Better regulation, better care: Consultation on improving how we assess and rate providers – RCGP response

Part 1: Improving our assessment framework

Describing our expectations of quality for all rating levels

Question 1. To what extent do you agree that we should publish clear rating characteristics of what care looks like for each rating as part of our new assessment frameworks?

Agree

The RCGP considers transparency and consistency in regulation to be fundamental to supporting high-quality general practice. A lack of transparency is a frequent concern for practices receiving unfavourable CQC ratings, and we strongly support efforts to clarify "what good looks like" across the system. Greater clarity about the characteristics of high-quality and safe care has the potential to improve fairness for providers and strengthen public confidence.

Regulatory approaches must be proportionate, supportive, and designed to empower practices rather than increase administrative load.

However, as with other aspects of quality improvement, setting out "what good looks like" must be rooted in genuine co-production with general practice and underpinned by robust methodological rigour. General practice operates within diverse local contexts, and any national characteristics must be sensitive to this variation to avoid overly simplistic or mechanistic interpretations. For example, practices serving deprived populations face higher workload lower funding, and poorer estates, yet the CQC does not adjust for these structural disadvantages. As of October 2025, GP practices in England were responsible for approximately 63.9 million patients – an increase of approximately 7 million compared to September 2015. Hidden and undervalued workload is especially acute in deprived areas, where GPs face higher demand and complexity, larger lists with lower GP-to-patient ratios, and about 10% less needs-adjusted funding than affluent areas - making staff recruitment and retention harder. For this reason, any associated questions or tools should be streamlined, relevant to the realities of general practice, and aligned with an overarching aim of reducing unnecessary bureaucracy.

Just as investment in primary care requires appropriate resourcing, delivering fair and transparent regulation requires inspectors to be well trained, able to draw meaningfully on qualitative evidence, and equipped to consider local context.

Ultimately, the characteristics of good quality and safety should sit within a fair, improvement-focused regulatory model – one that supports practices to provide high-quality care, rather than relying on prescriptive or punitive mechanisms. Such an approach is essential if the regulatory system is to command trust and genuinely drive better outcomes for patients and communities.

Providing a clearer view of quality and safety for the sectors that we regulate

Question 2. To what extent do you agree with our proposed approach to developing assessment frameworks that are specific to each sector?

Agree

The RCGP believes that applying uniform, system-wide standards across all health settings fails to reflect the realities of frontline care.

The current expectation that smaller providers, such as GP practices, meet hospital-level infection control standards is a clear example of a disproportionate and impractical approach for primary care. We therefore strongly support the development of sector-specific assessment frameworks and welcome the recognition that general practice must be treated as a distinct setting.

General practice has unique organisational models, resource pressures, and community-embedded responsibilities that differ significantly from those in secondary care. As set out in the College's CQC action plan, any assessment framework must be tailored to these realities to ensure it is fair, meaningful, and truly reflective of day-to-day general practice delivery. Co-production with the sector - particularly with frontline GPs and representative bodies such as the RCGP and BMA - is essential to developing expectations that are proportionate, context-sensitive, and supportive of improvement.

In addition, sector-specific frameworks must minimise unnecessary duplication with other oversight bodies (for example, through repeated inspections from commissioning organisations with parallel processes to the CQC) and incorporate sufficient flexibility to take account of local variation. In addition, it is vital that the primary care inspectors possess the appropriate expertise and experience in general practice

A regulatory approach built on these principles would promote greater consistency across the system while recognising the distinctive role, pressures, and strengths of general practice within the wider healthcare landscape.

Question 2a. Do you have any comments or suggestions on how we should develop the sector-specific assessment frameworks?

The RCGP believes that effective regulation must reflect what GP practices can reasonably deliver. Overly prescriptive requirements - such as the extensive paperwork

in preparation for an inspection - are disproportionate for primary care and risk diverting attention from patient care. A more collaborative approach, with inspectors engaging directly with providers to understand what is realistic and appropriate, is essential.
We strongly support the development of sector-specific frameworks built through genuine co-production with general practice. This must involve frontline GPs, practice staff, professional bodies and local communities to ensure expectations are grounded in the realities of day-to-day practice. As set out above, frameworks should be developed to be streamlined, context-sensitive, and aligned with other oversight bodies to minimise duplication and unnecessary bureaucracy.

These frameworks must be evidence-based, incorporate meaningful qualitative insights, and set clear minimum expectations while allowing flexibility for local innovation. Development should include robust equality impact assessment, input from practices serving diverse and high-deprivation populations, and transparent piloting to ensure fairness and consistency.

Critically, inspectors designing and applying the framework must have relevant and recent general practice experience. This is essential to ensure credibility, accuracy and a regulatory approach that genuinely supports improvement in patient care.

Making our assessment frameworks simpler and clearer

Question 3. To what extent do you agree with our proposed approach to making our assessment frameworks clearer and removing areas of potential duplication?

Agree

The RCGP supports efforts to streamline assessment frameworks, including a slimmer set of supporting questions that remove duplication and reduce administrative burden. Current overlaps between CQC, ICBs and other assurance processes place significant and unnecessary pressure on general practice, and clearer, better-defined expectations would help promote fairness and transparency.

However, simplification must not come at the expense of recognising the complexity and diversity of general practice. Standards that may be appropriate for a practice located next to an A&E department may be far less relevant for a remote rural practice many miles from hospital care. Any refinement of the framework must therefore be developed collaboratively with the sector to ensure indicators remain meaningful, context-sensitive and proportionate, and do not inadvertently increase workload or overlook the realities of frontline practice.

A clearer framework will only be effective if supported by improved inspector training, robust quality assurance, and strong alignment with other regulatory bodies, ensuring that duplication is genuinely reduced across the board.

Questions 3a. Do you have any comments on the content of our current single assessment framework, or suggestions for how we should make our assessment frameworks simpler and clearer?

RCGP members have highlighted that the current single assessment framework can feel overly complex, repetitive and insufficiently reflective of the realities of general practice. To create a clearer and more workable model, the number of statements and supporting elements should be streamlined, duplication removed, and language made concise, unambiguous and directly relevant to frontline primary care. Requirements must be proportionate, focused on what genuinely influences patient safety and quality, and supported by clear examples of acceptable evidence.

Strong alignment with ICB assurance processes is essential so that practices are not repeatedly asked for the same information in different formats. Much of the data required ahead of inspections – such as cervical screening figures – are already held within ICS systems and should be sourced directly wherever possible, with practices given the option to provide alternative data where discrepancies exist. This would significantly reduce the time practices currently spend preparing for inspections, including gathering documents, undertaking interviews, hosting site visits and responding to follow-up requests.

Simplification must also include robust quality assurance to ensure consistency and better recognition of contextual factors such as deprivation, staffing levels and premises constraints. Additionally, clearer guidance for inspectors tailored towards evidence-based process that supports improvement, encourages innovation, and considers local context within general practice.

Taken together, these changes would support a framework that is fair, transparent and genuinely manageable for practices.

Part 2: How we make judgements and award ratings

Simplifying our rating approach and strengthening the role of professional judgement

Question 4. To what extent do you agree that we should award ratings directly at key question level with reference to rating characteristics?

Disagree

The College does not support the continued use of ratings and therefore cannot support awarding ratings at key question level, as voted by Council in November 2024. Single-word judgements or aggregated ratings oversimplify the complexity of general practice, risk misrepresenting performance, and can undermine long-standing trust within

communities. They also fail to account for the contextual pressures under which practices operate and can have disproportionate impacts on staff morale and practice reputation.

Whilst the RCGP welcomes efforts to simplify aspects of the regulatory model, significantly more work is needed to ensure confidence in the overall fitness of the CQC inspection process. There remains uncertainty about whether CQC's primary purpose is to assess safety, overall quality, or minimum standards—three distinct concepts that are often conflated. Labelling a practice as "unsafe" can cause substantial and unwarranted damage to public perception, particularly when the issues identified relate to quality improvement rather than clinical risk. Greater clarity about what inspections are intended to measure, and how judgments are formed, is essential to ensuring assessments are accurate, proportionate and fair.
In place of one-word ratings, we advocate for a nuanced, qualitative, improvement-focused approach that highlights both strengths and areas for development, reflects current performance, and fosters constructive dialogue between practices and inspectors. Any assessment system must prioritise accuracy, fairness, methodological rigour and real-world context over simplistic rating labels.

Question 4a. Do you have any comments or suggestions on our proposed approach to awarding ratings?

The RCGP supports a more transparent and streamlined regulatory approach, which allow for the individual circumstances of each provider to be properly reflected.

The College does not, however, support the continued use of single-word ratings, and therefore has fundamental concerns about the proposed model, even in simplified form.

While removing underlying scores may ease internal processes, it does not address the core issue that single-word ratings cannot reflect the complexity of general practice or the combined impact of context, deprivation, workforce pressures and system demand. Negative ratings risk causing disproportionate harm, undermining community trust and damaging staff morale.

If CQC continues to use single-word ratings, the wider approach to assessment must incorporate several essential safeguards. These include ensuring that assessments are genuinely context-sensitive and reflect local pressures and population need; requiring inspectors to have substantial and recent experience of general practice; and embedding robust quality assurance and moderation processes to promote consistency and fairness. In addition, practices must be given the opportunity to address identified issues before any rating is published; improvements should be reflected without delay so that outdated ratings are not left in the public domain; and any rating should be accompanied by rich qualitative explanation, enabling providers and the public to understand the basis for the judgement and the nuances that a single descriptor cannot convey.

However, our firm view remains that publishing detailed, narrative, improvement-focused assessments would provide a more accurate, fair and constructive alternative to simplistic ratings in any form.

Supporting our inspection teams to deliver timely and expert inspections, publish impactful reports and develop strong relationships with providers

Question 5. Do you have any comments or suggestions for how we should support our inspection teams to deliver expert inspections, impactful reports and strong relationships with providers?

The RCGP believes that to deliver expert inspections, impactful reports, and constructive relationships with practices, CQC inspection teams must have substantial, recent, and directly relevant experience of general practice. This includes an understanding of the realities of small organisational structures, workforce and estate pressures, and the needs of diverse and high-deprivation populations. Inspectors also require high-quality, standardised training covering primary care operations, cultural competence, equality and bias, and the interpretation of data sources such as audits and searches, alongside robust quality assurance to ensure consistency and fairness across teams.

We support the allocation of local lead inspectors to build continuity and sustained understanding of practices and their context. Effective inspections must include clear, timely two-way communication, allowing practices to clarify evidence, correct inaccuracies, and raise concerns during the process. Impactful reports depend on methodological rigour, transparent reasoning, and clear explanations of how judgements were reached, incorporating both context and qualitative insights. Collaborative working with GP organisations, minimising unnecessary bureaucracy, and focusing on genuine improvement is essential to ensure inspections support rather than burden already stretched services.

The College has concerns regarding potential subjectivity in inspection methodology, particularly the role of GP Specialist Advisors. Inconsistent or unsupervised assessments can disproportionately influence ratings. Practices must be able to understand how ratings are calculated, provide additional evidence, and present mitigating circumstances. GP Specialist Advisors should have access to defined benchmarking statistics – for example, for Ardens Searches – so that judgements are based on consistent comparisons rather than isolated instances, avoiding arbitrary conclusions about safety.

Reviewing and clarifying our approach to following up assessments and updating rating judgements

Question 6. To what extent do you agree with the approach to following up assessments and the principles for updating rating judgements?

Agree

The RCGP supports the aim of making follow-up assessments more responsive, ensuring that judgements reflect current performance rather than historic findings. However, we remain concerned that the proposed approach does not go far enough to prevent outdated or misleading ratings from remaining in the public domain. Ratings must be updated in a timely manner, with clear mechanisms for rapid re-inspection or evidence-based review once improvements have been made. Practices should always have the opportunity to rectify issues before any public judgement is issued, and follow-up assessments must be proportionate, focused on relevant areas, and sensitive to local context.

While we agree with the principles of consistency, fairness, and transparency, their delivery will depend on robust quality assurance, inspectors with recent general practice experience, and a genuine commitment to ensuring published outcomes accurately reflect a practice's current standards. The current system in place to appeal ratings is reported by members to be slow and at-times unusable. Delays in updating ratings, such as those experienced by GP practices following repeat inspections, create significant challenges and highlight the impact of current backlogs within CQC.
Any feedback received from the follow-up assessment must therefore be proportionate, achievable, and realistic to implement.

Question 6a. Do you have any comments on our proposed approach?

See Above.

Potential changes to our approach to rating NHS trusts and independent hospitals

Question 7a. To what extent would you support CQC in re-introducing an overall quality rating for NHS trusts and trust-level ratings of all 5 key questions?

Partly Support

The RCGP has no view on this as we focus on the regulatory approach to general practice. We emphasise, however, that in any sector, ratings should only be applied if underpinned by robust, transparent methodology, meaningful contextualisation, and strong quality assurance. Without these safeguards, ratings risk oversimplifying complex services and misrepresenting performance.

Question 7b. To what extent would you support CQC in no longer aggregating key question ratings to produce an overall rating for an individual hospital location?

See above.

Question 7c. Do you have any comments to support your views, or suggestions for how we should award ratings for NHS trusts and independent hospitals?

See above.

Measuring the impact on equality

Question 8. We'd like to hear what you think about the opportunities and risks to improving equality and human rights in our proposals. Do you think our proposals will affect some groups of people more than others (for example, those with a protected equality characteristic such as disabled people, older people, or people from different ethnic backgrounds)?

Please tell us if the impact on people would be positive or negative, and how we could reduce any negative effects.

The RCGP welcomes the opportunity presented by CQC's proposals to advance equality and human rights, particularly through clearer assessment characteristics, improved inspector training, and stronger engagement with providers to support consistent, transparent, and context-sensitive judgements. However, without careful implementation, certain groups – including people from ethnic minority backgrounds, disabled people, older people, and those living in socioeconomically disadvantaged areas – may be disproportionately affected. Practices serving underserved or marginalised populations, which often face higher levels of ill health and have fewer resources despite greater demand, are particularly vulnerable if assessments fail to account for structural or system-level constraints.

In addition to supporting patients, the CQC's strategy must also recognise the wellbeing of the GP workforce. CQC's own analysis from 2022 showed that minority-led practices were more likely to report adverse consequences of the inspection process, including detrimental impacts on GPs' physical and mental health, disruption to personal and family life, and increased staff sickness. Although comprehensive data on the relationship between the ethnicity of practice leadership and inspection outcomes is limited, feedback from RCGP members raises serious concerns about potential discrimination. These issues must be addressed with great care and urgency in any redesign of the inspection and assessment processes.

To mitigate these risks, sector-specific frameworks should be co-produced with diverse communities and frontline general practice, supported by rigorous and regularly published equality impact assessments. Inspectors must receive robust training in cultural competence, anti-racism, disability inclusion, and the impact of deprivation on service delivery. Rating characteristics and judgements should explicitly recognise local pressures, resource limitations, and population needs to prevent reinforcing existing inequalities. Strong quality assurance, consistent moderation, and opportunities for providers to correct inaccuracies before publication are essential safeguards.

Implemented effectively, these proposals could support a fairer, more inclusive regulatory system that promotes equitable care for all patients.