Care Quality Commission consultation on Strategy for 2013 to 2016

1. I write with regard to the Care Quality Commission consultation on Strategy for 2013 to 2016.

2. The Royal College of General Practitioners is the largest membership organisation in the United Kingdom solely for GPs. Founded in 1952, it has over 46,000 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 enormous expertise in patient–centred generalist clinical care. Through our General Practice Foundation, established by the RCGP in 2009, we maintain close links with other professionals working in General Practice, such as practice managers, nurses and physician assistants.

3. The College welcomes the opportunity to respond to this consultation and we have responded to the individual questions below:-

Q1. What are your views on us making greater use of information and evidence to guide us in regulating services, which may mean we regulate different services in different ways?
This seems to us a very sensible way to operate, though there is an obvious need to ensure fair benchmarking so that like is compared with like. It is clear that general practice is a low risk service by comparison with services such as nursing homes, and we would expect to see the CQC applying a lower burden and frequency of inspection – with a concomitant lower cost both to the CQC and to practices.

Whilst on the topic of use of information, it will very important, in using metrics and benchmarking, that the CQC makes real efforts to take account of the challenges of deprivation when assessing providers, in both primary and secondary care. With all the new commissioning arrangements, there are real concerns that resource allocations may in places be inequitable. Many general practices in deprived areas have to manage with insufficient staffing or resources, relative to those in other areas – the CQC needs to acknowledge this when regulating these services, to support rather than punish those who making efforts to engage with inequalities.

Q2. What are your views on our approach to managing our independence and working with our national strategic partners and other organisations? Does it strike the right balance?

This section is, on the whole, very sensible and useful. There is however no specific mention here of Medical Royal Colleges such as the RCGP. If the CQC intends to use its regulatory role to drive quality improvement, it will do well to forge strong links with strategic partners such as us and the other Colleges, and work with us on issues around education, standards and work force.

The mention of developing joint licensing with Monitor is important here – the RCGP has expressed concerns since the Health White Paper in 2010 that there was potential for confusion between the roles of the two organisations. We will welcome moves to make better use of information to avoid duplication of regulation. At the moment the intention is that GP practices will be regulated by the CQC only, and not by Monitor – we believe this is the most suitable model. However, should this change in the future it is critical that the CQC and Monitor develop a consistent and efficient approach.

Other key partners obviously include CCGs and providers (both primary and secondary care). One of the priorities for regulation should be to ensure that providers are contributing fully to their local healthcare systems, playing their part in areas such as medical education and staff training, and providing a service that is responsive to the needs of their whole community. This may be more difficult to assess than the efficiency
and quality of providers in tackling their specific healthcare functions, but will be critical to the effectiveness of the whole system – and will require close working with commissioners, who will be best placed to assess the performance of providers in this respect.

**Q3. What are your views on our approach to building better relationships with the public?**

It is clear that this is something that the CQC needs to do, as public awareness of its work is very limited – only really increasing when there are major crises in organisations that they are regulating. Given the greater complexity of the new regulatory regime, and the wider remit of the CQC to cover primary care, public and patients do need to be made aware of its role. In particular, we would be interested to hear more about the suggestion of involving ‘people more in our inspections’ – does this imply that some form of lay panel may be established?

**Q4. What are your views on our proposed approach to tackle complaints?**

As above, if members of the public are expected to inform the CQC of complaints about service providers they will need to have much better information about the role and procedures of the CQC. The current system is often unsatisfactory and confusing for patients, and problematic for GPs who may feel their actions are being investigated by a large number of bodies. There is a concern that, if the CQC plays a greater role in each complaint, this will make the system more complex and more difficult for practices to resolve complaints quickly and satisfactorily. Is there even a risk that CQC investigations may interrupt or prejudice other formal investigations?

In any case, the call to work with the Department of Health to develop greater clarity is undoubtedly warranted, and will require collaboration with all the bodies involved in complaints processes. The suggestion that the CQC will clearly signpost patients as to appropriate procedures is warmly welcomed by members of our Patient Partnership Group.

**Q5. What are your views on whether our proposals will build respect and credibility among providers?**

Given the massive expansion in its remit and the many present changes in the English NHS, it is clear that the CQC will have a lot to do to establish trust and credibility with providers. The proposals around use of information and proportionate regulation, and to
work with Monitor to establish an efficient licensing regime, may help to build this if implemented successfully – mutual respect should come from this in the longer term.

Q6. What are your views on our approach to strengthening how we meet our responsibilities on mental health and mental capacity?

We welcome the CQC’s serious approach to this. As you may be aware, the RCGP is currently giving even greater attention to mental health issues, especially to the physical health problems that patients undergoing mental health treatment may also suffer1.

We asked our learning disability leads for a view on this. Their view was that the CQC should be asking why individual patients with challenging behaviour and autistic spectrum disorder in particular are:

1. resident for long times - Clinical assessment should be possible in 2-4 weeks maximum
2. resident for ‘assessment’ – which in many cases may appear more like ‘containment’
3. resident out of county - away from relatives and their community. People with challenging behaviour with difficult to assess mental capacity are not easy to care for in any situation and need properly trained and appropriately paid staff who care, wherever these patients are living. Care is more likely to deteriorate where a long distance separates patients from their family circle.

The CQC should be asking residential care companies and the responsible community clinicians to justify all three of the above,

Despite adequate nurses and care assistants these patients often have unaddressed medical conditions, as care home management may be focused on behavioural issues. It is vital that patients have easy access to GPs, and ideally to GPs who know them and their families from the community setting. Valuing People proposed that each move of address should trigger a comprehensive health check. Of course frequent changes of residence should ring alarm bells, but CQC should ensure that all these patients have an

1 See e.g. Professor Helen Lester - ‘Patients with mental illness 'under-treated for other conditions', researchers warn’ (GP Online 3/12/12) - http://www.gponline.com/News/article/1162504/patients-mental-illness-under-treated-conditions-researchers-warn/
annual comprehensive health check and medication review, preferably from their own GP.

Q7. What are your views on how we might most effectively measure our impact?

Impact may be the wrong word – much will depend on how disruptive CQC activities are seen to be. If CQC can achieve what it needs to in driving up quality with minimal administrative impact on organisations that are already performing well, whilst identifying and working with underperforming organisations, it is likely that everyone will recognise this as a good outcome.

Q8. What are your views on our proposal to become a high-performing organisation? Are there other factors that we need to take into account?

Perhaps understandably this section is long on aspiration and short on detail. One factor that does not appear to be considered, here or elsewhere in the paper, is the impact of external policy developments. So for example, even as the CQC is proposing a flexible regulatory system allowing it do more for less, there are news stories suggesting that the Secretary of State will be requiring a more rigorous and detailed standards regime. The CQC will need to be very flexible indeed to maintain the goals set out in this strategy document through the many external challenges that are sure to lie ahead.

4. We gratefully acknowledge the contributions of members of the College’s Council, our Patient Partnership Group, and our Centre for Commissioning in formulating this response.

Yours sincerely

Professor Amanda Howe MA Med MD FRCGP
Honorary Secretary of Council

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