CQC and BMA set out their positions on GP inspections

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Since it was first established, the Care Quality Commission (CQC) has been the subject of much criticism, culminating in the BMA’s survey of GP practices earlier this year, which demonstrated the extent of the dissent among GPs regarding CQC inspections. This article presents the arguments from both camps.

Since the publication of the BMA’s survey of GP practices in January, the Care Quality Commission (CQC) has been besieged by critics of its inspection programme. Over 1900 practices in England responded to the survey, which focused on GPs’ experiences of the CQC inspection process and its impact on their services. Their overall verdict was negative, with 80 per cent of practices calling the workload to prepare for a CQC inspection “excessive” and eight in ten practices rated as “good” describing the inspection as an inadequate measure of quality. In addition, three-quarters of GPs who responded said the inspections made it more likely they would want to leave general practice.

Following the survey’s publication, Dr Chaand Nagpaul, BMA General Practitioners Committee chair, called the CQC’s system “disproportionate, onerous and flawed”, saying it was taking time away from patient care when practices were facing unprecedented demand.

CQC responds to criticism

Responding to this charge, a CQC spokesperson tells Prescriber: “CQC works in the best interests of patients. They tell us they want to know care services are safe, effective and responsive. Not only do patients value our inspections, but GPs themselves have told us inspection has helped drive improvement [nearly two-thirds of those we surveyed].” This refers to the CQC’s own annual provider survey top line findings in the February board meeting’s paper, revealing 57 positive and 135 negative comments from primary medical providers (see Figure 1).

The CQC concludes that it has worked hard to ensure the inspection does not adversely impact on patient care by working with practice staff on designing the inspection day’s agenda, and their feedback “indicates that sur-
geries already performing well do not find the preparation for inspection onerous.”

**What prompted the BMA survey?**
The survey was provoked by widespread concerns about the CQC inspection process and its adverse impact, spontaneously expressed by GPs, practice managers and staff, says Dr Nagpaul.

They had voiced their dissatisfaction to the local medical committees (LMCs), in emails to Dr Nagpaul, and in motions to their annual conference last year. At this year’s special LMC conference on 30 January, convened to debate the “crisis facing general practice”, motions relating to CQC regulation began by saying the “conference believes that over-regulation and monitoring of the profession has eroded morale and had an adverse effect on the sustainability of general practice.”

“We know their inspection process is having a negative effect and affecting the running of practices,” Dr Nagpaul tells *Prescriber*.

Delegates at the special LMC conference voted unanimously to oppose any increase in CQC demands for fees from practices and for all fees to practices to be fully reimbursed. They also carried motions demanding that the General Practitioners Committee (GPC) should: actively campaign to abolish the CQC’s regulation of general practice; explore options by which GP practices could lawfully withdraw from engaging with the CQC; and produce realistic proposals for an effective peer-led quality assurance scheme based on criteria that improve patient care and safety.

Addressing the proposed regulatory fee rise for small GP practices from £725 to £4839 in two years, a CQC spokesperson explains that the regulatory body understands providers’ concerns in the present climate of financial pressures affecting them, but says the policy is not one of its own making. The spokesperson adds: “The government has set clear objectives that arm’s length bodies like CQC recover the full cost of their activities through fees.”

The NHS GP sector’s current 15 per cent cost recovery is much lower than any other sector. As regulating costs have risen since the NHS GP sector came into regulation in April 2013, the sector has fallen further back in cost recovery terms. Therefore, moving them to full recovery over a two-year period requires relatively larger percentage increases than in other sectors over the same timescales, explains the CQC. The government has recently announced additional funding for GP practices to cover the expense of the fee increases in 2016/17, which is intended to mitigate its impact.

**How did the CQC originate?**
The CQC is a nondepartmental public body, sponsored by the Department of Health, established as the regulator of health and social care in England in April 2009. Its purpose is to “make sure health and social care services provide people with safe, effective, compassionate, high-quality care, and to encourage them to improve.”

Figure 2 shows the governance framework of the CQC and Figure 3 shows its overall operating model. It was formed from the merger of three previous regulators: the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission.

The CQC was given more responsibilities; however, its budget was less than that of the combined budgets of its three predecessors. Since its early days, it has been the subject of severe criticisms, culminating in a Public Accounts Committee (PAC) report in 2012 that outlined its failures to act quickly on “vital issues such as information from whistleblowers” and to deal with problems effectively. The report concluded that the CQC had been poorly governed and led, with an overemphasis on reputation management and the inclusion of gagging clauses in its severance deals with staff, discouraging them from making information public that would help drive improvement and hold the commission to account.
Three years later, in December 2015, the PAC published a new report.6 This found that, while the CQC had made “substantial progress” since 2012, “it is behind where it should be, six years after it was established, in that it is not yet an effective regulator.”

Speaking at the time, PAC chair Meg Hillier MP said: “There’s too often a long gap between inspections and reports being published – and sometimes an alarming lack of attention to detail when reports are being prepared.” She pointed to one NHS Foundation Trust’s report that had identified more than 200 errors, including data inaccuracies in a draft CQC report. Ms Hillier added: “When the Commission falls short, there must be robust measures in place to enable parliament and the public to hold it to account.”

CQC chief executive David Behan responded: “We are not complacent and are working confidently to continue to improve what we do and how we do it. We look forward to reporting to the PAC in the summer on the progress we have made.”7

What does a typical GP surgery inspection look like?

There are two types of inspection: comprehensive and focused. The comprehensive inspection, as its name suggests, ranges across the full scope of practice care. It is guided by the CQC’s five key questions (see Figure 3) and (in GP practices, not out-of-hours practices) assesses all six population groups (see Figure 4). It is usually held once every three years, lasts for one day on site and is announced in advance.

The focused inspection is a follow-up to a previous inspection and is undertaken to respond to a particular issue or concern. It might not look at all five key questions and six populations and may be unannounced.

The BMA has issued practical guidance for GPs on preparing for a CQC inspection,8 with advice to read the CQC’s GP provider handbook3 beforehand and be aware of the CQC’s five key questions. The first step is to prepare for preinspection and ensure the CQC registration is up to date.

The CQC will notify the practice two weeks before the inspection is due to take place. The BMA lists the key documentation a practice should collate in advance and have ready for inspection. On the inspection day, the CQC inspector will introduce the team, outlining what will happen, then the practice will be invited to give a 30-minute presentation.

As part of the CQC’s new approach to inspecting, its inspectors follow key lines of enquiry (KLOE). It will construct a matrix around the six population groups and the five key questions that will guide
its ratings of the practice’s provision of care (see Figure 4).

What are the reactions of those who have been inspected?

Dr Nagpaul says: “We know the process has created huge stress, with thousands of practice appointments cancelled on the inspection day to accommodate inspectors, thus reducing access for patients. It has led to three in four GPs talking of leaving the profession because of the climate of threat. One in four practices – which is very telling – say they are less likely to express concern about practice pressures because they fear intervention by the CQC, so it has created a climate of fear and one that discourages openness. This is at total odds with the whole philosophy of the government approach, post the Francis report, so it is a process that needs to be replaced.”

The CQC asserts: “Our inspections are carried out by specialist teams, which include GPs and other professionals with experience in general practice acting as special expert advisors. They receive training and refer to agreed KLOE to ensure consistency. This ensures that the team has the skills and expertise to accurately report on what they find and make robust judgements. We will continue to work with the GMC, NHS England, CCGs, the RCGP the BMA, LMCs, patient representatives and other bodies to ensure our regulatory regime is fit for purpose and we value their feedback.”

Two practices have reported very different responses to their inspections. Janice Foley, acting practice manager of Park Edge Practice in Leeds, quoted as a case history in the BMA’s guidance for GPs on CQC inspection, describes the experience as “not as horrendous as we expected”. Having been notified 14 days prior to the visit, they used the time to ensure all “policies and protocols were up to date and easily accessible” and the practice booked a locum for the day to free up one partner, as the senior partner was on annual leave. On inspection day, two inspectors were at the practice all day and were “very friendly and not at all intrusive”. At the end of the visit, the practice was debriefed and “all in all not such a bad experience as we expected,” was the verdict. The CQC’s verdict on the practice was comprehensively “good”.

On the other hand, Rob Barnett, GP at Greenbank Road Surgery, Liverpool – whose practice was also given a “good” rating across the board – says it is a very bureaucratic system that focuses on ticking boxes on policies and protocols as opposed to scrutinising the quality of clinical care given to patients. “I think that’s the problem because it portrays itself to the public as doing that. It’s a very expensive, laborious way of undertaking an exercise that really tells you nothing,” he notes.

His practice manager was with the inspector for “virtually the whole day”, while Dr Barnett had to employ a locum to free himself to deal with the GP inspector, who worked his way through a folder of 70 questions.

Dr Barnett, who is also secretary of Liverpool LMC, acknowledges that some of the questions on processes were related to patient safety, but too many were irrelevant and he says there are existing methods for monitoring services, such as the CCG, that pick up failing practices. He says: “CQC, in some

Figure 4. How Care Quality Commission (CQC) ratings are decided. Ratings are awarded for the five key questions (see Figure 3) and (for GP practices only) the six population groups (older people; people with long-term conditions; families, children and young people; working-age people (including those recently retired and students); people whose circumstances make them vulnerable; and people experiencing poor mental health (including people with dementia)). CQC inspection teams review the evidence against the key lines of enquiry (KLOE) and use the guidance to decide on a rating by seeking to answer the questions: Does the evidence demonstrate a potential rating of ‘good’? If yes – does it exceed the standard of ‘good’ and could it be ‘outstanding’? If no – does it reflect the characteristics of ‘requires improvement’ or ‘inadequate’? (Reproduced with permission from: How CQC Regulates: NHS GP Practices and GP Out-of-hours Services. Provider handbook, January 2016)³
respects, isn’t adding very much, but it causes a lot of stress and anxiety. It isn’t looking at how you treat patients clinically in outcome measures and I think that’s why, from my perspective, it is a ludicrous exercise.”

Why did so many GPs respond negatively in the survey?
Dr Nagpaul says: “The problem is that the CQC has conflated its core function of registration with a much larger quality improvement agenda and it’s doing so in an erroneous and simplistic manner that is actually damaging the whole ethos of quality improvement.”

The CQC spokesperson explains: “The introduction of our new specialist and expert-led approach to inspection was a deliberate move away from a simple assessment of practices against basic minimum standards. We want practices to go above and beyond the regulations. Our ratings encourage improvement across general practice in England and help people to make informed choices about their care. We are really pleased that most general practices we have reinspected have improved, with many general practices now coming out of special measures.”

However, Dr Nagpaul believes it is “nonsensical” for a regulator to be in charge of quality improvement. It should be outside a registration process and part of a professionally-led, peer-reviewed process that would be supportive, facilitative and able to identify areas of need and assistance.

What is the BMA’s suggested solution to the disagreement?
Dr Nagpaul suggests the current inspection rating system (see Figure 4) should be replaced by a targeted approach rather than a blanket policy. The CQC also needs to move away from its judgemental approach to one of identifying where there are concerns and finding solutions to resolve them.

He says: “They need to be proportionate, measuring the right things rather than trying to measure a whole range of arbitrary processes that are potentially misleading, with huge emphasis on recruitment policies, practice meeting minutes and a tick-box, nit-picking approach. The CQC measures systems, not clinical care. While organisational systems are important, the judgement on the practice misleads the public into believing it’s a reflection of the care it provides. It isn’t.”

He adds: “In many cases we have seen practices rated as ‘inadequate’ purely on issues around their organisational processes when the clinical care has been superlative. The CQC instead could identify where organisational systems are not right and give the practice maybe two or three months to put them right, rather than making a judgement on that day.”

“The CQC registration should take into account context and circumstance. We are in a climate now where many practices are going through challenging circumstances, either through lack of recruitment or working in premises not of their choosing and it is quite unfair and punitive to make judgements on them as a result,” Dr Nagpaul argues.

“It cannot help patients or the practice when the rating might have nothing to do with clinical care, but is about systems. What it needs is support for improvement. Unless that support is provided, it turns into a negative cascade, where the practice is disabled, patients lose confidence, staff leave, there are greater recruitment problems and a damaging spiral develops rather than a supportive spiral.”

... and the CQC’s solution?
The CQC spokesperson says: “We know the majority of GPs we have inspected provide good or outstanding care; however, we also know there is still too much poor care. It is worth noting that over 90 per cent of practices have shown improvements in at least one of the key questions that we inspect against upon reinspection, showing the impact our inspections are having to improve patient care.”

The spokesperson adds: “There can be no improvement without genuine transparency. Sometimes this will involve telling uncomfortable truths. Refusing to acknowledge problems and blaming those who expose concerns neither supports the profession nor protects patients. We act in the interest of people who use services.”

The CQC states that when it completes its first round of comprehensive inspections at the end of the inspection year for 2016/17, it will work with stakeholders including the BMA, the RCGP and others to consult on changes to the regulatory model for the next round. It adds that it will examine how to reduce the number of inspections and reduce the workload for practices once it has completed the baseline.

References

Declaration of interests
None to declare.

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