

# Care Quality Commission (CQC): Consultation on the draft sector-specific framework for primary and community care - RCGP Response

June 2026



## About the RCGP

We are the professional membership body for GPs in the UK. Our purpose is to encourage, foster and maintain the highest possible standards in general medical practice. We support GPs through all stages of their career, from medical students considering general practice, through to training, qualified years and retirement.

## About this consultation

The Care Quality Commission (CQC) is consulting on four draft sector-specific assessment frameworks. These have been developed following the 'Better regulation, better care' public consultation, which sought views on introducing separate assessment frameworks tailored to the different health and care sectors that CQC regulates. The RCGP response to this consultation can be found on our [consultations and briefings](#) page.

This consultation seeks feedback on the draft frameworks to ensure they are clear, relevant and effective in supporting consistent, proportionate regulation across each sector.

## Response

1. **Do you agree that the draft assessment framework(s) will support CQC to make clearer, more transparent judgements about quality?**

Neither agree nor disagree

2. **Please tell us more details to explain why you gave your response above**

The RCGP welcomes the CQC's intention to bring greater clarity and transparency to the assessment of quality in general practice. The provision of explicit rating descriptors across four sectors represents a meaningful step forward from previous, less structured approaches. However, whilst the College supports independent regulation and public

assurance, we believe regulation is most effective when it is proportionate, consistent and focused on improvement.

We recognise that the framework provides detailed descriptors for each rating level, which is aimed at helping practices understand expectations in advance. The College also appreciates the explicit focus on equity, inclusion and health inequalities aligning with the RCGP's longstanding commitment to reducing unwarranted variation in patient outcomes.

However, the framework spans 60 pages of dense descriptors with relatively vague expectations on how providers will be assessed. While comprehensiveness is important, there is a genuine risk that this volume of material will overwhelm smaller or disadvantaged GP practices that lack dedicated governance or quality improvement resource. General practice operates under severe workforce and funding pressures; time spent navigating lengthy assessment matrices is time diverted from patient care. As of April 2026, GP practices in England were responsible for approximately 63.6 million patients – an increase of approximately 6.7 million compared to September 2015. Subsequently, the average number of patients cared for by each fully qualified full-time equivalent (FTE) GP has risen to 2,199, representing a 13.5% increase (261. additional patients per GP) since September 2015. We also note that qualitative judgements, for instance, whether a safety culture is "fully embedded" versus "inconsistent", remain inherently subjective requiring the need for further clarification. . Perceived inconsistencies in inspection outcomes have the potential to undermine confidence in the regulatory process, making robust inspector training and calibration essential. The inspection process should support improvement and learning, rather than inadvertently contributing to workforce stress, burnout or difficulties retaining staff in general practice.

Finally, much of the language remains generic across primary care and community services. Terms such as "admissions and discharges," "handover and patient flow," and references to inpatient-style restrictive practices do not straightforwardly map onto the realities of how general practice manages patients. Clearer, more transparent judgements require a framework that speaks directly to how general practice operates.

**3. Do you agree that the draft assessment framework for your sector will help providers to understand what CQC will look at in an assessment?**

Disagree

**4. Please tell us more details to explain why you gave your response above**

While the framework provides some additional detail regarding the areas inspectors may focus on, the College is concerned that the draft framework will not sufficiently help providers understand what the CQC will look at in practice during assessments.

Although the 'Key Lines of Enquiry' (KLOEs) are more structured than previous arrangements, the framework remains extensive and potentially difficult to operationalise within day-to-day practice settings. Similar themes appear repeatedly across multiple domains, particularly in relation to communication, inequalities, governance and person-centred care. As a result, practices may still struggle to understand what evidence is required, how different domains will be weighted and what inspectors will prioritise during assessments.

For example, communication needs are referenced throughout sections relating to assessment, consent, responsiveness and person-centred care, yet the framework does not clearly distinguish whether practices would be expected to provide separate evidence for each domain or whether the same evidence could reasonably apply across multiple areas. Similarly, expectations regarding “collaborative working” and “innovation” are referenced throughout the framework without sufficient clarity regarding how these concepts will be interpreted consistently across different practice contexts.

There is also concern that the framework does not adequately recognise the operational realities facing modern general practice. Practices are currently working within significant workforce shortages, rising demand and increasing system fragmentation, yet many of the descriptors appear aspirational rather than achievable within existing resource constraints. For example, practices may be expected to demonstrate proactive population health work or extensive multidisciplinary coordination despite limited staffing capacity and inconsistent access to community services. In addition, outcomes within the framework that assess the interface between primary and secondary care services are mostly outside of the GP's influence.

The framework also risks increasing administrative burden by encouraging providers to produce large volumes of evidence across overlapping domains. Without significantly clearer guidance regarding evidence expectations and prioritisation, practices may continue to experience uncertainty and duplication during inspection preparation. Ultimately, while the intention to create a sector-specific framework is welcome, the current draft does not yet provide sufficient clarity, proportionality or consistency to help practices fully understand how assessments will operate in practice.

**5. Do you agree that the draft assessment framework(s) will help CQC and providers to identify and address inequalities in care?**

Neither agree nor disagree

**6. Please tell us more details to explain why you gave your response above**

The College welcomes the focus on health inequalities throughout the framework and recognises the importance of embedding equity considerations across all aspects of care delivery. The inclusion of references to protected equality characteristics, communication needs and population health management reflects a broader

understanding of the role general practice plays in addressing unequal outcomes across communities.

The framework appropriately acknowledges that practices should consider barriers to access and proactively identify groups at greater risk of poor outcomes. For example, encouraging practices to improve screening uptake among underserved groups or adapt communication approaches for patients with language barriers reflects good clinical practice and aligns with wider NHS priorities around prevention and reducing inequalities.

However, it remains unclear whether the framework itself will meaningfully help providers and the CQC inspectors identify and address inequalities in a consistent or proportionate way. While inequalities are referenced throughout the document, there is limited clarity regarding how inspectors will assess inequalities in practice, what evidence providers will reasonably be expected to demonstrate and how wider social/system pressures will be considered during assessments.

There is also concern that practices serving highly deprived populations could be disproportionately disadvantaged if contextual pressures are not appropriately recognised. As written in the RCGP report on the inverse care law (2024) practices operating in areas of high deprivation frequently manage significantly higher levels of multimorbidity, safeguarding complexity and unmet need while simultaneously facing greater workforce and recruitment challenges. In these circumstances, poorer access metrics or outcome data may reflect structural inequalities and wider system pressures rather than shortcomings in the quality of care delivered by the practice itself. Similarly, some aspects of inequality sit largely outside the direct control of individual practices. Delays in access to mental health services, community care provision or secondary care appointments can all contribute to poorer outcomes despite practices making sustained efforts to coordinate care and support vulnerable patients.

The RCGP therefore remains concerned that, without clearer contextual safeguards and more consistent approaches to interpretation, the framework may identify inequalities without necessarily enabling meaningful improvement or fair assessment across different practice populations.

7. We will retain our 5 key questions, 1 statements, and 4 levels of quality ratings. New elements include **key lines of enquiry** to replace the current quality statements. They have been framed as structured questions that describe what we will look for on our assessments.

**Do you have any comments about the new key lines of enquiry (KLOEs)? For example, do they prioritise the aspects that are most important for delivering good quality care in the sector? Do any areas need a separate KLOE? Or can any KLOEs be combined?**

The College notes the revised KLOEs inclusion of metrics which overall broadly align with what delivering good quality care within general practice should look like. The stronger emphasis on safety culture, person-centred care, workforce wellbeing and integrated working fits well with the way general practice currently aims to deliver care, and with the proposed neighbourhood health model.

In particular, the prioritisation of psychological safety and openness within the “safe” and “well-led” domains is an important development. Creating an environment in which staff feel confident to raise concerns, discuss incidents openly and contribute to learning is fundamental to safe patient care and increasingly important within a pressured primary care workforce. The framework also appropriately recognises the importance of equitable treatment of staff and workforce wellbeing, acknowledging the relationship between staff experience, retention and patient safety. Given the significant workforce pressures facing general practice, it is important that assessment activity supports positive organisational cultures and continuous improvement. Inspection processes that are perceived as disproportionate or overly burdensome risk negatively affecting staff morale and may contribute to wider challenges around recruitment and retention within the profession.

We also welcome the emphasis on person-centred care, shared decision-making and consent closely aligning with the RCGP's position. The inclusion of KLOEs relating to consent, capacity and advance care planning reflects the importance of ensuring that patients are fully involved in decisions about their care and treatment which is well-evidenced. This is highly relevant within general practice, particularly in relation to long-term condition management, end-of-life care and personalised care planning.

However, several KLOEs would benefit from further adaptation to better reflect the realities of general practice. For example, the “admissions and discharges” terminology within the transitions KLOE feels heavily hospital centric. Within general practice, the more relevant focus would be the safe management of referrals, coordination between primary and secondary care, follow-up of test results and communication with community services.

The “safe environments and infection prevention and control” KLOE would also benefit from greater contextual flexibility. While infection prevention and premises safety are important, the current framing appears more applicable to larger healthcare facilities with extensive estates and multiple clinical environments. General practice operates across a wide range of settings, including smaller surgeries and single-handed practices working from modest premises, and the framework should better acknowledge this diversity.

The evidence base supporting relational continuity is strong, particularly in relation to patient safety, reduced hospital admissions and improved patient satisfaction, and continuity remains highly valued by both patients and clinicians. Therefore, the College broadly supports the imbedding of continuity of care principles across the health system. However, we are concerned with how continuity is being represented within the

proposed framework. At present, continuity is referenced across multiple KLOEs but lacks a sufficiently clear or dedicated focus. It's also unclear how this will be assessed at practice level and what evidence would reasonably demonstrate continuity of care in practice. The framework should more clearly recognise the value of continuity of care, while acknowledging that continuity cannot always be captured through a single metric. The framework should more explicitly acknowledge the operational realities facing general practice, including rising demand, workforce shortages and increasing patient complexity. Assessment should take account of how practices deliver safe, high-quality care within these constraints.

Finally, while the distinction between “kindness, compassion and dignity” and “person-centred care” is conceptually understandable, there is likely to be substantial overlap in the evidence used to assess these domains during inspection. Combining these areas may help streamline the framework and reduce duplication without losing focus on the quality of patient experience.

8. **Rating characteristics** will support us to make judgements about care. They aim to help the public and providers to understand what good care looks like, support our inspectors to make consistent judgements about quality, and recognise the important differences between sectors. They are not a complete checklist as we cannot include every aspect of care.

**Do you have any comments about the rating characteristics that describe quality under each key line of enquiry (KLOE) for each rating level?**

The College recognises that the rating characteristics provide a more nuanced and clinically relevant description of quality than previous frameworks. The increased emphasis on learning culture, prevention, equity and patient involvement is welcome and better reflects the complexity of modern care delivery.

The College would welcome greater clarity regarding the standards expected at each rating level. While some aspects of quality will inevitably require professional judgement, providers should be able to understand more clearly what distinguishes inadequate, requires improvement, good and outstanding care.

In particular, there should be greater transparency regarding the fundamental standards that would lead to an inadequate rating. Practices should not be surprised by such a judgement following assessment, and the framework should enable providers to identify when they are at risk of receiving an inadequate rating before inspection. More broadly, the framework should be sufficiently clear that practices are able to make a reasonable assessment of their likely rating in advance of inspection. This would improve consistency, reduce uncertainty and strengthen confidence in the assessment process among both providers and the public.

The College also believes that rating characteristics should be sufficiently clear, relevant and universally applicable across practices of different sizes, organisational models and populations. The standards against which practices are assessed should be capable of being met and demonstrated regardless of practice size, funding arrangements or access to additional managerial and leadership resource.

While there will inevitably be some variation in how high-quality care is delivered, the framework should focus on characteristics that are within the reasonable control of practices and that can be applied consistently across the sector. The highest ratings should be achievable by any practice that meets the required standards, rather than being dependent on circumstances, opportunities or resources that may not be equally available to all providers.

**9. Overall, how clear do you find this draft assessment framework(s), for example is the language clear and understandable?**

Somewhat unclear

**10. Please tell us more details to explain why you gave your response, including any specific areas that are unclear**

The framework is clearer in structure than the previous single assessment framework and the move towards sector-specific language is welcome.

However, despite these improvements, the framework remains lengthy and highly detailed, whilst also lacking clear applicability to general practice settings in certain areas. There is substantial overlap between domains and repeated use of similar concepts throughout the document. Themes relating to inequalities, communication and governance appear repeatedly across multiple sections, which may make it difficult for practices to clearly identify the most important evidence requirements.

A number of descriptors also rely upon aspirational or subjective terminology, including references to “innovation”, “psychological safety” and “proactive culture”. While these are important principles, it is not always clear how they will be assessed consistently in practice or what evidence providers will reasonably be expected to demonstrate. For example, smaller practices may be uncertain whether informal peer support arrangements and protected learning time would be considered sufficient evidence of psychological safety, or whether more formal workforce wellbeing programmes would be expected.

Practices would therefore benefit from clearer examples of evidence expectations, more concise descriptors and greater transparency around how professional judgement will be applied during inspections.

There should also be greater recognition throughout the framework of the wider system pressures affecting general practice, including workforce shortages, rising patient demand and reduced community service capacity. Without this contextual understanding, there is a risk that assessment outcomes may not fully reflect pressures beyond practices' direct control.

**11. We are keen to know whether these 4 assessment frameworks represent the sectors we regulate appropriately, or if they need to be separated in a different way, and if so, how?**

The College acknowledges the central role general practice plays within community and primary care services. However, general practice has the following distinct characteristics that are not fully captured by a combined "primary care and community services" framework:

- **List-based, longitudinal relationships:** Patients register with a practice and may remain there for decades. This relational model differs fundamentally from episodic community services or hospital services where patients are discharged; assessing 'patient-flow' will look differently.
- **Breadth of undifferentiated presentations:** GPs manage the full spectrum of health concerns, from minor illness to serious disease, mental health to palliative care. This generalist scope is unique and stands out from other primary care services which may require separate consideration when inspecting the service.
- **Entry point and coordinator role:** General practice serves as the entry point to the wider NHS and coordinates care across multiple providers. However, GPs cannot influence whether the referrals to secondary care get accepted which makes some aspects within the proposed framework irrelevant.
- **Independent contractor model:** Most GP practices are independent businesses which creates distinct governance, workforce and financial considerations that stand out from other primary care services.

Generally, we would support the development of a standalone assessment framework for general practice, or at minimum, a substantial general practice subsection to the primary care and community services framework. This would ensure that inspection genuinely reflects how general practice operates rather than requiring inspectors to mentally translate hospital-centric language. However, this would need to be co-designed with the general practice providers and stakeholders to ensure it is fit for purpose.

**12. The content of the assessment frameworks is still in draft; do you have any overall comments that would help us to improve them, for example is anything missing, or is there any overlap?**

The RCGP offers the following recommendations to consider as the draft continues to evolve:

- **Recognise external constraints facing general practice explicitly:** The framework should acknowledge that general practice operates within a wider system and that many factors affecting quality—workforce supply, premises, secondary care access, social care availability—lie outside practice control. Assessment should focus on how practices respond under constraints.
- **Ensure standards are universally applicable across practices:** The framework should be designed so that standards and rating characteristics are relevant and achievable across practices of different sizes, organisational models and populations. Expectations should focus on the quality and safety of care delivered rather than organisational scale, infrastructure or access to additional resource. While standards should apply consistently across the sector, evidence requirements should remain proportionate and avoid placing unnecessary administrative burden on providers.
- **Make greater use of existing data and minimise duplication:** The framework should support a more transparent and proportionate approach to assessment, making greater use of routinely collected data and reducing reliance on the production of large volumes of bespoke documentary evidence. This would reduce unnecessary administrative burden, improve predictability for providers and allow practices to focus more time on patient care while maintaining appropriate regulatory oversight.
- **Adopt a proportionate and intelligence-led approach to assessment:** Assessment activity should be proportionate and intelligence-led, focusing regulatory attention where there are clear concerns about quality or safety, while reducing unnecessary burden on practices with a strong track record of delivering high-quality care. This would support more effective regulation while minimising disruption to frontline patient care.
- **Ensure that inspector training aligns with the framework:** The framework's value depends on consistent application by inspectors. We urge substantial investment into inspector training, including calibration exercises, sector-specific knowledge, and mechanisms to address unwarranted variation in ratings.
- **Provide sector-specific guidance:** Translate the generic language used within the framework into GP-relevant language, examples and evidence expectations. This should be developed in partnership with the profession.
- **Supplement framework with further guidance and case studies:** Aspects of the framework still require further guidance to support understanding of how it will be applied in practice. Case studies will also allow providers to understand what 'good' and 'outstanding' look like in preparation for inspection.
- **Ensure the pilot phase adequately represents general practice:** Before full implementation, pilot the framework with a representative sample of GP practices and use findings to refine the descriptors and assessment process.