Consultation on Display of Performance Assessments

1. The RCGP welcomes the opportunity to respond to the Department of Health consultation on ‘Display of Performance Assessments’.

2. The Royal College of General Practitioners (RCGP) is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 49,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with expertise in patient-centred generalist clinical care.

Summary

3. The RCGP has significant concerns around the use of summary ratings by the CQC as a means to indicate the level of care provided within GP surgeries. Summary ratings do not take into account differences between practices, including age of the practice population, deprivation and population mobility, which have a fundamental affect on the level of care that can and should be provided. We set out our full opposition to this approach in our response to the CQC consultation on ‘How we regulate, inspect and rate services’ (contained in Annex A). As such we are strongly opposed to the compulsory display of CQC ratings within GP surgeries, as we have no faith in way in which the ratings are reached and therefore hold that their display would only confuse and concern patients with no benefit to the service or the patients themselves.

4. In particular we have concerns around the way in which the ratings are presented, with little or no accompanying information to give context as to how and why the ratings have been reached. As such, even if the RCGP had faith in the concept of summary ratings, it is difficult to see how the display of the ratings as they are given could inform patients in a meaningful manner about the standard of their care.
5. As an alternative to these ratings the RCGP proposes that the existing data collected and published by NHS England as part of their Primary Web Tool can be used to both provide information to patients around the level of care delivered within their practice and allow practices themselves to compare their activity to that of other similar practices, in order to reflect and potentially improve on the service they provide to patients. Practices could choose to display this information within their surgeries and/or on their website.

6. In addition, we are concerned about the possibility of fines being imposed on GP surgeries which fail to comply with these regulations. General practice is struggling to provide care with decreasing resources in the face of increasing demand. As such, any financial penalty being applied, runs the risk of further decreasing investment for patient care within general practice.

Question 1: Do you agree with the proposal to legally require providers to display the rating CQC has published about their services?

7. The RCGP is strongly opposed to this proposal. We are opposed to the use of summary ratings as a means to indicate the standard of care provided in GP surgeries, and set out our opposition to these measures in our response to the CQC consultation on ‘How we regulate, inspect and rate services’. Quality measures need to take into account differences between practices including age of the practice population, deprivation and population mobility. A single summary score is unlikely to take these factors into account and will therefore be unable to offer meaningful comparisons. As such we do not see the value in GPs being required to display the rating, and would in fact consider it positively harmful, due to its potential to confuse and misinform patients.

Question 2: Do the proposed regulations requiring providers to display the rating of their services help to deliver the policy objective of giving people who use services, their families and carers a straightforward means of understanding a provider’s performance?

8. The RCGP does not agree that the proposed regulations will help to deliver this policy objective. We hold that summary ratings are an insufficient means by which to codify and communicate the standard of care provided by GP surgeries. In particular the form in which these rating they are awarded and it is prosed that they will be displayed is particularly unhelpful as they are presented without any accompanying information and guidance as to how and why they have been awarded.

9. As such we think that rather than increasing awareness, the requirement to display the summary ratings within GP practices will be damaging for patient understanding, as they do not provide the requisite information to help patients to understand the level of care that is and should be provided within each surgery.

10. In order to promote transparency within general practice services the RCGP is proposing that the existing data collected and published by NHS England as part of their Primary Web Tool could be used to both provide information to patients around the level of care delivered within their practice and allow practices themselves to compare their activity to that of other similar practices, in order to reflect and potentially improve on the service they provide to patients. Practices could choose to display this information within their surgeries and/or on their website.

11. However, we would expect this information to be displayed on a voluntary basis. Given the workforce pressures faced by many practices, with not enough capacity in all parts of the workforce to meet current patient demand, the collation and display of this information could present an unacceptable administrative burden to many practices.

Question 4: Do the proposed regulations clearly prescribe what providers must do in order to clearly display their rating? Yes or No?

12. The regulations are clear in this respect. However very little information has been given as to how the requirement to display ratings would be enforced and inspected. Given this, we have concerns that there could be a danger of penalties being imposed on providers who lack a full understanding of what is expected of them.
**Question 5:** Is there any further information which providers should be required to display with the rating?

13. The RCGP does not think that the summary rating as given by the CQC gives sufficient information about the quality of care provided within GP surgeries. In order to fully communicate to patients the level of care which they should expect to receive, further information would have to be provided alongside the ratings. For example, a definition of terms and explanation for how each rating was achieved, with information regarding sources and method used, as well as a clear explanation of what the ratings mean in practice for patient care. Unless this information is displayed alongside the ratings, they will provide no information of use to patients.

14. In addition, we note from the recent CQC consultation on ‘How we regulate, inspect and rate services’ that the ratings will be imposed without any consideration of the unique challenges and concerns of each GP surgery (for example levels of depravation and income), meaning that their usefulness is further obscured. The RCGP believes that if the display of CQC ratings is to be imposed, then this information would have to be provided alongside in order for these ratings to be meaningful.

**Question 6:** Do you agree with the proposal to require providers to display their rating on their website?

15. See answer given to question one above, as we have doubts around the validity of the CQC ratings we do not see the value in their compulsory display.

**Question 7:** Do you think any additional requirements for the display of ratings are needed and if so, what should they be?

16. As explained in our answer to question five, a proper context must be given to the ratings in order for them to have any meaningful impact on patient awareness. The CQC ratings as they are currently given do not have sufficient information to communicate the quality of care within a GP surgery to patients.

**Question 8:** Do you agree that the failure to display a rating should be an offence with a maximum penalty of a level 2 fine?

17. The RCGP strongly disagrees with the imposition of a penalty fine on GP surgeries that do not display the CQC ratings. GP surgeries are under increasing financial pressure, with many GPs surgeries facing closure due to a decrease in funding in the face of increasing workload. Imposing fines for a failure to display these ratings would only worsen this situation with the association impact on patient care, which should be the priority for all aspects of the healthcare system. Given that we do not hold that these ratings would impact positively on patient care, we do not think that their lack of display should justify a fine.

**Question 9:** Are there any other mechanisms or locations that would increase the transparency and impact of quality ratings?

18. See answer to question five above. The use of explanatory notes and a definition of terms, would in our view go some way towards increasing the legitimacy of the rating system.

**Question 10:** What are the likely costs to business of familiarisation with the regulations likely to be?

19. We do not have any specific costs for this. However, we do have concerns that there is currently not enough capacity with the general practice workforce (including general practice nurses and receptionists) for staff to spare the time to familiarise themselves with what we consider to be a task that does not add value to patient care within general practice.

**Question 11:** What are the likely costs to business for displaying a rating a) physically at their premises? b) on their business website?
20. See answer to question ten above, while we have no specific costings for this, we do have concerns that there is a lack of capacity within the general practice workforce to the extent that the completion of administrative tasks which cannot be proven to add value present an unacceptable burden.
ANNEX A

Consultation on how we regulate, inspect and rate services

1. The RCGP welcomes the opportunity to respond to the CQC’s consultation on ‘How we regulate, inspect and rate services’.

2. The Royal College of General Practitioners (RCGP) is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 49,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. We are an independent professional body with expertise in patient-centred generalist clinical care.

Summary

1. The RCGP supports the development of good quality information systems for health and social care. However, the College does not believe that a single summary score for a GP practice would be helpful and that it would, in fact, be positively harmful. Quality measures need to take into account differences between practices including age of the practice population, deprivation and population mobility. A single summary score is unlikely to take these factors into account and will therefore be unable to offer meaningful comparisons.

2. The RCGP supports measures to promote quality in general practice and are open to working with the Government and the CQC to devise a system that is going to create the right incentives to improve standards. But we believe this should be done without introducing a system of ratings for GP practices.

3. The implementation of the new inspection regime must be seen in the context of the current intense workforce and workload pressures facing practices, and declining resources being allocated to general practice. These pressures are leaving many GP surgeries unable to cope with demand (particularly in those areas of the country that face workforce challenges and historically poor health outcomes). Consideration must be given to this when auditing the ability of GPs to provide care. Indeed, many of the proposals put forward in the consultation document have the potential to further increase the bureaucratic burden on GP practices, thereby additionally impacting their ability to provide care.

4. We also have concerns that the proposed inspection system appears to not take into account the unique resources available to each individual surgery, both in terms of funding and workforce. While it may be the aim of many surgeries to provide a wide
number of services, a small but significant proportion of GPs still operate as single handed services, or with a limited skills mix, and it may not be possible for all surgeries to deliver additional services. Indeed, the assumption that providing multiple services forms a fundamental part of good care fails to take into account the possibility of a lack of genuine need within an area.

5. We agree with the conclusion of the recent Kings Fund report *Reforming the NHS from Within* (June 2014) that the NHS has in the past been over-reliant on external stimuli, such as inspections, to bring about change. In particular we agree with the Kings Fund that engagement with doctors, nurses and other healthcare professionals in quality improvement programmes is vital if any meaningful change is to be implemented.¹ With this in mind we were concerned by the findings of a recent poll conducted by Pulse which found that 74% of GPs “do not believe the CQC process as it stands is a fair way of assessing the quality of GP practices”². We believe that at present there is a lack of confidence in the inspection process and are concerned that this will seriously impact the ability of the CQC to influence change.

6. Indeed, we were also particularly concerned that the first round of inspections of GP surgeries, the results from which were announced in December 2013, led to a level of negative publicity for general practice in the national media that does not accurately reflect the overall high levels of performance and patient satisfaction with GP services. Whilst we absolutely agree that failures in standards must be identified and dealt with, this must be done in a proportionate way.

**Detailed response**

*Please note that we have responded only to the questions that are relevant to the work of the RCGP.*

**Question one.** We have identified the population groups that we will inspect and rate during our inspections of NHS GP practices.

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² Pulse Online, Survey finds that GPs have little confidence in CQC, 13 December 2013 http://www.pulsetoday.co.uk/your-practice/practice-topics/regulation/cqc/survey-finds-gps-have-little-confidence-in-cqc-as-practice-challenges-maggots-claims/1/20005337.article?pageno=3&sortorder=dateadded&pagesize=10#U5rPYP4U_yM
Do you agree that these are the right groups for us to look at?

7. The RCGP agrees that each of the distinct subgroups mentioned should be reported on, and notes that these subgroups encompass the entire practice population. However, we are concerned about the grouping together of the working population with the recently retired, as these groups will have differing needs and priorities, so it is difficult to see how they can be treated as one group.

8. It is also worth noting that no significant plans have been laid out for how the practice population will be subdivided in these groups for the purpose of rating the service especially given that many patients may fit easily within more than one subgroup. The RCGP would be strongly opposed to any suggestion that the GP services could be expected to carry out the subdivision themselves, as it would represent an unacceptable bureaucratic burden.

**Question two.** Do you agree that we should rate and report on each of these population groups for GP practices?

9. The RCGP opposes the application of summary ratings to general practice services as these ratings fail to take into account differences between practices, including age of the practice population, deprivation, population mobility, and available resources. As such, any ratings applied will not fully reflect the ability of general practice services to provide care.

10. However, if ratings are to be applied, the RCGP agrees that each of these groups should be reported on, if consideration is given to separating those who are in work from the recently retired. In addition, if ratings are to be applied to each group, greater consideration should be given to the performance of the service in providing care to vulnerable groups, such as the homeless or the vulnerable elderly.

11. Consideration should also be given to the unique challenges faced by each GP service when applying ratings. For example the population make up can differ drastically from practice to practice, as can the available resources, with a small proportion of GP surgeries still operating in the single handed model. If consideration is not given to these differences then ratings will not properly reflect the current situation within general practice, for example an area with a high number of vulnerable elderly will prioritise that group if faced with shrinking resources.
**Question three.** Do you feel confident that the key lines of enquiry and the list of prompts will help our inspectors judge how safe, effective, caring, responsive and well-led NHS GP practices and GP out-of-hours services are? Is there anything we are missing?

12. We have concerns that the questions appear not to have been ranked by order of importance. For example questions about safety, the qualification of staff or opening hours should take clear precedence.

13. What the ideal service based on the key lines of enquiry would look like in practice is not made clear. Many of the characteristics given are open to interpretation. For example the key lines of enquiry which relate to treating patients in a culturally sensitive manner are extremely vague.

14. Indeed, many of the key lines of inquiry in fact relate to issues which are outside the control of many GP services, for example the ability to share information between the out of hours and in hours periods, which in an issue which affects the wider health service, and is not necessarily something that individual GP services will have the capability to address.

**Question four.** Do you agree that the key things we have highlighted for each population group are the right things for our inspectors to consider when they are inspecting GP practices?

15. The RCGP broadly agrees with the key points for each population group, with the following caveats:

   i. For the sub group ‘vulnerable elderly’ mention is made of the need for GP surgeries to have a named accountable clinician in line with the government’s aspirations in this area. In principle we support the proposal to introduce a named accountable clinician for vulnerable elderly patients, and recognise that GPs would be best placed to act as that named clinician. However, there is a lack of understanding about how the introduction of a named accountable clinician would differ from the current system in operation within GP surgeries. In addition, the way in which the named clinician will be held accountable and for what is not currently clear.

   ii. With regards to the section on patients with long term conditions, while the RCGP recognises the proactive monitoring of the prevalence of long term conditions in the patient population as best practice for GP practices, it is important to note that due to increasing demand at a time of shrinking
resources, many GP practices may simply not have the resources to undertake this work. This is especially true of single handed practices. Given this the RCGP believes that the unique pressures faced by each GP service in terms of staffing or funding should be taken into account when auditing the service against this requirement.

iii. In the section on child and maternity health, reference is made to the ability of GPs to demonstrate ‘Communication, information sharing and decision making with other agencies, particularly midwives, health visitors and school nurses’. The RCGP has longstanding concerns around the ability of different parts of the health to communicate with each other. This is a problem faced by all sections of the health service and the RCGP has concerns that GP surgeries face being judged for situations which are outside of their control.

iv. Reference is made within the characteristics of the ability for working age people to access additional services within GP practices, for example in-house phlebotomy. General practice varies drastically in the form it is provided UK wide, from large Federations to single handed practices. The RCGP has concerns that given the number of single handed and small practices it may simply not be possible for every practice to provide additional services. This must be taken into account when calculating the score for this point. In addition, no consideration appears to have been given for whether or not there is demand for additional services within a GP practice population.

v. Under the sections for vulnerable people who have issues accessing primary care (particularly the homeless) and those suffering from mental illness, it is noted that there should be ‘no barriers’ to access, especially in the case of the of those who have no fixed address. While we welcome in principle the idea of greater access for hard to reach groups such as the homeless, little detail is given for what this would mean in practice, and consequently how GP services would be judged against it. The RCGP believes that primary care practitioners should provide a welcoming and sensitive service to homeless people and enable them to access the full range of health and social services required to meet their needs. However as homelessness is often a wider social health issue, engagement between general practice services and the local CCG may be necessary in order to make this a reality, and we urge the CQC to take this into account. Indeed, rising workloads in conjunction with a
decreasing workforce and resources in themselves act as a barrier for people accessing GP surgeries, without any formal barriers being put in place.

Questions five to seven. Do you agree that the characteristics of ‘outstanding’ ‘good’ ‘requires improvement’ and ‘inadequate’ are what you would expect to see in an outstanding NHS GP practice or GP out-of-hours service?

16. As previously stated the RCGP does not think a rating system such as is being proposed would adequately reflect the ability of general practice to provide care. However, for the purposes stated the RCGP agrees that the characteristics given for each band seem broadly appropriate. However, very little detail is given as to what these characteristics would look like in practice. If best practice case studies were given alongside each classification, it would help GPs to understand what is expected.

17. Moreover, the RCGP has concerns that many of these characteristics would be open to interpretation, for example many of the characteristics which relate to showing sensitivity around cultural issues are poorly defined and leave wide interpretation for the assessor.

18. Indeed, many of these characteristics assume parity of resources and demand between every GP service, and no consideration appears to have been given for either available resources or the existence of need within a practice population.

Question ten. How confident are you that the sources of information we plan to look at will identify risks of poor quality care and good practice?

19. The list given of possible sources given is fairly comprehensive. However it is not made clear whether or not sources that rely on formal data will be given more prominence in identifying risks, than forms of soft intelligence such as online feedback. Direct experience of what happens in practice should also be given high priority.

20. Moreover, it is difficult to see how many of the sources of information relate to the Key Lines of Enquiry that will be followed.

Question eleven. During our inspections of NHS GP practices and GP out-of-hours services, we will use a number of methods to gather information from the public about their views of the services provided.
Do you agree that the proposed methods of doing this are the right ones to use? Will they enable us to gather views from all of the people we need to hear from?

21. The RCGP agrees that the proposed methods of collecting information from the public are correct that that they should in theory allow for the CQC to gather views from all the people they need to hear from. However, we have significant concerns that the possible sources have not been given any order of importance. Information gathered via face to face interviews should have significantly higher weight that views gathered via social media.

**Question twelve.** Are there ways in which we could promote learning between providers and services, particularly where we have identified outstanding care?

22. The RCGP is committed to sharing best practice and there could be a role for the RCGP in working directly with the CQC to disseminate best practice to our members via our website, through direct communication, and possibly through events or workshops. We would be happy to discuss this further with the CQC.

23. In addition, learning could be spread by publishing best practice examples on the CQC website, and working with local CCGs and quality improvement advisors to disseminate best practice locally.

**Question thirteen.** Do you agree with the grounds on which practices and services can challenge their inspection reports and ask for a review of their ratings?

24. Given the vague nature of many of the key lines of enquiry we would like for GPs to be given the option to challenge the inspection on the ground that the interpretation of the results of the key lines of enquiry is faulty.

25. Moreover, the system described appears to involve a large amount of bureaucracy. Many GP surgeries may simply not have the resources available to challenge the inspection reports.

**Question fourteen.** Do you agree that the five key questions are equally important and should be weighted equally in our aggregation method?

26. The RCGP agrees that each of the five key questions should have equal weight.