

DEFINING 'GOOD' IN HEALTHCARE
TOPLINE SUMMARY 3: GP AND OUT OF HOURS SERVICES

1. INTRODUCTION, BACKGROUND TO THE RESEARCH AND OBJECTIVES

In April 2013, CQC published its new strategy 'Raising Standards, Putting People First'. In this document, CQC stated its intention to redevelop its inspection methodology and the information that is provided to the public following an inspection. This change focuses not only on how services are inspected, but also the five key questions which inspectors will ask about services: Are they safe? Are they effective? Are they caring? Are they well led? Are they responsive to people's needs?

CQC is working to develop new fundamental standards that focus on these five questions. As part of this work, CQC seeks to define the criteria that will be used to assign a rating to a service provider – in other words, understanding the features of a service that is considered inadequate, a service that 'requires improvement', is 'good' and 'outstanding'.

For this new inspection model to be credible with the public, it is essential that these criteria reflect the public's expectations. There is a particular focus on understanding what the public expects 'good' and 'outstanding' services to look like, across all care settings, and at all service levels.

Qualitative research was commissioned to provide a clear understanding of what the public and service users think 'good' and 'outstanding' look like in GP and Out of Hours services. In addition, the research will explore what information requirements the public have in relation to inspection reports about all of the above services. The business objective is:

<p>To inform the criteria that are developed for rating services and to inform the development of a new style of inspection reports for each of these services.</p>
--

2. GP AND OUT OF HOURS SUMMARY

2.1 Method and sample

12 triads (3 respondents, 1.5 hours duration) were completed w/c 12th and w/c 19th May with users of GP and Out of Hours services.

- 2 x triads with people aged 70+ years (1 x male, 1 x female)
- 3 x triads with mothers (1 x mothers with babies under 12 months; 1 x mothers with children under 5 years old; 1 x mothers with children with disabilities)
- 3 x triads with people with long-term conditions (1 x ABC1, 2 x C2DE)
- 2 x triads with carers
- 2 x triads with less frequent users, including working-age people (1 x ABC1, 1 x C2DE)

In addition:

- A mix of ethnic minority groups was achieved across the sample
- A mix of GP practices was included (i.e. single-handed GP practices and multiple practices)
- A mix of urban and rural locations was included
- There was representation of users of OOH services

2.2 Care standards experienced

When asked to rate their GP or Out of Hours service, respondents often felt naturally inclined to give two ratings – one for the GP (the person) and one for the practice or surgery. Views on the relative importance of these two aspects of the service were mixed. For some (most likely to be infrequent users, or older males), their expectations of the

interaction with the GP were relatively low; as long as the GP was professional and courteous, and they felt that their problem was resolved, that was sufficient. For them, their focus was on ease of access and being seen quickly.

Respondents who were caring for others (children with disabilities or elderly parents) or had LTCs were more inclined to place emphasis on the interaction with the GP. Maintaining a history of contact, displaying empathy, feeling 'listened to', discussing treatment options and displaying an understanding of the patient's specific condition often assumed more significance amongst these groups, although ease of access was also of high importance.

All standards of care had been experienced across the sample.

A minority of respondents described their care as '**outstanding**' overall. Some others characterised their individual GP as 'outstanding' but not the overall service. Outstanding care was characterised as:

- A GP with a highly sympathetic attitude, who really listens and engages with the patient and displays real empathy: *"I just feel like they actually care"*
- The 'personal touch' *"My daughter had a baby last week, and her GP personally rang her to congratulate her and ask her how she was doing. It was such a personal touch, that's outstanding care"; "At my surgery, the GPs encourage us to use their first names. So she's Karen to me, she's not Doctor Whatever"*
- Explaining alternative treatment options and the consequences of each, helping the patient to choose an option (where applicable)
- Next day / same day appointments

Older respondents in particular frequently referred to 'the old days' when the GP was a familiar local face, who knew everybody, who treated whole families (often across generations) and was a real part of the community. While these older respondents accept that society has changed, they still yearn for GPs to capture the essence of these times again – to them, this is 'outstanding' care.

“My doctor knows me and knows my problems and responds really fast. He is my family doctor like in the old days”

Many respondents across the sample rated their GP or OOH service as **‘good’** overall, although some highlighted areas where improvements were required. Good care in this context has a somewhat practical overtone; essentially ‘getting the job done, quickly and courteously’. Specific characteristics of ‘good’ are:

- Receiving the care and treatment you need
- Kindness, courtesy and respect from all staff (including receptionists)
- Not having to wait more than a couple of days for an appointment
- A prioritisation system for appointments (priority given to the elderly or children)
- Surgeries and clinics running on time
- Efficient systems for conveying test results (e.g. having a specific number or time to call up, and the results being available when they should be)
- Following up as promised (i.e. if further information or a subsequent phone call is promised)
- Good parking facilities

“It’s just the basics. Getting the job done, and be nice to me while you’re doing it”

“To me, the GP is just a clearing house. You want them to find whatever’s wrong, either treat you or send you to someone else, while being nice and respectful”

“They’re only good because they have too many patients. They would be outstanding if they had more time to talk to you, and they knew you and your family; the personal connection. You could talk to them about anything, worries or fears”

Most respondents described elements of care they received which **‘required improvement’**. These elements were nearly always centred on access, appointments and waiting times, although there were some issues relating to GPs themselves here. Care which requires improvement can be characterised as:

- Telephone triage systems. Although some appreciated the practicalities of this, most detested this type of system, as they believed it breached their privacy. This was particularly true for those living in rural areas or small communities who often knew or were acquainted with receptionists and therefore felt extremely uncomfortable divulging their medical problems to them
- Long waiting times (i.e. over a week to get an appointment)
- Being kept on hold for a long time when ringing for an appointment
- Persistently late running surgeries and clinics
- Not being able to see the same GP each time (unless you're prepared to wait longer for an appointment). Respondents do grapple with the practicalities of this issue, as they appreciate that practices have high patient numbers. However, this is particularly frustrating for carers or those with LTCs who place real emphasis on continuity of care
- Related to the above, high use of locums
- GP who does not make eye-contact or express any interest in the patient
- Rude receptionists
- Not following up on promised behaviours (saying they'll call with further information, results etc and then not doing so)

"My son lives in Wellingborough, and he has to wait 3 weeks for an appointment"

"I hate it when you're explaining what's wrong and they're not even looking at you, they're looking at their computer or writing something, and you think 'are you even listening to me?'"

There was minimal evidence of **'inadequate'** care, although it did exist within the sample. Inadequate care was characterised generally as:

- Not having problems / conditions resolved
- Lost results / being given other people's results

- Being ‘cut off’ at the end of an appointment slot or not feeling ‘allowed’ to discuss multiple problems: *‘He said you’ll have to make another appointment if you want to discuss that’*
- Some, who were strongly against the telephone triage system rated it as a feature of an ‘inadequate’ service

2.3 Definition of good care

General public priorities for safety were often expressed in the context of the environment itself; feeling safe in the waiting room, a lack of ‘slip and trip’ hazards, nothing for small children to hurt themselves on, presence of sharps bins and hand gel in Doctor’s rooms. Security of data and patient records, CRB checks of staff, and a private area for conversations with the receptionist (for confidentiality reasons) were also seen as being elements of the ‘safe’ domain. Finally, from a medical perspective, criteria such as prescribing the correct medication and providing a good OOH service were considered important.

Although all agreed with the description of ‘safe’, the list was considered somewhat abstract and some respondents struggled to engage with it. It felt very impersonal, not particularly patient-centred and also seemed repetitive.

“It’s hard for me to connect to this. It’s like something I’d expect Ikea or Debenhams to use, not a GP”

The elements from which all respondents identified as particularly important were: *‘The people using the service, those close to them and staff are protected from abuse and avoidable harm’; ‘The practice/out-of-hours provider has a good track record on safety performance that shows ongoing improvement’; ‘The practice/out-of-hours provider understands risks, has a clear picture of safety and is focused on improvement’ and ‘Staffing levels are set and reviewed to keep people safe and meet their needs and at all times the practice/service is open’.* ‘Safety is a priority’ was important to all, but seemed somewhat generic and to encompass all the other elements listed.

While identified as important, respondents struggled with the concept of the above being characteristics of a 'good' service in the safe domain – to them, these were expected or fundamentals of safety. *"Aren't these just the basics?"*

Some were confused over the statement *'Risks to individuals are effectively assessed and managed'*. While management of risks per se is regarded as a key feature of safety, some respondents did not know what kind of 'risks' were being referenced here.

For carers, *'Safeguarding vulnerable adults and children is a priority and appropriate systems are embedded'* was of particular relevance.

For this sample, 'effective' care was care that resulted in positive outcomes for the patient (i.e. 'you get better', 'you are prescribed the right medication'). Demonstration of good administration and smooth running of practices also was thought to fall under this domain – for example, good record-keeping, as was staff training and development (regular CPD), staff being up to speed with developments around treatments and medicines.

Although all agreed with the description of 'effective', the elements from which patients identified as particularly relevant to their needs were: *'People receive care, treatment and support that achieves good outcomes, promotes a good quality of life and is based on the best available evidence'; 'People's needs are assessed appropriately and care and treatment is planned and delivered in line with current legislation, standards and nationally recognised evidence based guidance'; 'Care and treatment consistently achieves positive outcomes'.*

Some were alarmed by the inclusion of *'Staff are appropriately qualified and competent at the right level to carry out their duties'* as a characteristic of 'good' – this was seen as the most basic of requirements.

Finally, some were unfamiliar with the term 'multi-disciplinary'. This statement was thought particularly non-user friendly; a statement along the lines of 'Good communication between healthcare professionals' spoke more to the general public.

General public priorities for ‘caring’ were very much focused on the personal attributes of the staff (including receptionists). They felt that medical staff, and receptionists, should display empathy, kindness and treat all patients as individuals. *“It’s about feeling like a person, not a number”*.

Other manifestations of caring included: adapting to the specific needs of individuals e.g. not asking elderly, frail patients to get up onto the examination couch; handling the patient gently during physical examinations when they are in pain and apologising for causing pain if this cannot be avoided; taking on board individual’s own instincts about their (or those close to them’s) health *“I took my son to the GP for months because I was concerned about him, and they kept telling me there was nothing wrong. I knew things weren’t right so I persisted, in the end it turned out he did have quite a serious condition”*; and treating all individuals equally (some older patients felt they were patronised or dismissed as a ‘silly’ old person or hypochondriac, just because they were old).

All strongly agreed with the description of ‘caring’ with all elements being considered important. There was some debate around the point *‘Staff build positive relationships with people using the service and those close to them’*. While this was important in principle, and should be strived for, respondents did not see how this was realistically achievable, in light of their personal experiences of a lack of continuity of GP / seeing a different person each time they went.

When considering, ‘responsive’ care, respondents focused on ease of getting appointments, getting quick referrals, getting home visits if required, and the availability of ‘specialist’ doctors within a practice (e.g. a doctor specialising in sexual health or back pain).

All agreed with the description of ‘responsive’, however the elements which respondents identified as most important were: *‘People are able and supported to access the right care at the right time. Appointment systems are easy to use and support choice’* and *‘People wait as short a time possible for services, treatment or care’* (this was regarded in the context of getting an appointment quickly with the GP).

Some respondents felt that the characteristic *'People are encouraged, have the information they need and are supported to provide feedback or make a complaint about their care'* seemed to sit better in the 'well-led' domain, as it appeared to relate to improving standards of service, rather than to the patient's clinical outcome.

As with the nursing home and residential care sample, this sample was better able to conceptualise the 'well-led' domain than previous research done with other service users, perhaps because so many judgements of 'good' care are anchored in the availability of appointments, smooth systems and so on – perceived as 'management' issues, rather than medical factors.

Characteristics of good in the 'well led' domain were expected to be: sufficient staffing levels, feeling able to complain without fear of being 'struck off', having the outcome of complaints conveyed back to the patient, ensuring all staff undertake regular refresher training and are up to date with latest thinking, techniques and practices.

All agreed with the described characteristics of 'well-led'. *"It's all important, it feeds downwards to the patient, top to bottom"*.

2.4 Information requirements

The decision-making process for choosing a GP was consistent across the sample, however, this was seen as somewhat irrelevant, as the vast majority claimed they had no choice of practice; this is largely driven by geographical factors and 'catchment' areas:

The key information which was of interest to respondents was:

- Can you get an appointment quickly?
- What are the opening hours?
- Is there parking?
- Are they friendly?
- Can the Doctors speak good English?

- Is it clean?
- Do they have a good system for managing repeat prescriptions? (for those for whom this is relevant)

3. INSPECTION REPORTS (new style)

3.1 Rating inspection reports

Example 1 (which was rated as ‘action needed’ by CQC) was rated as ‘requires improvement’ overall, and some respondents considered there to be elements of ‘inadequate’ in the description. This was due to a perceived strong emphasis on what this practice was not doing i.e. no policy on safeguarding the vulnerable, no effective supervision or appraisal regime, no evidence that actions arising from the audit had been implemented, no evidence that views were sought. While this establishment sounded as if it might be ‘caring’ (people were asked for their consent, and treatment was provided accordingly) they believed the high number of negative elements should lead to a negative rating overall.

Example 2 (which was rated as ‘all standards met’ by CQC) was unanimously rated as ‘good’, with some respondents seeing elements of ‘outstanding’. Elements of outstanding were the person who was ‘made to feel at ease and comfortable’, evidence of one-to-one supervision and the manager who is described as ‘great, really knows what they’re doing’. Respondents liked that this provider had responded positively to demands to make improvements after the previous inspection – this was indicative of a ‘try hard’ attitude, a provider who wants to be the best they can be. The one surprising element for some was that *‘staff were assessed to ensure they were competent before they were able to administer medication’*; this would be taken as a given.

Example 3 (which was rated as ‘improvements required’ by CQC) was given a range of ratings from ‘requires improvement’ through to ‘outstanding’, although most perceived this provider to be ‘good’. Respondents highlighted the positive feedback from patients, ‘lovely and helpful staff’, awareness of responsibilities around safeguarding, appropriate staffing levels and secure holding of medical records as indicators of a good standard of

care. Elements that required improvement were that *‘the quality assurance and monitoring of the service was not as effective as it could be’*. Some also interpreted ‘complaints had been acted on’ negatively; *“It’s telling me there have been complaints. There must be problems there”*.

Revealing that this provider had been rated ‘requires improvement’ by CQC led to a wider debate around how ratings are arrived at. Some respondents expressed an interest in knowing more about the algorithm or ‘weighting’ that is used to determine overall ratings.

3.2 Report structure, content and language

BEDOC OOH Service Report

Respondents generally reacted positively to this report. It was clear, easy to read and well laid out, and did not contain language or jargon they did not understand. Where acronyms were used, they were generally explained. All of these things were contrary to respondents’ expectations before viewing the report, when they expected a huge ‘tome’, full of jargon and being impossible for a member of the public to navigate or understand.

“It’s very plain speaking. That’s good”

The reference to the ‘five questions’ was appreciated as this meant the reader could focus on the areas of specific interest.

Respondents tended to focus on the summary page. They appreciated the brevity of the summary (*‘It’s not too long winded’*) but at the same time it did not always appear to address the questions that were of most importance to them:

- How long do people wait for an appointment?
- Do patients get seen quickly?
- Do the Doctors speak English?
- What services are available there? (Specific clinics etc)

Some elements of the summary were difficult for patients to interpret, for example '*We found locum doctors were not employed at BEDOC...this significantly contributed to the safety of the patients*'. For some, the absence of locums was viewed positively, as it meant there was higher likelihood of continuity with the same GP. For others, however, this was interpreted negatively, because the policy of not using locums might mean that the practice is under-resourced at times. Therefore, to be of use to the public, statements such as this should be explained more fully.

The report was criticised overall for a lack of a rating. This leaves it up to the reader to interpret whether the provider was outstanding, good, requires improvement or inadequate; it was surprising to respondents that this was not shown.

Homerton Hospital

As above, there were no issues with the language or layout of the report.

This report was very well received, simply because there are ratings evident on the front page of the report. Patients can determine at a glance the performance of the provider. The breakdown of different areas within the hospital was also welcomed, as the reader could hone in on the areas of specific relevance, as was the rating for each of the five questions. This style of report would be considered particularly useful if a patient was trying to choose between alternative providers, as they could be quickly and easily compared.

There was some division about how a GP/OOH report could be sub-divided in this way. Some felt that splitting out different areas of service provision would be most sensible (e.g. GP consultations, family planning, diabetes clinics etc); for others, separate ratings for different types of staff felt more useful (GP, receptionists, nurses, pharmacists).