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Academic general practice: supported by the RCGP

This article¹ by one of our esteemed former presidents and academic leaders sets out the history and continued challenges in ways we all recognise, but we want to challenge some claims made in the article. We disagree that the RCGP no longer inspires GPs. We are constantly working to engage with our members and non-members at all stages in their career. The NHS environment for GPs may be causing recruitment and morale problems, but the recent RCGP campaign has been our most successful ever, and we spread our active membership engagement ever wider through social media, conferences, and evidenced resources.

We do not understand the claim that the RCGP 'abandoned' its Research Committee — it chose to develop the Clinical Innovation and Research Centre (CIRC), which has a much wider remit and impact. Under the auspices of CIRC, the Research Surveillance Centre continues to publish weekly reports, and has just had its tender renewed for another 3 years; the Scientific Foundation Board awards research grants that are constantly generating innovative and highly relevant research. The College annually celebrates high-quality primary care research through its Research Paper of the Year award,² and there is a huge regular opportunity for academic units to showcase research and its impacts on practice at both regional and national conferences.

Many current officers and clinical leads additionally hold or have held senior academic appointments; and they all work to encourage relevant, timely research and encourage interested colleagues to follow this path. The RCGP and the Society for Academic Primary Care have regular cross-representation, including with the heads of departments of general practice and GP teaching.

We assure the author that academic general practice continues to be at the heart of the RCGP. Thanks for the challenge — and we respect the lifelong effort made to make this all work, for which we are all grateful.

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Competing interests

ACH was an officer of the RCGP until December 2015.

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Response from the CQC: the importance of effective leadership

The intention of the special measures framework is to make patients, providers, and commissioners aware that we have serious concerns and to identify the need for urgent coordinated support within clear timescales. As you highlighted,¹ there can be local awareness of issues long before the CQC inspects. We strongly back the need for earlier identification of problems rather than waiting for an inspection to unearth the issues. This will involve closer collaborative working with CCGs, NHS England, and the local health economy.

At the CQC we are passionate about improving standards. We have for the first time provided a comprehensive description of good-quality care.² We encourage improvement by championing examples of good, innovative, and outstanding practice.³ Indeed, the vast majority of England's GP practices are providing a good service to their patients, so why are the 4% rated inadequate

falling significantly short? As identified in our State of Health Care report,⁴ the key may be in effective leadership.

The CQC assesses leadership and organisational culture of providers in the 'well-led' key question; by well-led, we mean that the organisation assures delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture. Every practice in special measures has been rated inadequate in 'well-led'.

Investing in leadership has consistently been shown⁵ to pay off in the ongoing running of a successful organisation. This has been a central theme in supporting Acute Trusts in special measures, and should be for general practice. The RCGP's Pilot Scheme has been doing essential work. However, we must take more collective responsibility in identifying struggling practices early, championing innovation, driving improvement, and providing long-term support.

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Care home placement and human rights

In their editorial examining the pros and cons of different places of living for older people, Bally and Jung considered who enters residential and nursing (care) homes and how care in these settings might be improved.¹ Research cited drew attention to factors that have a bearing on quality of life and respecting people's wishes.² GPs should be able to identify those who may benefit from a care home,³ but should consider the person's cognitive abilities, perceptions, and preferences.⁴ They noted the importance of advance care planning, integrated care models, and individualised care.

We feel that some of these matters should also be considered from a legal and human rights perspective, as care home placements will often have a profound and enduring impact on older people's liberty, security, and family life — which are fundamental human rights. In England and Wales, the Mental Capacity Act 2005 (MCA) is an essential safeguard in this respect and its provisions are often at the forefront of GPs' minds when residence capacity assessments and best-interests decisions are being made. Yet widespread evidence suggests that the MCA's principles are still not 'embedded' as well as they should be in clinical practice.⁵ This is concerning, particularly when a move into care is being considered, given the impact that this will have on an older person's dignity and human rights. A recent study of patients with dementia discharged from general hospital found that ill-conceived capacity assessments and 'best interests' decisions that failed to adhere to the legal (and ethical) standards of the MCA could result in institutional placements being the 'default position' for those with questionable capacity.⁶ The older patients concerned would often fade into the background during these decision-making processes, so their long-standing preferences were not heard.⁷

GPs with an appropriate understanding of the principles and ethos of the MCA (including the Deprivation of Liberty Safeguards) can be very influential in their 'patient advocate' role, when the rights of people whose home — which is so much a part of who we all are — is under scrutiny in relation to their health,

care, and wellbeing.

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Can we trust studies using audit software?

We must say how disappointed we were on reading the paper 'Can we trust studies using audit software?' by Rice *et al*.¹ We certainly hope it does not have an adverse effect on the use of the GRASP tools in the future, as our experience with them has been very positive.

First, one must question how representative this experience of one practice is.

Second, much of the difference between the GRASP-AF results and the 'manual' search used in the paper (which actually was an electronic audit too as they used the practice computer system to do this) is clearly due to a difference in the definition of AF used in the two methods and in the

high use of free text in this practice to record exclusions.

The manual search described looked for patients with 'unresolved' AF, which allows GPs to exclude some high-risk patients from the audit, whereas GRASP-AF searches for a 'history of AF'. Therefore, the GRASP search includes patients that the QOF would exclude under the category of 'resolved'. As we know, no audit software can search free-text entries, hence the need to ensure accurate coding is used in the first place. The use of free text rather than predefined Read codes to record patient refusal or contraindication explains why the software could not identify patients. This highlights issues about appropriate use of coding in this practice rather than any inherent problem with the audit software.

One important feature of the GRASP-AF audit software was omitted from this paper: that GRASP offers the opportunity to easily share anonymised data for benchmarking using CHART Online. We feel the article missed an important opportunity to show that the issue is not about comparing automated versus manual processes, but rather how best to make use of our most precious resource — clinical time. The paper's proposal to return to manual audit will exasperate already busy GPs. Clearly the only sensible option for the future is to use audit software and ensure that coding is improved so that the results are as accurate as possible.

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Correction

In the December article by Pedersen AF, *et al*. Association of GPs' risk attitudes, level of empathy, and burnout status with PSA testing in primary care. *Br J Gen Pract* 2015; DOI: 10.3399/bjgp15X687649, Figure 1 incorrectly stated 'prostrate' instead of 'prostate'. We apologise for this error and the online version has been corrected. DOI: 10.3399/bjgp16X683137