Consultation on the Care Quality Commission's next phase of regulation – consultation 2

1. The College welcomes the opportunity to respond to the Care Quality Commission’s (CQC) consultation on the next phase of regulation – consultation 2.

2. The Royal College of General Practitioners (“the College”) is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 52,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. The College is an independent professional body with expertise in patient-centred generalist clinical care.

3. Through the Chair’s weekly blog and the recent College Council meeting we have sought the views of our members to be considered for inclusion in our response.

Executive summary

4. At a time when GPs are struggling to cope with increasing patient demand and insufficient investment, effective regulation should add value to patient care and not distract from the quality of their care.

5. Whilst GPs are generally supportive of regulation, they have considerable concerns about the cost effectiveness of the current model which is imposing unnecessary
administrative workload on practices. The College carried out a survey with Ipsos MORI in Autumn 2015 to understand GPs’ overall experience of a CQC inspection, including the final report. 88% of the respondents agreed with the inspections in principle but only 15% agreed with the current CQC approach.

6. The College is supportive of a revised approach to regulation that will reduce the regulatory and administrative burden on GPs, encourage quality improvement and promote accountability, whilst addressing long-standing unacceptable performance.

7. Whilst each of the proposals may make sense in isolation, collectively they do not address the issue of the growing regulatory and administrative burden on GP practices. Elements of the proposed new approach will be welcomed by general practice, in particular extending the inspection interval for good and outstanding practices, however the overall impact on the regulatory burden on GPs does not seem to be sufficient enough to make a significant difference to GPs on a day-to-day basis. A detailed impact assessment is necessary to fully understand the burden of the proposals in more detail.

8. Lifting the level of regulatory activity is key to reducing the burden on GPs. The workload associated with CQC inspections in general practice is estimated to be equivalent to 1.3 million consultations a year and more than three in four respondents to the Ipsos MORI survey agreed that they had needed additional staff resource for support during the inspection process. Effective regulation should not divert resources away from GPs providing high quality care to their patients.

9. To have a greater impact on reducing the overall burden, we propose a more focused approach on the least well-performing general practices, perhaps the bottom 10 - 20% of the performance curve. These practices could be identified by using routine data and local intelligence. This may reduce the overall cost of regulation and limit the burden on practices providing an acceptable or high standard of care. The proposal to increase the time between inspections for good and outstanding practices is a step towards this approach.

10. The CQC has confirmed that the overall cost of regulation will not increase as a result of the changes and that the fees will “remain proportionate” however there is a lack of evidence that the current model of regulation represents value for money. As stated in the College’s response to the CQC consultation on fee increases earlier this year, it is disappointing that the CQC has made no clear effort to reduce the fee schedule for GPs under the new regime, nor provide evidence that the size of the current fee is justified given the proposed changes to the regulatory regime.
Response to consultation questions

PART 1: REGULATING IN A COMPLEX CHANGING LANDSCAPE

Question 1a: What are your views on our proposal that the register should include all those with accountability for care as well as those that directly deliver services?

11. We agree that the structure of an organisation should be transparent to the public and to the GPs working within the organisation to aid understanding of accountability and proportionality.

12. The emergence of complex providers creates a risk of confusion around accountability. There must be a clear distinction between the decision-makers and those that deliver high-quality services to ensure the correct person is held accountable in the event of a regulatory breach.

Question 1b: What are your views on our proposed criteria for identifying organisations that have accountability for care?

13. The proposed criteria appear to be generally sensible however it is unclear how the CQC will determine and demonstrate whether a part of an organisation has exerted ‘significant influence over the quality and safety of services’ and is therefore accountable.

14. There may also be an increase in the administrative burden on GP practices should they be required to provide information to help determine accountability.

Question 2: We have suggested that our register show more detailed descriptions of services and the information we collect. What specific information about providers should be displayed on our register?

15. This proposal provides a good opportunity for more complex organisations to be better reflected in the context of the services they provide.

16. Any information that is displayed on the register must be meaningful to the people who use it and to the providers themselves. The proposal appears to include a lot of additional information however the register must be clear, concise and easy to understand.

17. If the register is to be reliable and robust, it is important that the information is kept up to date and verified. It is assumed that it will be the responsibility of the provider to keep the information up to date which is likely to add to the administrative burden.

Question 3a: Do you agree with our proposals to monitor and inspect complex providers that deliver services across traditional hospital, primary care and adult social care sectors?

18. The College has some concerns.
Question 3b: Please explain the reasons for your response.

19. The College is supportive of regulation at a corporate level and reducing the burden at the level of individual providers.

20. One of the challenges for general practice is that the administrative burden associated with responding to regulation is proportionately greater for small organisations because they do not have the support infrastructure available to larger organisations. Smaller organisations should not be unfairly tied up with unnecessary bureaucracy because they do not fit into the regulatory framework designed for larger organisations.

21. A single relationship-holder for each complex provider should help to develop a more productive and effective relationship with the CQC and reduce multiple requests for information. This also ensures that there is accountability of leadership and may also encourage similar quality standards, processes and reporting across all of the provider’s services.

22. Some of the emerging care models are complex with varying levels of integration and governance, therefore the approach must be flexible enough to be readily applied to the variety of models whilst retaining common standards and without being overly complicated.

23. It is important to note that historical information and a provider’s track record is not always an indicator of current performance. The CQC must make use of up-to-date information and not just rely on past performance when assessing the information for monitoring and inspection purposes.

Question 4a: Do you agree that a provider-level assessment in all sectors will encourage improvement and accountability in the quality and safety of care?

24. The College neither agrees nor disagrees. It is unclear how a provider-level assessment will encourage improvement and accountability in the quality and safety of care.

Question 4b: What factors should we consider when developing and testing an assessment at this level?

25. Ratings should be approached by assessment and professional judgement. Complex providers should not be identified by their lowest practice rating but at an overall organisational level.

26. Providers that take on struggling practices should not be at a disadvantage for doing so. They should be given appropriate support and not have their ratings lowered due to the aggregation of ratings.
Question 5a: Do you think our proposals will help to encourage improvement in the quality of care across a local area?

27. The proposals may be useful in highlighting issues that arise across the interface between primary care and other sectors, and the impact they have on patient care. The information gathered through monitoring should be used to encourage better collaborative working between providers across all sectors.

Question 5b: How could we regulate the quality of care services in a place more effectively?

28. The College has no further comments however it would be useful to see the findings from the work the CQC has carried out in Cornwall and the London Borough of Sutton.

PART 2: NEXT PHASE OF REGULATION

Question 6a: Do you agree with our proposed approach to monitoring quality in GP practices?

29. The College has some concerns.

Question 6b: Please give reasons for your response.

30. Monitoring and intelligence gathering must be effective to ensure resources are committed to those areas which are most in need. It is crucial that collecting and collating this information does not increase the administrative burden on GPs or deter the development of new models of care.

31. New models of care are less likely to emerge if they think that they will increase their administrative burden to meet regulatory requirements. It would be helpful for practices to understand the benefits of working at scale from a regulatory perspective, for example the proposal for a single relationship-holder for each complex provider.

32. A proportionate and locally responsive approach is required to meet the needs of the practices and population groups. Some of the emerging care models are complex with varying levels of integration and governance, therefore the approach must be flexible enough to be readily applied to the variety of models whilst retaining common standards and without being overly complicated.

33. The College agrees that the relationship between GP practices and inspectors are likely to improve through ongoing engagement and sharing of information resulting in more targeted and focused inspections.

Question 7a: Do you agree with our proposed approach to inspection and reporting in GP practices?

34. The College agrees but has some concerns.
Question 7b: Please give reasons for your response.

Inspections

35. The College is concerned that inspections do not regulate practices on criteria that are most important to minimising risk and improving care to patients. If staff do not feel inspection criteria are relevant to the quality of patient care, practices will only view the inspections as a box ticking exercise, defeating the aim of the inspection altogether.

36. The College recently published its position statement on quality which was developed for people who provide general practice care for patients, and for those making judgements about the quality of general practice care. The CQC should consider the elements of a GP practice that are less tangible but which are crucial to high quality care, such as continuity of care and managing risk, which are outlined in our position statement.

37. The transition period to a new inspection regime may be disruptive to GPs who have developed internal quality assurance or monitoring processes around the existing framework. The changes must be clearly communicated with plenty of notice to allow practices to update their internal processes. The CQC should produce guidance material to assist practices with the changes.

Reporting

38. The CQC’s ratings system fails to take into account the differences between practices, and the challenges they face - for example age, deprivation or available resources. Reports should clearly reflect these and other challenges faced by practices and how they may impact on their ratings.

39. It is important that the ratings and reports are relevant, concise and clear to the public, people using the services and providers. Only 49% of GPs that responded to our survey agreed that the reports are easy to understand.

40. The information published for patients must be easy to understand, in plain English and contain information which is pertinent to patients’ needs. It may be appropriate for the report to contain different sections with varying degrees of information for different audiences.

Question 8a: Do you agree with our proposal to rate population groups using only the effective and responsive key questions? (Safe, caring, and well-led would only be rated at practice level.)

41. The College has some concerns.

Question 8b: Please give reasons for your response.

42. The key lines of enquiries and prompts should be able to be easily applied to different models of care that have a range of complexities. A shared understanding of what good looks like must be clearly communicated to allow GPs to best demonstrate the quality of their services and understand the ways in which they may be able to improve.
Question 9a: Do you agree with our proposal that the majority of our inspections will be focused rather than comprehensive?

43. The College has some concerns.

Question 9b: Please give reasons for your response.

44. The College supports the proposal for less frequent and more focused inspections to address particular areas of concern. This should reduce the inspection burden on GPs but it may in fact increase the overall regulatory burden by requiring ongoing data input and information gathering for monitoring throughout the year.

Question 10a: Do you agree with our proposed approach for regulating the following services?

i. Independent sector primary care

45. The College agrees.

ii. NHS 111, GP out-of-hours and urgent care services

46. The College agrees.

iii. Primary care delivered online

47. The College agrees.

iv. Primary care at scale

48. The College agrees.

Question 10b: Please give reasons for your response (naming the type of service you are commenting on).

49. Independent sector primary care:
   
   High quality care should look the same irrespective of whether the service is provided by the NHS or an independent provider.

50. Primary care at scale

   It is important that the revised regime is flexible enough to enable it to adapt to the many different types of emerging models. The CQC must clearly communicate how it intends to regulate a particular complex provider to enable them to prepare adequately.

PART 3: FIT AND PROPER PERSONS REQUIREMENT

Question 15a: Do you agree with the proposal to share all information with providers?

51. The College does not agree. Sharing all information with providers appears to be unnecessary and is likely to increase the administrative burden. If the provider requires
further information to establish the fitness of a director, there should be an option that allows them to request it from the CQC.

**Question 15b: Do you think this change is likely to incur further costs for providers?**

52. Yes. This proposal is likely to incur financial and other opportunity costs for providers due to the increased administration and time required to review the information. This proposal increases the burden on providers with an apparent limited benefit to regulation.

**Question 16: Do you agree with the proposed guidance for providers on interpreting what is meant by “serious mismanagement” and “serious misconduct”?**

53. Yes, the College agrees.