Care Quality Commission

The state of health care and adult social care in England 2015/16

PRIMARY MEDICAL SERVICES

STATE OF CARE

Primary medical services

Key points

- The vast majority (83%) of GP practices we inspected were rated as good and 4% were rated as outstanding. However, there is variation in the quality of care across general practice, ranging from outstanding to inadequate.
- Where improvements are needed, general practices have shown that most of the time they do improve after a CQC inspection (75% of inadequate ratings were improved on re-inspection). It is too soon to know if improvements are sustainable.
- Safety remains a problem. Although most GP practices deliver safe care, there is a small number of practices where we had concerns: more than 800,000 people are registered with services that are rated inadequate on our question of safety.
- Some general practices came out of special measures when they improved communication between staff and introduced systems to enable learning – better quality improvement processes, including incident reporting, analysis and action were seen as factors behind ratings that went from inadequate to good.
- CQC monitors the quality of all dental practices across England and inspects 10% every year. Although CQC does not give ratings to dental practices, the vast majority (90%) that we inspected were providing safe care. The care provided by larger dental practices tended to be better quality, particularly on safety.
- Integration of services involving primary medical care is happening in some places and there are some good outcomes for people but it is too soon to fully assess their impact because new models of care are only just emerging.

Introduction and context

CQC is responsible for regulating and inspecting a wide range of primary medical services across about 20,000 locations (figure 2.29).

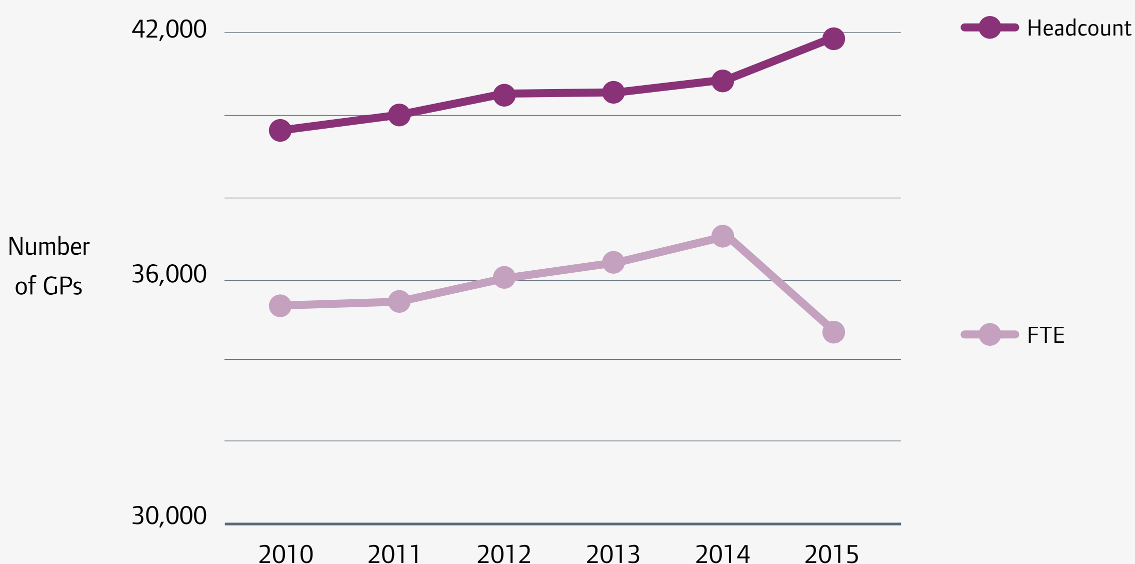
These services are operating in an increasingly challenging environment and they face greater demand that is putting pressure on their ability to deliver effective services. This is coupled with a shortage of general practitioners (GPs), who provide the majority of primary care. Despite this context, the sector is performing well and quality overall remains high.

The shortage of GPs combined with increasing vacancy levels means that practices may be understaffed. The number of full-time equivalent GPs has recently started to fall (figure 2.30) while the number of people registered with GPs is rising. One projection suggests certain areas of the country will need to increase the number of GPs working in the community by at least 50% over the next five years. NHS England's *GP Forward View* describes a plan to create an extra 5,000 doctors in general practice by 2020.

General practice is at the heart of the system, but these frontline services must be flexible to cope in a fast-changing environment: some services have shown they are able to innovate and rise to challenges by transforming into modern, patient-centred organisations; others are struggling with the pace of change and increasing demands, such as ageing populations with needs that are more complex. We have found from our inspections that strong leadership and culture are important to cope with change and we will point to this where we find it.

CQC is a signatory to the *GP Forward View* and recognises the challenges facing the sector. The primary care environment is changing fast – some general practices are joining together in federations, forming larger group practices and developing new models of care. This is a significant change for general practice in a fast-evolving health and social care environment where GP and other services, along with wider system partners, are expected to consider what changes may be needed to maintain the quality and range of services for patients.

Figure 2.30 Changes in GP headcount and full-time equivalent (FTE), 2010 to 2015



Source: NHS Digital

Integration of services, for example in Yeovil, Somerset and Northumbria, is happening and CQC is supporting providers that want to innovate, collaborate and improve services for people through new models of care. We are helping with registration and regulation.

Figure 2.29 CQC's regulation of primary medical services

GP practices	There are around 8,000 GP practices in England. As at 31 July 2016, we had inspected and rated 4,511 GP practices and 15 out-of-hours services. We aim to have inspected and rated all GP practices by March 2017. We are also seeing an increasing number of multisite practices, both through mergers and acquisitions between trusts and GP surgeries, and consolidation and federation of GP practices.
Dental services	There are around 10,300 dental care locations on our register. We inspect these services but we do not give them ratings.
GP out-of-hours, urgent care services and NHS 111	We inspect and rate a range of GP out-of-hours services, urgent care services such as NHS 111, walk-in centres, minor injury units and urgent care centres.
Digital healthcare services	There is an increasing number of applications to register new providers of digital services. There are more than 50 online services already registered with CQC. We are piloting a new methodology for inspecting providers of digital services, such as video consultations.
Independent doctors	CQC only directly regulates a small number of independent doctor services - around 700 across just over 1,000 locations in primary medical services.
Health and justice	We inspect, but do not rate, health and social care in prisons and young offender institutions. We also inspect, but do not rate, health care in immigration removal centres, police custody centres, secure training centres and youth offending teams in the community. We conduct this work with HMI Prisons, HMI Probation, HMI Constabulary and Ofsted.
Children's health and children's safeguarding	We inspect, but do not rate, local health service arrangements for safeguarding children and improving the health of looked after children. Some of this work is conducted with Ofsted, HMI Constabulary and HMI Probation. In 2016, we published *Not seen, not heard*, a summary of our findings in this area so far.
Medicines optimisation	Medicines are the most common form of healthcare intervention in all care settings and crucial to almost all care pathways. The medicines team provides support across all directorates, focusing on how providers use medicine safely and effectively, and how they support patients to get the best outcomes from their medicines.

Overview of the quality of care

General practice

More than half of all GP practices in England have been inspected and we have the best picture yet of the quality of care they provide. After all inspections and ratings are completed by the end of 2016/17 we will have a comprehensive assessment of the quality of general practice across England.

Most practices (87%) were rated as good (83%) or outstanding (4%) as at 31 July 2016 (figure 2.31). One in 10 practices was rated as requires improvement and 3% were rated inadequate overall.

We have concerns about safety. There is still a proportion of practices delivering unacceptable standards of care – about 800,000 people were registered with practices that were rated inadequate for safety (31 July 2016).

Where there were problems with safety, inspectors found:

- Health and safety incidents were regularly not recorded and action was not taken to prevent reoccurrence.
- Equipment and training for medical emergencies was often incomplete.
- Some premises were not suitable or are poorly maintained.
- Not all practices had safeguarding policies in place or staff members trained to the appropriate level.
- Regular equipment checking and servicing was not always carried out.
- In the management of medicines, important things were not happening, such as checks on storage conditions and expiry dates, correct administration, and appropriate audit trails and prescription logs.
- Clinical waste was sometimes not stored correctly or disposed in the right way.

Where we have rated practices as good or outstanding for safety, there are some common characteristics about leadership and learning. We found a culture of, and proactive approach to, anticipating and managing risks to patients. Also, learning about problems is shared, not only within the practice and following a thorough and open investigation, but also in the local health community so other practices can work to best practice, and learning can be maximised so the likelihood of problems is reduced.

Nurses are sometimes involved in such safety improvements, and they have an important wider role in general practice care delivery. Policy for many years has been to shift care from hospitals to general practice, and this puts greater emphasis on the nursing role in general practice.

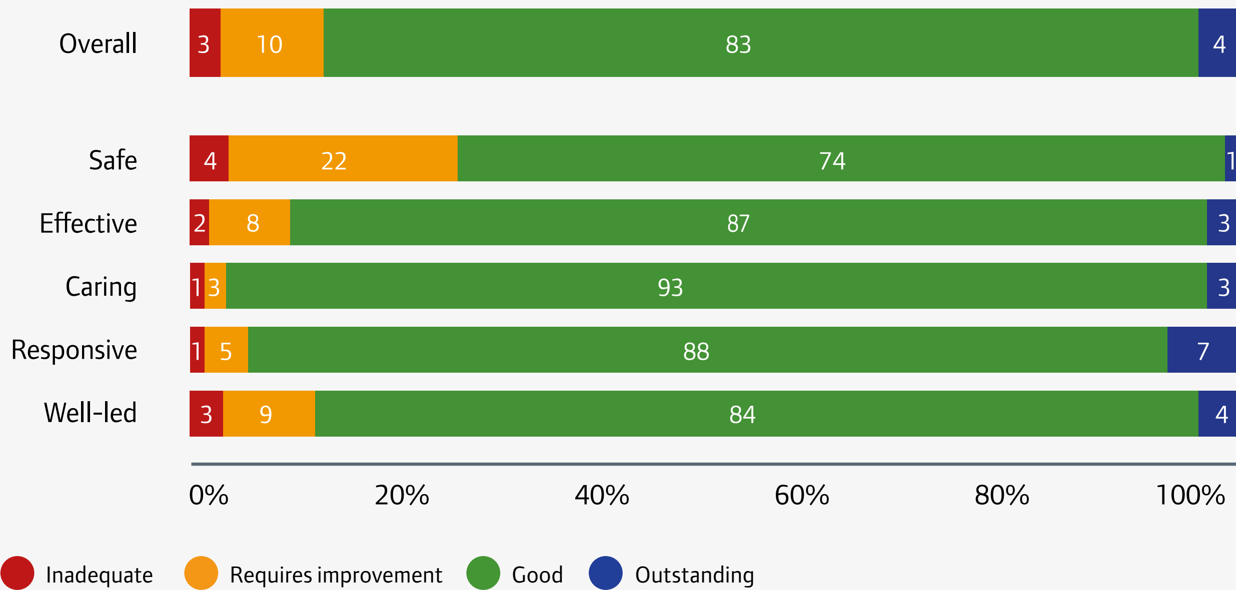
The skill mix in general practice increasingly includes healthcare assistants, practice nurses, advanced nurse practitioners and physician associates who are involved in the decision-making for the practice.

GPs also learn from one another about good practice – for example, some have responded to problems by designating a specific member of staff to take responsibility for improvement. Our inspection programme is helping to drive improvements in quality, particularly in practices that are isolated professionally, or those perhaps unaware of what standards are expected – or possible. There are problems with a lack of learning and management that usually underpin ratings of inadequate in safety.

Most GP practices are performing well on leadership, with 84% that were rated as good for well-led and a small number (4%) that were outstanding as at 31 July 2016. Twelve per cent (covering about 3.3 million people registered to those practices) were rated inadequate or requires improvement (figure 2.31).

Where there is poor leadership, sometimes through governance issues or lack of support for staff, inspectors have noted the importance of a more open culture. This helps drive improvements, as well as a clear vision, a strategy and values that are known and shared by staff.

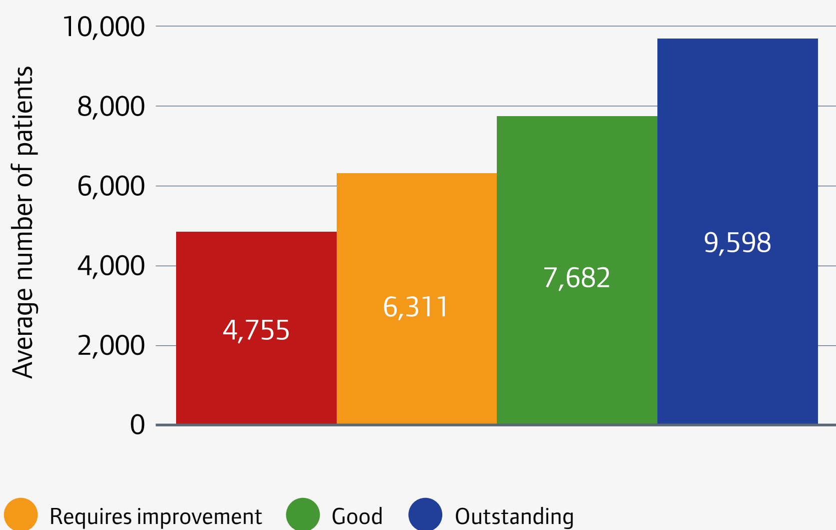
Figure 2.31 GP practice current ratings, as at 31 July 2016



Inadequate Requires improvement Good Outstanding

Source: CQC ratings data, total of 4,511 GP practices

Figure 2.32 Average patient list size of rated general practices, as at 31 July 2016



Inadequate Requires improvement Good Outstanding

Source: CQC ratings data, NHS Digital

Note: Average is based on weighted patients.

There are concerns around information sharing: we frequently see there is no effective process for recording and sharing national and local information, and guidance about best practice or alerts about patient safety.

The vast majority of general practices are performing very well across the questions of effective, responsive and caring. At least 90% of practices were rated either good or outstanding in each of these categories as at 31 July 2016.

We also saw weak correlations between particular types of practice and their overall ratings – for example, while there were many outstanding smaller practices, larger practices tended to be rated better (figure 2.32). Smaller practices that work in isolation have often struggled, but we have seen good results where smaller practices have worked together.

Where there were concerns about leadership, they included:

- Staff training and supervision – adequate training or evidence of training was not always provided and there could be a lack of staff appraisals to identify development.
- Referrals – the process was not always monitored effectively (effective practices demonstrate quality improvement activity).
- Complaints and concerns – a robust system was not always in place or accessible, or if it was in place then action was not taken quickly enough.
- Some practices were not aware of the needs of the population they serve.
- Dignity – patients' privacy was not always protected.
- A lack of support for carers and poorer patient satisfaction.

Population groups

We look at the quality of care of services for specific population groups, including:

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)

Caring for carers

Windhill Green Medical Centre, West Yorkshire

Windhill Green is rated outstanding overall and it is outstanding for caring. The practice's computer system alerts GPs if a patient is also a carer.

The carers are often identified by district nurses on community visits, or by GPs and practice nurses during consultations or on home visits.

Carers were also identified in 'Community 4' meetings, where GPs from five practices met with district nurses, physiotherapists, social workers, mental health team workers and voluntary agencies to discuss specific cases and management plans to improve the care of the patients, as well as how they could help carers to cope. This was a result of greater clinical input, community involvement and social interventions.

Carers are sent invitations for health checks and carer registration cards were on display in the waiting areas. They are encouraged to complete carer registration forms and the practice then makes sure the people are clearly marked on the computer records.

The practice encourages carers to maintain their own health and it supports carers by working with groups and charities. These in turn can support carers (for example, Age UK, Windhill & Baildon community centres, luncheon clubs, expert patient groups and the Alzheimer's Society).

The resource groups were frequently invited to attend meetings to update the practice teams on the services they could offer to patients, which the practice team shared with patients.

- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people with dementia).

The ratings for these groups were fairly consistent with ratings for a whole population. However, we identified some practices that deliver outstanding specialist care for particular groups of people.

Many of those rated good or outstanding for responsive will actively identify the needs and preferences of people and groups of people. This might include working with local organisations and engaging with staff and local people to seek out unmet needs, and ensuring provision reflects the perspectives of people who use – or who may need to use – GP services.

We have received positive comments from practices about CQC's methodology and our reporting on population groups, which some say has enabled them to showcase their work with certain groups.

Ratings and survey findings

There are some weak correlations between CQC ratings and patient survey findings. Among practices that are rated good or outstanding overall, there are some common characteristics. Patients said:

- They would recommend the practice to others.
- The GP showed care and concern.
- The GP involved them in decisions about their care.
- They had a good overall experience of care.

The 2016 GP Patient Survey showed that 73% of people surveyed had a good overall experience of making an appointment. However, over the last three years, the number of people waiting a week or more to see a GP rose by almost a third, to 18% of patients.

The number of survey respondents who said they had failed to get an appointment at all was 11%, which is an increase from 9.6% in 2012.

Dental care services

On the whole, most dental care in England is safe. For over a year, we have been inspecting dental practices under a revised methodology and with the support of dental specialist advisers.

CQC monitors all of the dental surgeries in England every year and inspects 10% of them each year, and we have demonstrated that most of the practices are safe.

We visited 1,023 dental practices in our 12 months of inspections. We found that 90% of practices were providing care that is safe, effective, caring, responsive and well-led (figure 2.33). However, practices have told us that even where no breaches were found, inspectors' feedback has been helpful.

Where there were breaches (in 10% of those inspected), there were a relatively small number of concerns about governance and safe care and treatment. These include:

- completion of appropriate risk assessments
- infection control
- medical emergencies
- safeguarding
- managing complaints and concerns
- recruitment and supervision
- support and staff training.

In addition, where we found problems, dental care records were often incomplete or did not have current information.

Some practices did not complete audit cycles or take action to deal with identified risks.

Importantly, where we found regulatory breaches and carried out follow-up inspections, all but one practice made the necessary improvements.

Tailored for the population's needs

The Doctor Hickey Surgery, Central London

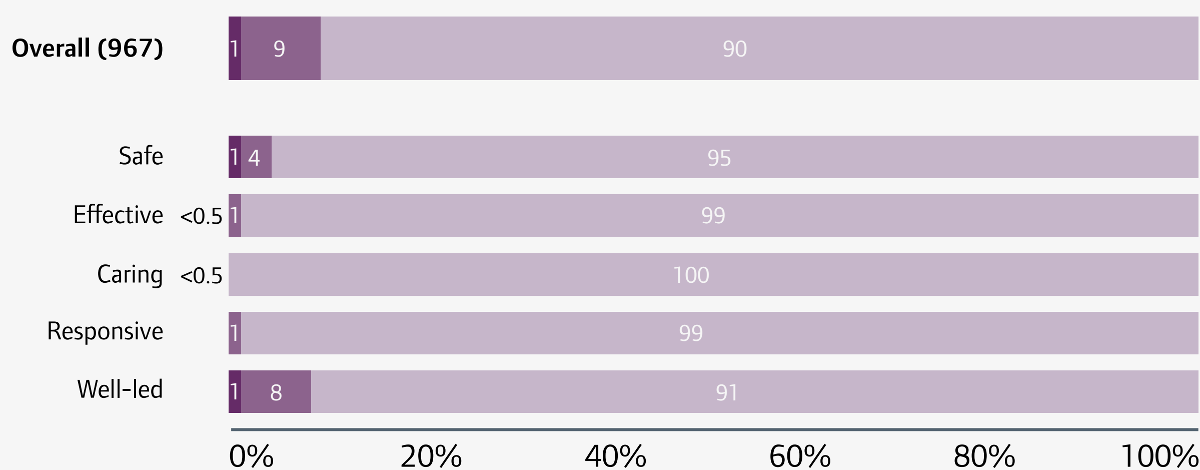
Most patients at the practice were homeless. However, the practice recognised that even within a homeless population, there were people who were particularly vulnerable.

The GPs provided medical outreach to rough sleepers in Westminster. They ran a street doctor programme where GPs and practice staff, along with the city council outreach teams, would carry out night walks through the local streets and parks. They spoke with rough sleepers, identified their medical needs, and addressed those needs in ways that were likely to improve both their overall health and their ability to use general homelessness services, with the aim of permanent resettlement.

From its own research and analysis, the surgery believes that life expectancy among the homeless people they help is more than 10 years longer than the UK average for homeless people.

The practice had developed a bespoke clinic for hepatitis C because this condition was common among homeless people and a cause of preventable death. The practice also provided services for failed asylum seekers and undocumented migrants, who were frequently referred to the practice because of its reputation for access.

Figure 2.33 Outcome of dental care inspections, as at 30 June 2016



Source: CQC inspection and enforcement data

GP out-of-hours services, urgent care services and NHS 111

Providers delivering this range of services are an important part of the system – and they can also help to relieve pressure on often stretched accident and emergency services.

NHS 111 and out-of-hours services can be provided by NHS trusts or the independent or third sectors. In line with the NHS England urgent and emergency care national review and the *Five-Year Forward View*, we are seeing changes in the way urgent care services are provided.

Some providers are moving to a more integrated system of care. For example, an integrated NHS 111 and out-of-hours service might mean a person contacting NHS 111 may be seen by the same organisation in their out-of-hours service. NHS 111 staff are able to book appointments with the out-of-hours service, and also refer people to a range of other services.

As at 31 July 2016, 14 of the 15 out-of-hours providers we had inspected were rated good; 12 out of 17 urgent care services was rated good, and one service was outstanding. There were no services rated inadequate.

For NHS 111 services, a challenge is to get the right staffing levels to meet demand, as well as good governance and quality monitoring.

Independent doctors

The private healthcare sector is diverse, with providers delivering services from an array of settings and in different ways. Independent doctors provide services mainly in consulting rooms or surgeries, but some are private call-out mobile services (for example to a patient at home).

There is a wide range of people and services in this category, including specialist consultation and treatment, slimming clinics, online consulting and prescribing, travel medicine and private GP services.

CQC does not have the regulatory powers to give ratings to these providers, but in 2015 we consulted on an approach for regulation and inspection with a pilot programme among 40 services.

The pilot included a range of independent services such as 'single-handed' medical practitioners providing services to private organisations that employ specialists offering a range of private, non-acute, out-of-hospital treatment. They may operate for one day a week in a private practice, moving between NHS and independent services. And patients using services may move between private and NHS providers.

We found a few areas for improvement under safety, effectiveness and leadership. These included issues around managing emergencies and supply of unlicensed medicines, as well as safeguarding systems and processes, information sharing and governance arrangements.

Serious problems at NHS 111 service

The NHS 111 service provided by one NHS foundation trust was rated inadequate after inspectors found too many calls were being abandoned or callers had to wait too long for an answer.

There were significant staffing problems – people reported long hours, high levels of stress and fatigue – and calls were sometimes answered by staff who were not trained to assess patients' symptoms.

CQC has worked with strategic partners to help address the many problems uncovered on inspection in this example. Among things we asked the service to put right, it had to make sure that call queues awaiting initial assessment and call-back were robustly monitored – and managed by staff with clinical authority to intervene and allocate resources.

Inspectors found that patients were at risk of harm because the triaging system was not good enough. CQC is monitoring the service's progress on a series of required improvements.

Digital healthcare services

Care delivery is changing in many ways and there is an increasing use of new technology.

We are considering how we can develop the right regulatory approach for these services. So far we have registered more than 50 providers of digital healthcare services.

These providers' services are offered as digital-only. These might be online prescription requests, for example, or video consultations provided on a computer or smartphone.

A programme of inspections will start in 2017/18, preceded by publication of our new methodology.

Health and justice

CQC was a partner in 53 joint inspections, conducted from 1 July 2015 to 30 June 2016, at a variety of services providing care to people in secure settings.

There were also eight focused follow-up inspections. These were led by CQC and resulted because we found breaches of regulations.

We inspected 35 prisons/youth offender institutions, two immigration removal centres, five secure training centres, five youth offending services, and custody suites in six police force areas.

Among the concerns from our inspections, we saw that recruitment and retention of healthcare staff across the criminal justice services remains challenging. This commonly means that a high level of agency staff are used, sometimes leading to a lack of continuity of care and specific skills.

We also found:

- Prisoners' use of illegal psychoactive substances is a growing problem. These are difficult to detect and cause health problems and frequent medical emergencies. This puts a strain on the prison healthcare team as well as local ambulance and accident and emergency services.
- The older prison population requires health and social care services that better meet their needs. Progress is variable and some prisoners cannot access the services they require. For example, bowel cancer screening and specialist dementia support services are not available to prisoners in some areas.
- Healthcare providers deliver clinical services in secure environments that are largely outside their control, which limits their ability to provide a safe and positive experience for patients. Common environmental issues include poor cleanliness, inadequate maintenance of fixed clinical equipment and a lack of privacy.

CQC does not rate health and justice services, but we inspect and regulate criminal justice services in an integrated way that encompasses people's experiences of health and social care services.

Many of the people in these places are less likely to have engaged effectively with mainstream health and social care services. By ensuring that health and social care services within the criminal justice system are as proactive, accessible and effective as possible, we can improve the way that health needs are met in this vulnerable group.

We work closely with the joint inspectorates and we share information. Where we find that substandard environments in prisons or prison staffing issues are adversely affecting the delivery of health services, we can work with HMI Prisons to recommend that prisons make the necessary improvements.

A revised joint framework for the inspection of secure training centres was consulted on and published by Ofsted in 2015. This has enabled us to report separately on healthcare provision and to improve the way we seek the views and experiences of young people and staff.

And since the introduction of the Care Act (April 2015) we have been influencing how prisoners with personal care needs are supported through our regulation of the adult social care services provided to prisoners.

Children's health and children's safeguarding

Not all children get the help they need, when and where they need it.

CQC is responsible for inspecting all registered health services provided to children. We evaluate the effectiveness of safeguarding arrangements and the quality of health provision to looked after children and their carers.

CQC's joint health and justice inspections

- Inspections of prisons, youth offending institutions and immigration centres in partnership with HMI Prisons (Includes Ofsted and HMI Probation)
- Inspections of secure training centres in partnership with Ofsted (Includes HMI Prisons)
- Inspections of youth offending teams in the community in partnership with HMI Probation (Includes HMI Constabulary and Ofsted)
- Inspections of police custody suites in partnership with HMI Prisons (led by HMI Constabulary)

"Meticulous in planning"

Young Offenders Institution, Feltham

Our inspectors found many positive aspects in the health and care services at this prison for young people and young adults.

For example, a visiting consultant described the prison's overall sexual health service as the best seen in any prison – services were age appropriate and included screening for chlamydia and other sexually transmitted diseases.

Boys were able to influence developments in health care through monthly prisoner forums – and there was a project to improve health literature, to make it accessible to the age group. There were several new initiatives to encourage boys to take responsibility for their health, such as teaching boys to re-order their medicines before supplies ran out.

Healthcare staff were reported as "meticulous in planning appointments". Boys received a reminder before their appointments and those who did not attend were followed up. Non-attendance rates had fallen from 33% to 8% (2013 to 2015).

For dental care, appointments were triaged and then prioritised according to clinical need. There was liaison with community dentists to ensure continuity of treatment, which was excellent practice.

Other positive aspects in health and care included "high-quality mental health services" with a rich skill mix available from specialist practitioners in learning disability, nursing, occupational therapy, psychiatry, psychology and speech and language therapy. A consultant child and adolescent psychiatrist visited weekly and a psychiatrist offered 24-hour advice to officers.

This was part of a joint inspection with HMI Prisons.

CQC's July 2016 report, *Not seen, not heard*, has findings from our first 50 reviews and shows considerable variability across the health system. We recommend that much more must be done to listen to, and involve, children in their care. Services should improve outcomes, strengthen the quality of information sharing and joint working, and identify and protect those at risk from hidden harms.

Services have to be reactive to new and emerging forms of abuse and harm to children. But they should be constantly aware and up-to-date with information about risks – and they should be engaging with children to understand their needs and concerns.

The independent inquiry into child sexual exploitation in Rotherham from 1997 to 2013 further highlighted the need for services to focus on the prevention of such abuse in the future. When resources are tight it is possible to lose focus on support for those people who would benefit from early help and support. This need is also particularly relevant to protecting children who are at risk of neglect. The importance and effectiveness of early intervention cannot be overstated and must be addressed with urgency.

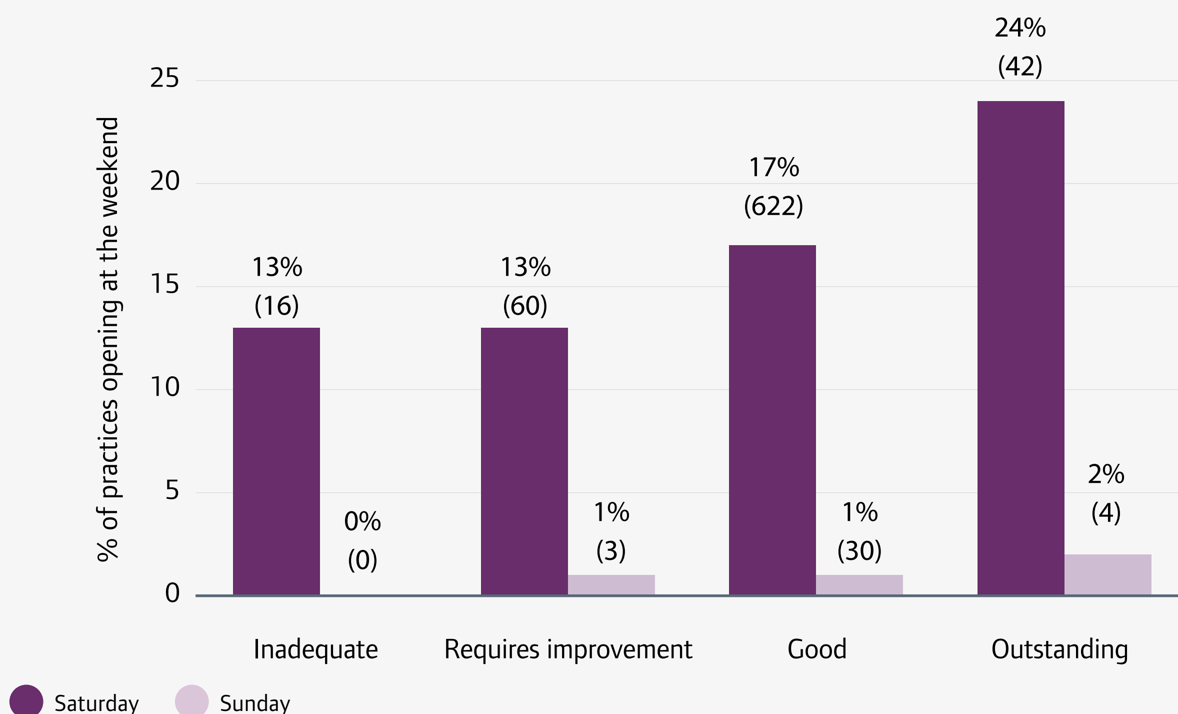
How good and outstanding GP practices respond to people's needs

We have seen a number of examples of outstanding care across general practice.

Inspectors told us that outstanding services tend to have a detailed understanding of the communities they serve. They also demonstrate their responsiveness to people's needs in terms of the services they offer both within and outside the practice. These practices also involve patients in improvements for services.

Many of the GP practices that we have rated outstanding are providing care to some of the most vulnerable people in society, particularly homeless

Figure 2.34 GP practice weekend opening times and ratings



Source: CQC ratings data; NHS Choices

people. There is a lot that can be learned from the way in which these services are delivered, and how responsive they are to the needs of particular population groups.

Some characteristics are common among outstanding practices – those that are stronger on person-centred care are more likely to receive a higher rating.

Providers' attitudes towards people in different population groups reflect their approach and commitment to being person-centred. One inspector summed this up by saying that the better practices "don't just pay lip service to involving patients in coming up with solutions". Some practices have active patient engagement strategies that support patient groups (for example, older adults at risk of isolation) and they help the organisation or coordination of activities for these groups.

Some practices are better at understanding the needs of the population they serve – they gather information from people's perspectives and then use it to plan facilities and services that match needs and preferences. For example:

- A practice provided information about safe needle disposal in bathrooms, acknowledging the needs of their patients who used intravenous drugs.
- Telephone appointments were offered in response to patient feedback.
- A dedicated 'child's hour' before and after school was set up for same-day GP appointments.
- Social prescribing for patients with mental health conditions.
- Practices promoting that they saw emotional and social needs as being as important as medical ones.

Staff engagement is an important factor in responsive provision. For example, inspectors described a practice where each GP partner had 'led' on a particular area, for example care homes or schools. This built expertise and rapport on specific issues and with particular groups.

Some practices are especially responsive: they identify and react to potential unmet needs, or

"One of the best"

Bevan House, Bradford, West Yorkshire

Rated outstanding in all areas of our inspection, Bevan House is an exemplar in meeting the needs of people in all the population groups that we identify.

This practice serves homeless people and people in temporary or unstable accommodation, refugees, people seeking asylum and others who find it hard to access the health and care they need.

After the CQC inspection, it was described as "one of the best practices in England". Among the many positive examples of its work, inspectors commented on staff at the practice, who were described as "motivated and inspired" to offer kind and compassionate care.

Risks to patients were assessed and well managed. And the practice has improved access to services in numerous ways.

An example of extending access is its street medicine team, which holds mobile outreach clinics in city centre locations for vulnerable people. There is also a late night (until 11pm) clinic for female sex workers, as well as an early morning clinic, in liaison with a local women's support team.

Among inspectors' findings, they noted how patients were given 'cold weather packs' consisting of gloves, socks, a hat and scarf, water and a bar of chocolate. Several staff told the inspection team that on winter mornings they would take a pack to people they had noticed sleeping rough on their way to work, and encourage them to come to the surgery. A similar and appropriate pack was available for the summer.

to specific population groups in their areas where particular attention is needed. Others were proactive in their links with community groups, or churches and other organisations.

Among the GP practices that we have rated, those with better ratings tend to be open more often outside core hours. For example, out of the 178 practices rated outstanding as at 31 July 2016, 42 of them (24%) were open on a Saturday (figure 2.34).

In October 2013 there was a government-led £50 million fund set up to help improve access to general practice and stimulate innovative ways of providing primary care services.

In the first year, across the 20 sites selected to participate, approximately 400,000 additional appointments were provided in extended hours (weekday evenings and weekends) and 520,000 additional appointments were provided in core hours. It was also reported that in May 2015 there had been a 15% reduction in minor self-presenting A&E attendances across the pilot schemes, compared with the same period in the previous year.

Improvement

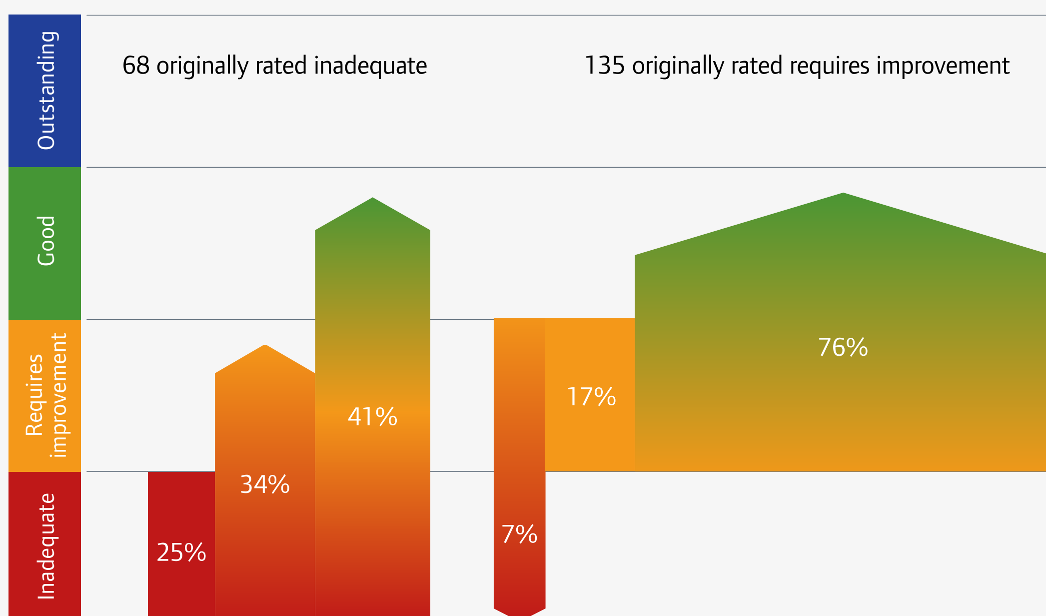
The majority of the general practices that we have re-inspected have improved.

Although some practices we have rated inadequate may have subsequently closed, three-quarters of the inadequate practices that we re-inspected had improved sufficiently to receive a better rating (figure 2.35). Twenty-eight improved their rating to good, and 23 changed to requires improvement.

Inspectors usually remark that a positive change is more likely in services that have an open culture where continuous improvement is encouraged.

Among the numerous examples of safety improvements, cleanliness, hygiene and infection control are covered in detail in inspectors' reports. Many practices appointed specific members of staff (often nurses) to lead on this area.

Figure 2.35 Change in overall rating on re-inspection in primary medical services, where initial rating was inadequate or requires improvement, as at 31 July 2016



Source: CQC ratings data. Note: The width of each cluster of arrows is relative to the number of re-inspections carried out.

Governance and governance frameworks are important areas of improvement identified in inspection reports – for example, introducing a new electronic management workflow system to provide an automatic audit trail for all documents that were read and reviewed by staff. Other improvements included the implementation of comprehensive assurance and audit systems, and putting in place a compliance officer.

Other factors behind good ratings included evidence of fostering an organisational culture of continuous learning, improvement and innovation – and having a clear vision, strategy and values.

An open culture at a practice often enables higher performance or improvements. Inspectors gave examples of where CQC's intervention provided support to staff. In poorer practices, a change of management or partners often stimulated improvement.

Inspectors have emphasised that every practice is different and that culture can be more important than how things appear on paper. There was an example of where a practice appeared to have good systems and processes in place, but on inspection was found to be "chaotic and badly organised".

This contrasted with a practice that appeared to have 'absent' practice owners, but which was found to be well organised and supported by the partners nonetheless.

A common characteristic in practices rated outstanding is that they have a well developed learning culture. They have a 'no blame' culture among the staff – everyone is aware of their own role and feels important in supporting and promoting change.

Inspectors told us that in poorer practices that had improved on re-inspection, they had seen a considerable change in culture and greater patient involvement had played an important role.

We have found that professional isolation can have a serious impact on quality of care and be a major barrier to improvement. GPs who work with other GPs, or practices that work with one another, can share knowledge and good practice, and collaborate to improve.

Where practices have got better, inspectors have seen notable improvements in how they manage and learn from significant events and quality improvement methods including clinical audit. They also pointed to factors including cleanliness, hygiene, infection control, medicines management, governance frameworks, safeguarding and staff engagement.

Our analysis shows that the attitude of general practice to CQC inspections is often cited as a major factor in whether providers are likely to improve from ratings of inadequate or requires improvement. While some GPs have told us of their apprehension about CQC inspections, there is also much positive feedback and GPs have acknowledged the "robust" role of inspection teams in helping practices to improve.

Care Quality Commission

How to contact us

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