The Royal College of General Practitioners (RCGP) is working in partnership with the Department of Health and NHS England in a pilot programme to support practices which have been placed in special measures following a Care Quality Commission (CQC) inspection.¹

Although it is too early to evaluate the pilot, our early experience of working with practices in special measures has uncovered some unintended consequences of being placed in special measures, which could impact negatively on the quality of care received by patients.

Blake, Sparrow, and Field outlined the new methodology for CQC inspections focusing on quality and highlighted the five key questions introduced in April 2014.² Since 1 October 2014, CQC reports have rated practices on a 4-point scale: 'outstanding', 'good', 'requires improvement', and 'inadequate'. This January the CQC announced that all practices rated as inadequate would enter special measures, acknowledging that previously there had been a lack of clarity over which inadequate practices would enter special measures.³

By the end of May 2015, of the 1164 general practices inspected, 33 (2.8%) have been rated inadequate and placed in special measures. To set this in context, 29 (2.4%) have been rated outstanding, 656 (56%) rated as good, and 106 (9.1%) rated as requires improvement, the remainder not being rated for a variety of reasons. Currently there are 9325 providers of general medical services registered with the CQC. The experiences detailed below are derived from a mix of practices in disparate parts of England, all sharing the common characteristic of being rated as inadequate following a CQC inspection.

EMERGING THEMES

Difficulty with recruitment and consequent staffing costs

Common themes within practices in difficulty include inadequate clinical staffing and lack of effective leadership or practice management. Attempts to rectify these issues may be hampered by placing the practice in special measures. We have experienced staff recruited prior to the announcement of special measures either withdrawing their application or deciding not to sign a contract once the situation is public. There appears to be a fear among healthcare

"... it is much better to make improvements when practices are first struggling than deal with the many negative outcomes of being placed into special measures."

professionals, especially GPs, that they could be placing themselves or their career at risk by working in such an environment. There is also a risk that struggling GPs unable to get jobs elsewhere can end up in struggling practices, which may contribute to complaints and poor practice.

Not surprisingly, we have found that suitable applicants willing to work in a challenging environment are tending to seek a financial premium. For GPs this can be significantly above the usual rate. Because of the current difficulties in GP recruitment and retention, which is a national and well-documented issue, these requests have been acceded to, as the alternative would be a shortfall in clinical cover further compromising the effectiveness and safety of the practice.

This issue can be mitigated by advertising specifically for GPs and practice managers who are interested in helping turn a practice around, seeing this as a challenge and a way of furthering their career aspirations by taking on an unusual situation and being tested in the leadership competences.

The secondary consequences of this for the local health economy on driving up GP salaries and locum cover rates is apparent and it would seem that this is a significant worry for neighbouring practices and the local medical committees (LMCs). In addition, higher salary levels have the potential to cause difficulties to any provider seeking to merge with or take over the practice in special measures.

Undue strain on management systems

All practices placed in special measures to date have been judged as inadequate in the 'well led' domain and one could therefore assume that there are already significant leadership issues, both clinical and managerial, in this group of practices.

Being placed in special measures generates a significant workload to respond to CQC warning and compliance notices.

Writing improvement plans, responding to similar requests from NHS England, and attending quality meetings takes resources and personnel away from their usual roles. This puts the ongoing safe running of the practice at risk with staff torn between producing CQC and NHS England paperwork to tight deadlines or trying to run the practice. One or other suffers as a consequence. The workload would be immense for a well-functioning practice and for those in special measures that are likely to have underlying management issues the risk is that the tipping point is reached.

This could and should be mitigated by coordination between the CQC and local stakeholders to reduce the number of written reports, and balance the requirements for written reports, with the need to undertake urgent actions necessary to ensure patient safety. The RCGP teams, where involved, have played a significant role in supporting and facilitating the generation of the required documentation.

Staff morale

Inevitably, working in a practice that is struggling puts a strain on staff, but when your workplace is publicly reported as being inadequate this can take a huge toll on staff, many of whom work in their own local communities. We have heard anecdotal reports of receptionists being harangued in the supermarket, but also of cakes being brought for staff by sympathetic and grateful patients. Staff meetings (in known struggling practices) need to be more frequent and communication more robust, thus increasing the strain further on an already overstretched leadership team and risking taking time away from patient care.

We have observed that practices are less likely to be stressed by the experience of special measures if there is effective and timely communication between the CQC, the practice, and key stakeholders such as NHS England area teams, clinical commissioning

groups (CCGs), and LMCs. When feedback to the area team and practice at the end of a CQC inspection has not reflected the final written report, valuable opportunities have been lost. Where such communication has been good (approximately 30% of practices we work with), and practices have acknowledged the improvements needed, they have been able to prepare staff for the CQC outcome, start working on identified weaknesses, and think about how patients will be involved in the process.

Patient morale

No patient wants to hear that the practice with which they are registered is offering an inadequate service, despite the fact that some may have been dissatisfied for some time and indeed expressed their concerns. Some patients want to express their sympathy and support to the practice staff and we have seen examples of very constructive help being offered by well-functioning patient participation groups (PPGs). A good example of this would be the chair of a PPG working closely with a newly-appointed practice manager to improve access. However there is also an inevitable loss of confidence in the service which, in itself, can lead to increased demand and risks to health outcomes.

We have also witnessed concerns from neighbouring practices that they could become inundated with requests to transfer from practices in special measures. Some local practices have discussed the possibility of closing their lists with NHS England. By and large, these fears have not been born out and patients have not deregistered in significant numbers. NHS England data on patient registrations and deregistrations could help to confirm or disprove major shifts in patient flow.

Increased financial costs

As discussed above, practices in special measures may have to pay premium rates to attract staff and extra costs to obtain standard assessments, such as for *Legionella* risk and health and safety. In addition, there are significant costs associated with the rapid drive to meet the multiple deadlines required in writing and implementing an action plan and producing timely reports to key stakeholders. In a well-functioning practice these costs are usually budgeted for across the financial year. There is a correlation between practices in special measures and low income per patient. When premium rate personnel are needed to manage multiple management issues, this can serve to further exacerbate strains

on cash flow, which add considerably to the challenges of turning around the practice.

HOW CAN THESE ISSUES BE MITIGATED?

In highlighting some of the corollaries of special measures we hope to open the door to dialogue and discussion rather than say that practices that are failing to deliver good services should not be identified.

Indeed, implicit in all of this is the need for patient safety and improvement in those practices which are not providing good care. We have seen that many of the issues identified in this editorial can, unfortunately, work against rapid improvements in patient safety, rather than having the desired effect of improving the service to patients. Significant resources are made available for acute trusts placed in special measures with 'buddying' from another trust being common. The responsibility for the improvement in quality is currently deemed to be the responsibility of the practice with the independent contractor status being sighted as justification for this.

The RCGP pilot programme partners a small team of two or three advisors, usually including a GP and a practice manager, with a practice. It offers the practice support for the turnaround process. How that support is utilised is dependent on the needs of each practice. Discussions can begin as soon as a practice knows it may be entering special measures. There is a maximum contribution of £5000 from NHS England to fund the intervention dependent on this being matched by the practice itself. This is regardless of practice population size.

Our teams have helped with writing and implementing improvement plans, staff recruitment, and general support to GPs and practice managers as well as engagement with, and support to, the wider practice team. However, what it cannot and should not do is make changes that are not embedded in ongoing practice processes, which is why long-term ongoing support and staffing need to be identified at an early stage.

The support from local networks including neighbouring practices, the NHS area team, CCG, and LMC has varied. Often there have been rapid offers of initial support, although finding the personnel to undertake the work needed has sometimes been a struggle. Providing resources to effect sustained change is even more problematic.

The use of non-contextualised data in the form of 'intelligent monitoring' has been criticised and the banding of practices has now been abandoned by CQC. Local health economies including the LMCs, local area

ADDRESS FOR CORRESPONDENCE

Sue Rendel

Royal College of General Practitioners, 30 Euston Square, London NW1 2FB, UK.

E-mail: sue.rendel@btinternet.com

teams, and CCGs, which have a historic relationship with practices are often aware of problems before formal CQC inspection.

Many of the practices placed into special measures are already known to be outliers, either from data such as the Quality and Outcomes Framework and referral and prescribing patterns, or from whistle-blowing of staff members concerned about the leadership within the practice. We would urge the CQC and local health economies to work closely together to support these practices, and importantly the patients they care for, by acting quickly on soft intelligence about struggling practices and developing an infrastructure that allows for the rapid deployment of help when a need is identified.

After all, it is much better to make improvements when practices are first struggling than deal with the many negative outcomes of being placed into special measures.

Sue Rendel,

GP Advisor to Special Measures Pilot Programme, Royal College of General Practitioners, London.

Helen Crawley,

Clinical Lead for Special Measures Pilot Programme, Royal College of General Practitioners, London.

Tim Ballard,

Vice Chair, Royal College of General Practitioners, London.

Provenance

Freely submitted; externally peer reviewed.

DOI: 10.3399/bjgp15X686809

REFERENCES

1. NHS England. *Framework for responding to CQC inspections of GP practices*. <http://www.england.nhs.uk/wp-content/uploads/2014/10/frmwk-respond-cqc-insp.pdf> [accessed 26 Aug 2015].
2. Blake A, Sparrow N, Field S. The CQC inspections: what they mean for general practice. *Br J Gen Pract* 2015; DOI: 10.3399/bjgp15X683845.
3. Care Quality Commission. *An update: CQC's proposals for special measures for GP practices*. <http://www.cqc.org.uk/content/update-cqcs-proposals-special-measures-gp-practices> [accessed 26 Aug 2015].