



Royal College of
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Care Quality Commission: The world of health and social care is changing. So are we.
Strategy consultation

Executive Summary

1. The Royal College of General Practitioners (RCGP) welcomes the opportunity to respond to the Care Quality Commission (CQC) consultation on the document '*The world of health and social care is changing. So are we.*'¹
2. The RCGP is the largest membership organisation in the UK solely for GPs. Founded in 1952, it has over 54,000 members who are committed to improving patient care, developing their own skills and promoting general practice as a discipline. The RCGP is an independent professional body with expertise in patient-centred generalist clinical care.
3. The RCGP is broadly supportive of the aims of the strategy to move to a more targeted, intelligence led approach to regulation that reduces the regulatory burden for practices that are working well. A revised approach to regulation must reduce the regulatory and administrative burden on GPs, encourage quality improvement and promote accountability.

¹ CQC, *The world of health and social care is changing. So are we.* (2021)
https://www.cqc.org.uk/sites/default/files/20200111_cqc-consultation_doc_new_strategy2021.pdf

4. The proposed strategy rightly focuses on the patient and community groups accessing health and care services. However, it is disappointing that there is very little in the strategy on ensuring regulatory activity does not disproportionately affect providers with protected characteristics, such as Black, Asian or minority Ethnicity (BAME), or providers serving populations with high levels of socio-economic deprivation. The College would like to see an explicit commitment to improved transparency and accountability in exploring the relationship between CQC ratings and provider characteristics.
5. The CQC has the regulatory responsibility for assuring the quality of care for those using services, as well as identifying requirements for improvements to meet certain standards. The College welcomes the focus on encouraging improvement, although other stakeholders within local healthcare system must be responsible for supporting those improvements. For quality improvement to effect long lasting change, this must be accompanied by a systemwide commitment to the provision of long-term, funded, quality improvement support for GP practices.

More focused regulation

6. During the Covid-19 outbreak, practices saw the suspension or relaxation of many of the routine regulatory processes and contractual requirements that are usually placed on general practice. This includes the suspension of routine inspections of practices. As the system prepared for the pandemic, GPs were trusted to use their experience and professional judgement to provide the care their patient needed.
7. A better balance needs to be struck between giving GPs sufficient time for clinical consultations while also assuring the safety and quality of patient care. At present, we have low trust, high regulation regimes. We need to shift the dial towards greater trust in professionals, where the 95% practices that are rated 'good' or 'outstanding' by CQC are trusted to continue their work without being required to participate in recurrent CQC assessments.²
8. In the RCGP report, *General practice in a post-Covid world*³, we called for a more proportionate, intelligence led approach to regulation and inspections. The College therefore welcomes the proposals to begin using an approach informed by intelligence and data, which should allow providers to focus resources on improving aspects of care where improvement is needed.
9. Methods of monitoring providers will be a key factor in the success of this new approach. CQC must ensure that providing data and information for monitoring purposes does not add to the workload of staff that are already overstretched as the system begins to manage the backlog of care from the pandemic. As the system moves away from routine

² RCGP, *General practice in a post-Covid world* (2020)

³ CQC, *The state of health care and adult social care in England 2018/19, 2019*
<https://www.cqc.org.uk/publications/major-report/state-care>

inspections with CQC "crossing the threshold", it will also be important that remote monitoring is not experienced as stressful, excessive surveillance by providers.

People and communities

10. The RCGP supports the CQC approach to ensure the lived experience of care is a key factor in understanding the quality of care. It is right that the approach should seek out the experiences of those seldom heard, and those more likely to experience poorer health outcomes.
11. There is a perception among some of our members that practices led by or mostly staffed by BAME GPs are more likely to be inspected, or more likely to score poorly, than practices led by non-BAME GPs. The RCGP is disappointed to see that there is not more detail on how the CQC plans to ensure the regulatory approach does not unfairly impact on practices staffed by BAME clinicians and staff, often working in areas of high socio-economic deprivation.
12. The RCGP would like to see a review of currently available information, the development of plans to collect new information in the future, and the establishment of mechanisms by which the experiences of BAME-led practices can be gathered. The CQC must use this information to examine how it can become more reflective of the patient and provider communities it serves, particularly in terms of ethnicity, to help build confidence in fair regulation.
13. Specifically, we would like to see a commitment to further analysis of the relationship between CQC inspections, ratings and ethnicity. This should consider practice size, levels of deprivation and GP and staffing levels. This reflects a motion recently passed by RCGP Council.⁴ CQC should explore how these processes can be evaluated independently to build confidence in the profession and avoid any perception of a conflict of interest

Quality Improvement

14. The RCGP has a longstanding commitment to quality improvement (QI) principles. It is vital that providers are encouraged to embed a QI culture, and that GPs are adequately supported to do so. It is good that CQC is able to identify areas where change and improvement may be necessary through their monitoring of care delivery. However, it is equally important to recognise that CQC are not responsible for delivering quality improvement activity in general practice.

⁴ <https://www.rcgp.org.uk/about-us/news/2021/march/college-calls-on-care-quality-commission-for-action-to-address-impact-of-inspections-on-bame-gps.aspx>

15. Establishing improvement coalitions within local systems will have limited effect if they are not supported by committed resource from system leaders responsible for delivering QI culture and activity. The RCGP would like to see a stronger requirement for protecting time and resource for practices to engage with QI activity, which would yield more tangible outcomes. However, we recognise that this is not within the gift of the CQC.
16. Accelerating improvement cannot be the responsibility of the CQC: rather there must be impetus within the wider system to support providers to improve on the aspects of care identified as needing attention. The CQC will remain an important stakeholder in this agenda, working with others - including practices themselves - to help develop systems and processes to identify aspects of care in need of improvement and support practices. Still, the leadership on this important agenda must come from the integrated care system, and the practices themselves.