Editorials

The CQC inspections:

what they mean for general practice

CQC INSPECTIONS: WHAT HAS CHANGED?

The Care Quality Commission (CQC) is the independent regulator for Health and Social Care providers in England. CQC started to inspect general practice in April 2013 using a compliance focused model. Between April 2014 and September 2014, CQC piloted a new inspection methodology for general practice. As of late November 2014, over 500 GP practices have been inspected with this new methodology, which was rolled out nationally from 1 October 2014.

The new inspection regime reflects a significant culture change in the CQC. We have moved away from a regulation-focused approach, to a more holistic assessment of the quality of care by asking five key questions:

- Is a practice safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs? And
- Is it well led?[1]

Our inspection teams are also different; comprising an expert inspector and a GP specialist advisor. In addition, practice nurses, practice managers, and 'experts by experience' (members of the public who have had substantial experience of using services) may also be part of the team, making an inspection more of a peer-review process than before.

In keeping with our commitment to transparency about our regulatory approach, we published our GP 'intelligent monitoring' (IM) risk bandings in November 2014.[2] IM is a tool we use to prioritise which practices to inspect and is information we have already been publishing about the acute sector for over a year. We acknowledge that the decision to make this data publicly available caused some controversy within the profession. We publish the results of our IM to promote greater transparency and better understanding of our work. IM is not our judgement on the quality of care. Our inspection visits are central to the way we make judgements, informed by local intelligence, the views of other organisations, and our IM. We advised the media against distorting the story, and we adopted the six bandings to provide information and prioritise our inspections.

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We continue to work constructively with the General Practice Committee at the BMA and the Royal College of General Practitioners to improve further development of the tool.

Since 1 October 2014 our reports now rate practices on a 4-point scale: 'outstanding', 'good', 'requires improvement', and 'inadequate'. We rate practices for several reasons. First, we have an obligation to be transparent with the public about the quality of the services they use. Second, we believe that rating practices enables us to celebrate excellent practice as well as highlighting areas for improvement. We know that the vast majority of England's GPs are providing a service which is safe, effective, caring, responsive, and well led. If that is what we find on inspection, we will give the practice a rating of 'good'. Patients should be able to expect high quality and consistent care from every GP practice. Where we have stated a practice 'requires improvement', we will expect it to take the necessary steps to address the issue, and we will return at a later date to check that those improvements have been made. The CQC, while not formally being an improvement agency, is therefore able to be a powerful agent for change.[3]

In this editorial we present the 'top 10' areas of outstanding practice and areas requiring improvement from the pilot inspections undertaken between April 2014 and September 2014. These findings are drawn from the reports of the 196 pilot inspections which were published as of 20 October 2014.

HEADLINE FINDINGS: VARIATION AND THE IMPORTANCE OF LEADERSHIP

The CQC's annual State of Care 2014 report[4] highlighted how the quality of general practice varies substantially: most practice is 'good' but some areas of care require improvement or are inadequately meeting patients' needs.

The link between effective team working and patient outcomes is well known in the academic literature,[5] and our findings confirm this; practices which are well led were more likely to offer better patient care.

LOTS TO BE PROUD OF: AREAS OF OUTSTANDING PRACTICE

The CQC saw many examples of excellent general practice during its pilot inspections. There was a median of one area of outstanding care per practice, while 20 practices had four or more. Box 1 illustrates the most common areas of excellence.

The most common area of excellent practice was multidisciplinary working. Most often this was for patients who were older or receiving end-of-life care. Excellent examples demonstrated strong links with secondary care teams, community nurses, and third sector organisations with weekly multidisciplinary team meetings held in the practice to discuss these complex or vulnerable patients. Other practices demonstrated strong partnership working with other local GP practices, out of hours services, and local councils for different groups of patients.

Access was another area where many practices excelled. Examples of effective online or telephone appointment booking systems were noted, as was a range of innovative approaches to efficiently use the scare resource of home visits.

Box 1. Areas of outstanding practice (practices inspected)

- Effective multidisciplinary team working (32%)
- Access (23%)
- Identifying and meeting the clinical needs of patients (20%)
- Responding to the needs of the population (18%)
- Clinical care (11%)
- Leadership and management (8%)
- Staff development and training (6%)
- Audit/research (5%)
- Safety culture (4%)
- Buildings and premises (2%)

"By publishing ratings we encourage practices to improve, and by sharing examples of good practice and poor practice we help spread innovation and prevent common problems."

Many examples of outstanding practice stemmed from the practice's understanding of its patients' needs. Some surgeries offered services to proactively manage patients at risk of developing long-term conditions such as diabetes by using risk stratification software. Others offered additional services to meet the needs of certain population groups such as the homeless or students.

STILL SOME WAY TO GO: AREAS FOR IMPROVEMENT

It was common for inspectors to identify areas where a practice could improve its patient care or governance processes. There was a median of three areas for improvement per practice, although this number varied considerably: 26 of the 196 practices had no identified areas of weakness; on the other hand, 16 practices were recommended to improve 10 or more areas. Box 2 illustrates the most common areas for improvement.

Safety culture was the most common area for improvement affecting 41% of practices. For example, 17% of practices had problems with the way Significant Events were reported, investigated, and findings shared among staff. Again there was significant variation: some practices had no systems in place for reporting errors and no evidence of undertaking investigations into Significant Events, while others had a good safety culture, but were unable to demonstrate how learning was shared in a robust way to staff. Other safety culture issues included a lack of adequate whistleblowing or safeguarding policies, or a poor understanding of them among staff. A practice that CQC would rate as 'good' ensures that the learning involves the whole team and becomes embedded in everyday practice. 'Good' is linked to the impact and learning resulting from the Significant Events Analysis.[6]

The process of recruiting and managing staff was the second common area requiring improvement. Problems with recruitment mainly focused around pre-employment processes, especially Disclosure and Barring Service checks (DBS) (37% of all practices). These were often not performed or no risk assessment about whether a DBS check should be done was evident. Other pre-employment requirements such as checking a clinician's registration status and collecting references from previous employers were also commonly missed, particularly when employing locums. CQC recommends that all clinical staff have DBS checks. Access to medical records alone does not mean that staff are eligible for a DBS check, however, non-clinical staff may be eligible for a DBS check if they carry out chaperone duties or look after a baby or child while their mother is being examined by a GP or nurse.[6]

A number of practices needed to improve their staff appraisal process. We saw a range of practice that required improvement: from practices that did not offer any staff an annual appraisal through to practices that merely needed to improve their documentation of the process.

Medicines management was the third common area for improvement. Shortcomings here ranged from problems with the expiry dates on medicines, to the record keeping and storage of vaccines and controlled drugs. These storage issues were the most common problem affecting 18% of practices and typically related to refrigeration of vaccines and other medicines. We recommend that practices have processes and systems in place to check that drugs are in date and equipment is well maintained.[6]

Box 2. Areas for improvement (practices inspected)

- Safety culture (41%)
- Recruitment and staff management (40%)
- Medicines management (30%)
- Staff training (25%)
- Responding to the patient population (24%)
- Infection control (22%)
- Audit (20%)
- Leadership and management (20%)
- Complaints (18%)
- Buildings and premises (18%)

THINKING TO THE FUTURE: WHAT WILL THE CQC DO TO FOSTER IMPROVEMENT?

The CQC can be a powerful agent for improvement. By publishing ratings we encourage practices to improve, and by sharing examples of good practice and poor practice we help spread innovation and prevent common problems. However, we acknowledge that inspection can be a stressful time for practices. The CQC *Handbook for General Practice Inspections*[1] explains our process and the CQC website contains useful guidance, tips, and information such as mythbusters.[6]

Through the mythbusters page, we plan to address all of the common areas for improvement in the coming months.

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