution of all, the problems were addressed and a satisfactory scheme had been produced. Subsequently, the practice achieved a Good rating.

Four practices had partners Away Days, three to address tensions within the partnership, and a fourth to support inexperienced partners to address workforce and sustainability issues. The facilitators were one of the teams of GP and PM Advisors who had been working with [redacted] practices. By first talking to all partners individually to gain understanding of the issues, the team then spent a day with the partners, creating as relaxed and supportive atmosphere as possible. This enabled issues to be discussed openly leading to better understanding and compromise. It also fostered better understanding of each other as

individuals and as team members and of their wider roles and responsibilities as partners. We are pleased to see that one partnership in particular, which had been on the point of breaking up, remains intact.

One other clinically competent practice with a Good rating but significant vulnerability was also provided with a DR and FP to enable appropriate ongoing support from the peer support team. Some of the underlying problems are insoluble but since they were seen, the practice has been able to address many of the actions that were advised, including holding a very successful partners Away Day which they managed themselves. This has had the outcome of enhancing effective working relationships and improving personal communication. They have commented that the RCGP input made them stop and think, gave them ideas and a fresh outlook and prompted discussion both among the partners and with the wider team. They feel that despite all the problems of this year, they are in a better place than before support was given,

Comments about RCGP support from practices

“The team was thorough and data gathering helpful and well researched. We appreciated the critical friend aspect and the independence of the team and the GP was firm but friendly. We realise that the documents and review meeting have enabled all the support we are now getting”

“The support was excellent. We desperately needed guidance and this was given. The adviser was comfortable to talk to and never felt critical but produced a very truthful report. The whole experience felt cathartic.”

“Thank you for the feedback. I personally found it to be a very helpful meeting and the template gives clear direction on the areas we need to focus”

“The team was friendly and supportive and they were open to what was said and gave constructive feedback”

“Your help is still very much appreciated”

Comments from other stakeholders

“The quality of the report was of a very high standard as was your patience and perseverance with the practice”

*“*The RCGP Diagnostic Action Plan is the best resource to assist the Peer Support Team whilst supporting any practice. It is easy to understand, interpret and is simplified for ease of discussion and instruction”

Acknowledgements

I have a number of people to thank, both for developing and supporting the RCGP programme since its inception, and also for assisting in the production of this report and my apologies to anyone I have inadvertently missed out.

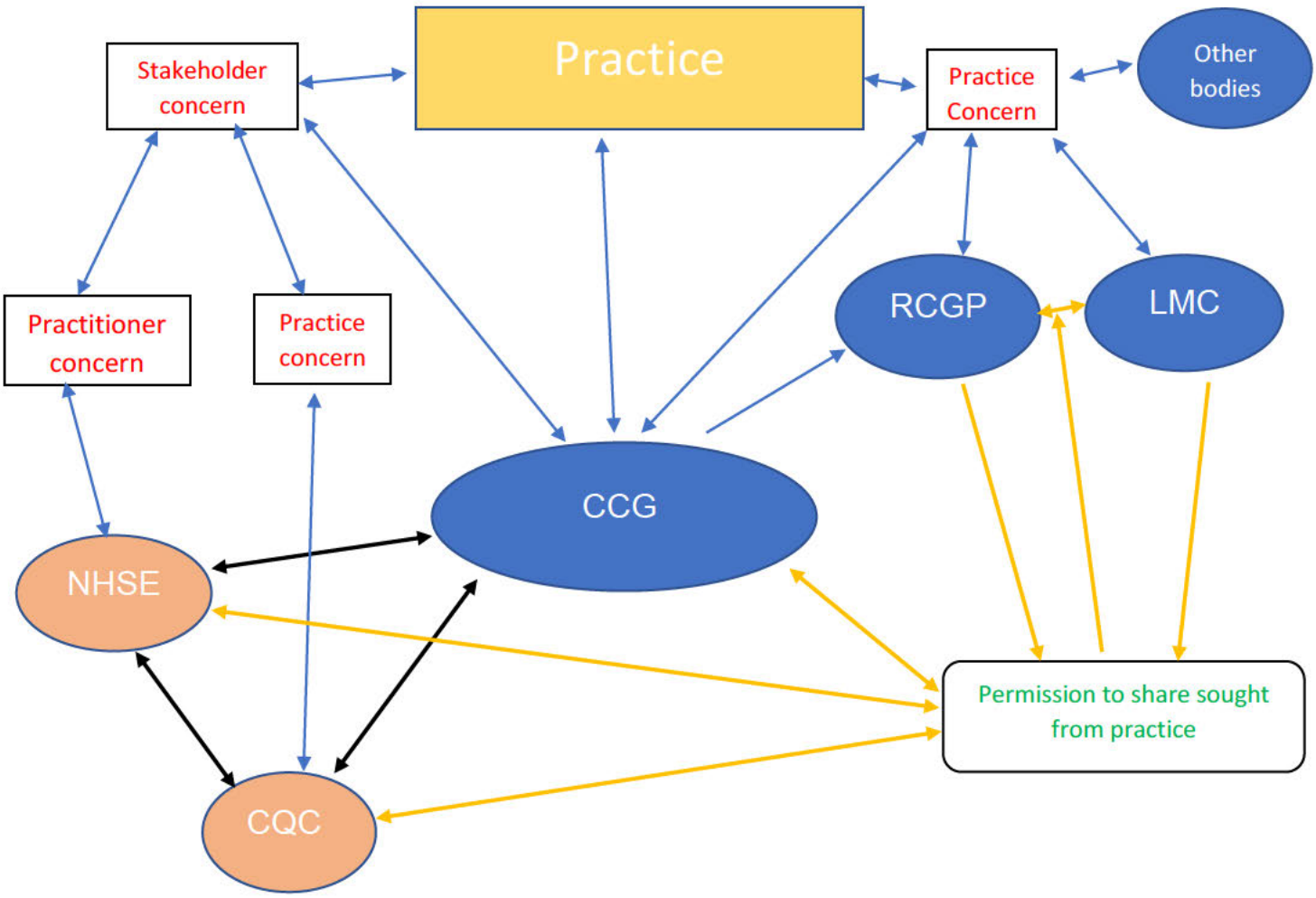
The first person to thank is [redacted] without whose willingness to be proactive and forward thinking, none of this would have happened. [redacted] she has been a valuable and valued partner. She is supported by an excellent peer support team led by [redacted] without which our work would have been much less effective. The LMC have also been consistently helpful and in particular I would like to thank [redacted], the Director of Practice Support, and the previous Executive Secretary [redacted]. CQC has also been generous with their support and my thanks go to them and in particular [redacted], the Inspection Manger.

The early work of the RCGP in [redacted] was established due to the pioneering efforts of Dr [redacted] and [redacted] who started the original Special Measures programme and the Vulnerable Practices programme. This was further developed by the ongoing management support of Dr Pauline Foreman, Naren Duffy and Cassie Forbes. Jayne Dewhurst was my predecessor as Deputy Lead and not only did she establish the close working relationship with [redacted] that helped to smooth processes, but she has always been a splendid mentor to the advisers. We owe them all a considerable debt, as we do all those advisers who have worked with practices over the years. I also owe a personal debt to Pauline who is always there for advice and support and who has been an invaluable help in preparing this document.

Finally thank you to all of the practices who have worked with us, GPs PMs and all team members as well as managers and Federation members who have been generous with their trust. You have shared your worries and problems; you have given freely of your time and effort and you have worked hard to take on board our comments. We are delighted to see your success, congratulate you all and wish you well for the future.

Appendix 1

A diagram demonstrating the pathways taken in managing practices where there are concerns



Appendix 2

Outcomes of RCGP contracts

2015/16	Before	After	
1	SM	RI	
2	SM	Surgery closed	GP supported to retire & hand back contract
3	SM	Good	
4	SM	Good	
5	RI	Good	
6	RI	Good	Declined offer of support
7	RI	Good	
8			Declined offer of support - Unidentified
9			Declined offer of support - Unidentified
10	RI	RI	Declined offer of support
11	RI	Now new management	Declined offer of support
12	RI	Good	
13	RI	Good	Declined offer of support
14	SM	Good	
15	RI	Good	
2017			
16	RI	Good	
17	RI	Good	
18	Good	RI - > Good	Major changes caused acute vulnerability
19	SM	No reinspection	Changed reg. [redacted] and again 18/6/19 with merger with [redacted]
20	RI	SM -> good	Only involved just before inspection - plan enabled good result at re-inspection
2018			
21	RI	Good	Whole team Away Day
22	RI	No reinspection	Changed reg. 1[redacted]
23	RI	Good	Declined offer of support
24	SM x 2	RI	
25	RI	Good	
26	Good		Vulnerable practice
27	RI	Good	
28	RI	Good	
29	RI	RI	Accepted initial contact then failed to engage
30	RI	RI	The practice has significant underlying issues

31	SM		DR & FP - led to second contract
31 A	SM	RI	In depth support
32	RI	Good	New CQC reg. 16/7/20
2019			
33	Good -	Good	Partners Away Day (Workforce & sustainability)
34	RI	Good	
35	Good		Partners Away Day (Partnership at risk) - the partnership remains
36	RI	Not yet revisited	
2020			
31 B	RI	Not yet revisited	New Contract
37	RI	Not yet revisited	
29 A	RI	RI	Limited scoping done then failed to engage
38	RI	Not yet revisited	DR & FP led to second contract
38 A			Partners Away Day
39	RI	Not yet revisited	
40	RI	Not yet revisited	

References

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