Care Quality Commission

PRIMARY MEDICAL SERVICES

The state of health care and adult social care in England

2014/15

STATE OF CARE

Primary medical services

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Key points

- While most of the GP practices and GP out-of-hours services that we have rated up to 31 May 2015 are providing good care to their patients, we have been shocked at the very poor care provided by the 4% of practices that we have rated inadequate.
- Our inspections have highlighted a strong link between good leadership and good care. Likewise, the practices rated inadequate suffer from poor leadership and a failure to focus on what they need to do to improve.
- There is room for improvement in the safety culture in GP practices. We have seen examples of poor incident reporting and a lack of learning from significant events, as well as evidence of poor medicines management.
- GP practices deliver a better quality of care when sharing learning and providing joined-up care through multi-professional networks. Single handed practices are more likely to work in professional isolation, resulting in a lack of communication and engagement with staff and patients, and an environment that is not open and transparent.
- There is a need for GP practices to review access to medical advice and treatment to ensure they are in line with patients' needs.

Introduction and context

General practice and wider primary care services are under increasing strain. As well as tackling financial challenges, GPs are under pressure to effectively manage the rising demand on their services. An ageing population, more people with multiple health conditions and an increase in people living with long-term conditions (the number of people living with diabetes in the UK has soared by 60% in a decade) are all placing a high demand on GPs across the country.

Pressure is also mounting from a rise in the number of patients registered with a GP and the number of unfilled GP posts. With fewer people entering the profession (in 2014, 12% of GP training posts went unfilled) and 34% of GPs considering retirement in the next five years, the sector faces pressure to ensure that existing workforce numbers are sufficient to meet the current demand.

Through our Primary Medical Services and Integrated Care directorate we regulate and inspect a wide range of services:

Figure 2.23 Primary Medical Services and Integrated Care directorate – what we inspect and regulate

GP practices and GP out-of-hours services	By 31 May 2015 we had inspected and rated 976 GP practices and out-of-hours services* (11% of the total we have registered). We aim to have inspected and rated all services by Autumn 2016. Overall there are 8,405 GP service locations on our register. We have started to see new types of provider entering the market that are using Skype, email and web-based methods for consultation. We are also seeing an increasing number of multi-site practices – both through mergers and acquisitions between trusts and GP surgeries and consolidation and federation of GP practices.
Dental care services	There are 10,295 dental care locations on our register. We began our new approach to inspecting and regulating dental services on 1 April 2015 (we will inspect 10% of services a year and we will not rate them). In 2014/15, we continued to inspect services under our old approach.
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.
Remote clinical advice	We have started to develop a methodology for regulating providers of remotely-delivered clinical advice.
Urgent care services	We inspect and rate a range of urgent care services such as NHS 111, walk-in centres, minor injury units and urgent care centres as part of our inspection of the primary care provider.
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.

* This figure includes two urgent care services and one independent consulting doctor service.

Overall ratings

Despite the challenges faced by the sector, the vast majority (85%) of the GP practices and GP out-of-hours services that we rated up to 31 May 2015 are providing good or outstanding care (figure 2.24). At a challenging time for primary care, there are many practices finding innovative ways of meeting the needs of their local population, and this is something that should be celebrated.

Almost one in nine (11%) of the GP practices we inspected required improvement.

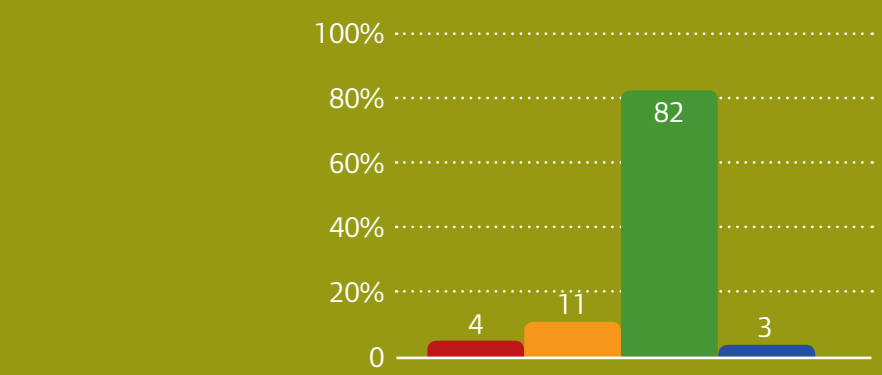
Four per cent of those we inspected were rated inadequate. During 2014/15 we introduced a special measures programme for GP practices. Where we rate a practice as inadequate, the practice is given a defined amount of time to address the issues we have identified, normally six months. The practice is supported in this by NHS England and, in some cases, by the Royal College of General Practitioners. At the end of this period, we inspect again to check whether enough improvement has been made by the practice to bring it out of the regime. If the practice has not made sufficient progress they have another six months to improve before enforcement action is taken against the practice, normally resulting in the cancellation of its registration with CQC.

Up to the end of May 2015 we had placed 30 GP practices that were rated inadequate into special measures. As of 2 September 2015, we had re-inspected two of them, with one now being rated good.

We remain concerned by the very poor care we find in some practices through our inspections. Some of this care is shocking. We have recently cancelled the registration of some practices where we found very poor care, and where there was a real concern about the safety of patients. Where we cancel a registration, it means that the provider cannot legally continue to provide a service, and we work with NHS England to ensure alternative arrangements are made for patients.

For example, following an inspection in June 2015 we cancelled the registration of a GP practice because inspectors had serious concerns about the service and the risks to people using it. During the inspection we identified one locum staff member who had treated patients but could not provide evidence that they were medically qualified to do so. The management of medicines was found to be unsafe and placed patients at serious risk of harm.

Figure 2.24 Overall ratings for GP practices and GP out-of-hours services



Source: CQC ratings data

Medicines were found to be out of date, which rendered them unsafe, and requests for prescriptions had not been processed in a timely manner to ensure patients had access to their medicines. Despite urgent appointments being available on the day they were requested, patients stated that they had to wait a long time for non-urgent appointments and found it very difficult to get through to the practice when phoning to make an appointment.

We also have the ability to temporarily suspend a provider's registration where we have serious concerns but we think that these concerns can be addressed. An example of where we have used this power is with a single-handed GP based in London. CQC had concerns about the performance at the practice since its first inspection in December 2013. Further inspections in 2014 identified serious concerns about risks to patient safety and an urgent notice to suspend the registration of the practice was issued in January 2015. Inspectors found a number of failings that led us to take enforcement action.

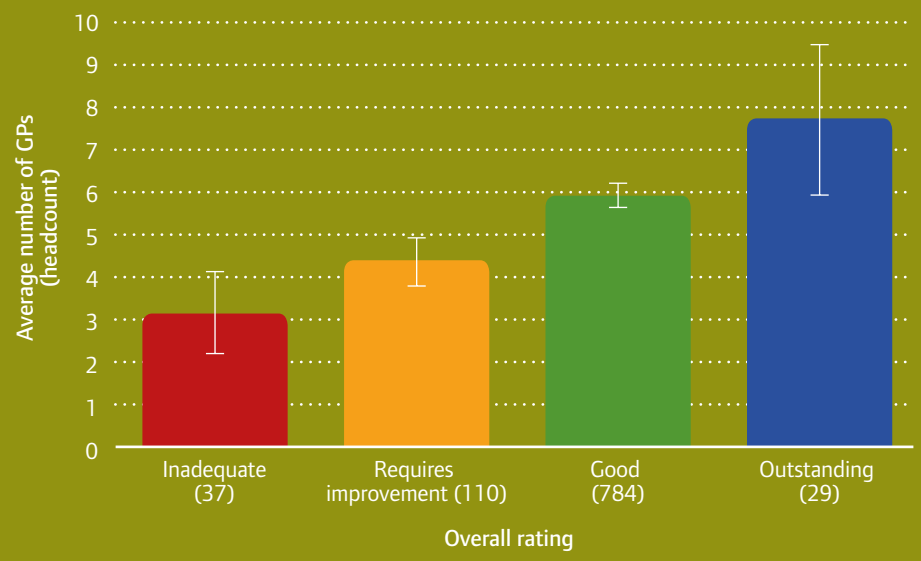
We have analysed GP practice ratings by locality and demographics and by organisational aspects such as staff, numbers of patients and financial data. The factors most strongly associated with a better rating included a higher percentage of patients who would recommend the practice (according to the GP Patient Survey), and a higher number of GPs in the practice (figure 2.25).

Ratings for population groups

Through our ratings, we are starting to look at the quality of services delivered to patient groups. Using six population groups, we want to make sure that our inspections include the quality of care delivered to different types of people, especially those who are particularly vulnerable.

Overall, our inspections show that GP practices typically provide good services to their population groups (figure 2.26). We have not yet carried out

Figure 2.25 GP practice ratings and number of GPs in each practice



Source: CQC ratings; GP Patient Survey 2014
Note: We have so far rated only a minority of services. We have produced 95% confidence intervals for the average values by rating, as these values will fluctuate until all services have been inspected. The error bars in each chart show the width of these confidence intervals. If the confidence intervals do not overlap then the differences between the values are statistically significant.

Inadequate Requires improvement Good Outstanding

Findings from GP practices rated outstanding

The striking feature of outstanding practice is the breadth and diversity of the different examples we observe. We see a wide variety of initiatives that demonstrate:

- Effective leadership, manifested in a strong shared vision among practice staff, effective staff training and support, and a positive patient-centred culture.
- Effective working with multi-professional colleagues, including those from other organisations.
- Extra services that are empowering patients to self-manage long-term conditions and acute minor illnesses.
- Support for patients and carers with their emotional needs (for example, coordinating support groups) and close working with the community to raise awareness of health conditions and contribute to community wellbeing programmes – such as walking groups and social enterprise programmes.

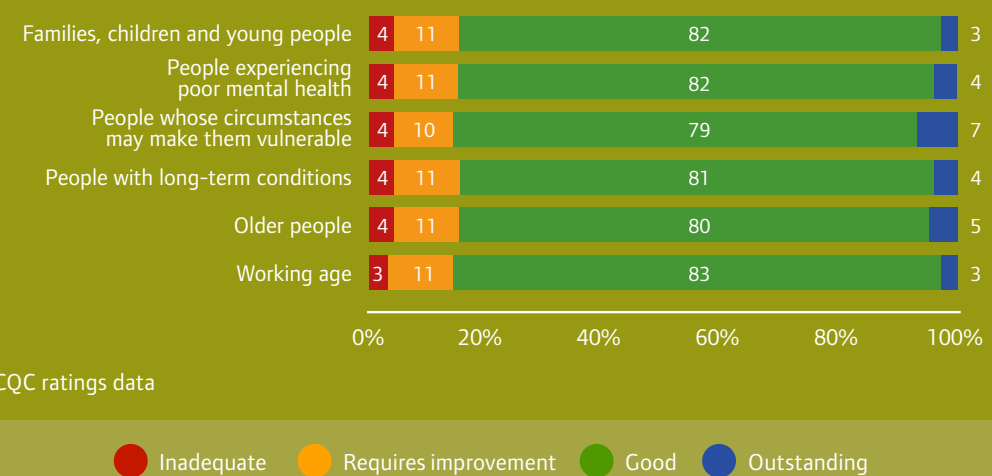
In July 2015, we published our online examples of outstanding care in GP practices. These have been well received (all respondents to an online survey agreed the web tool is useful, with two-thirds reporting it is very useful). We encourage all primary care services to use the tool for learning and improvement opportunities.

Findings from GP practices rated inadequate

From our inspections we find that inadequate practice tends to reflect an absence of important systems or processes and poor outcomes for patients. Practices rated inadequate typically demonstrate:

- Weak leadership and a chaotic and disorganised environment.
- Isolated working – not working closely with other local services to share learning and provide a wider mix of services.
- A lack of vision for the organisation and clarity around individuals' roles and responsibilities.
- A poor culture of safety and learning (for example, a lack of significant event analysis or learning from complaints), poor systems for quality improvement, including quality audit, and limited examples of assurance of the quality of clinical care.
- Disregard for HR processes (for example, Disclosure and Barring Service checks).
- Unsafe medicines management.
- Limited access to advice and treatment.
- Lack of practice nurses or very low number of practice nurse sessions.

Figure 2.26 GP population group ratings



Source: CQC ratings data

enough inspections to determine whether there is any particular variation of ratings between different groups. We did, however, find that in areas where there is a large number of people in one particular population group (for example, older people), some GP practices had done more to adapt their services to the specific needs of those patients.

Between May and July 2015 we surveyed 19 GP practices who have a high density of asylum seekers in their population. We captured the awareness of staff about the needs of asylum seekers, who often have significant physical and mental health needs. Around half of all staff surveyed showed a general lack of awareness of the healthcare needs and rules regarding the care of asylum seekers.

The main barrier to effective care was language differences and access to interpretation services. Clinicians often did not feel confident in the ability of interpreters to accurately convey patient histories and explain diagnoses. They also said they need more guidance and support in referring asylum seekers to specialist services, such as for survivors

Examples of GP services adapted to specific needs

Population group	Example
Working age people	Offering appointments before 8am, after 6.30pm and at weekends. One practice set up a sexual health clinic that ran on Wednesday evenings and Saturday mornings. The service was available to the whole community – not just patients of the practice.
People with long-term conditions	Educating patients to self-manage their long-term conditions more effectively and providing additional services that usually require a hospital visit. For example, managing intravenous lines used for prolonged treatments such as chemotherapy, long-term antibiotics and intravenous feeding.
People whose circumstances may make them vulnerable	Being flexible in their approach to vulnerable people by offering longer appointments, and allowing homeless patients to register at the practice using the practice address as their 'home' address.
Poor mental health	Working collaboratively with local mental health services and improving access to psychological therapies and substance misuse services. Also helping patients with mental illnesses to access high-quality, better coordinated care outside of hospital and therefore improving the number of patients being cared for in the community.
Older people	Managing beds in a care home that led to a reduction in hospital admissions and the number of days many older patients remained in hospital.
Families, children and young people	Offering information in age-appropriate formats for young people and ensuring staff are well-trained on local safeguarding processes. In one practice the nurse practitioner offered a texting service for young insulin-dependent diabetics. Teenagers were able to text their blood test results to the nurse practitioner if they had any concerns about managing their diabetes.

of sexual violence and torture. The complexity of managing this patient group raises concerns that clinicians are struggling to provide appropriate care under the confines of a standard 10-minute consultation.

Ratings for the five key questions

In the vast majority of cases, the services provided by GP practices are caring and responsive to people's needs. Ninety-six per cent of services were rated good or outstanding for caring, and 93% for responsiveness (figure 2.27). This latter figure reflects the fact that services are typically organised to meet the needs of their patients, and they commonly try innovative and effective ways to improve access to services and provide additional support for particular patient groups.

Where we do see inadequate care, this is often driven by poor safety or leadership ratings. Six per cent of the services we rated were inadequate for safety, and 4% were inadequate for well-led.

Safe

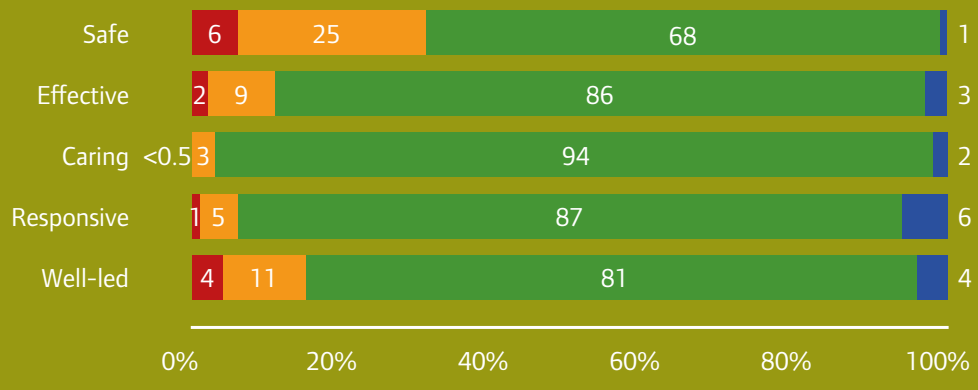
Of the services we rated up to the end of May 2015, 69% of GP practices and GP out-of-hours services were good or outstanding in terms of safe care. The most common theme underpinning safe practice is significant event analysis (SEA). We have seen evidence that most practices discuss and share their learning from SEAs with the multi-disciplinary team and external bodies such as the clinical commissioning group and other local GP practices.

However, we have concerns that incident reporting is not routinely carried out and often lacks the detail required.

In February 2015 a new GP e-form was launched as part of the National Reporting and Learning System. Approximately 100 practices are using it to report patient safety incidents for local and national learning. We encourage all practices to adopt it and we expect, in the near future, to see a significant improvement in the number of incidents being reported.

Although many practices are providing safe care, safety overall remains our main concern. Of the 976 services we rated, 25% required improvement and 6% were inadequate for this key question.

Figure 2.27 Primary medical services ratings by key question



Source: CQC ratings data

Inadequate | Requires improvement | Good | Outstanding

We have found a range of safety issues that show a general lack of system and process, meaning risks are not properly monitored or assessed. For example:

- Insufficient evidence of risk management and learning from incidents, including as mentioned above, the completion of incident reports.
- Poor responses to patient complaint letters and a failure to act on the issues raised.
- Lack of effective and timely safeguarding training.
- Poor infection control procedures.
- Poor practice with the condition and storage of emergency equipment and the management of medicines is not satisfactory.
- Fridges at the wrong temperature, insufficient emergency drugs and expired medicines.
- Poor recruitment processes, where services may have had policies in place to ensure that staff were recruited in a safe manner but in reality some services were not properly implementing these. This meant that staff were being recruited without proper checks such as the Disclosure and Barring Service.

Effective

The range of activities provided in general practice is increasing. Eighty-nine per cent of practices and services were good or outstanding for the effectiveness of their care. Our inspections have highlighted multiple examples of good, effective clinical practice, expanded to account for the needs of local populations.

We see practices focusing on good outcomes for patients through quality improvement programmes, coordinated referral processes and joined-up care with other healthcare providers. We also see

Quality and safety are the priorities

Orchard Court Surgery, Darlington

Orchard Court Surgery is an outstanding GP practice that has excellent systems in place to keep people safe.

Inspectors could see that the arrangements for reporting, recording and monitoring significant events were consistently used to improve practice. This included identifying trends and themes and taking action on, for example, medication, clinical assessment and consent, communication and confidentiality.

The whole team contributed to this approach. All safety concerns raised by staff and patients were taken seriously, used as learning and to improve the service provided to patients. Staffing requirements to meet patient needs were clear and staff received the training and support they needed to deliver a good quality service.

Inspectors commented that the practice had a clear vision, which had quality and safety as its top priority. High standards were promoted and owned by all practice staff and there was evidence of team-working across all roles.

evidence of innovative services tailored to the individual needs of specific population groups.

Practices have worked hard over many years to build and maintain strong working relationships with organisations such as schools, universities, and local fire and benefits advisory services. The practices then use these relationships to deliver enhanced services.

Over the last 10 years the number of single-handed GP practices has fallen dramatically. We are now seeing the benefits of larger practices and joined-up models of working. These include offering appointments to patients outside normal working hours by taking shared responsibility for extended accessibility, and providing a wider range of services than most practices are able to deliver on their own.

There are clear improvement opportunities for services rated below good and outstanding – in particular, for smaller isolated practices where collaborative working would be hugely beneficial.

Caring

We see significant examples where practices go the extra mile to involve and treat their patients with compassion, kindness, dignity and respect.

An inspector's view

"They were recording absolutely everything. A RAG (red, amber, green) rating system was in use, and 95% of incidents were green (no patient impact). The learning was clear and obvious."

The practices we rated as outstanding are able to demonstrate specific support for individual population groups, innovative programmes for certain health conditions and flexible access to services.

We rated two practices as inadequate for being caring – a very small number but wholly unacceptable. Our main concerns were based on feedback from patients who found staff to lack compassion and respect. We also observed poor concern for patients' privacy and dignity at the reception desk and waiting area in these surgeries.

Responsive

Typically, practices that are rated as outstanding consider the needs of their population and implement changes to improve the experience for their patients.

As demand for primary care grows, we have seen a sharp increase in the number of GP surgeries offering consultations over the phone and implementing telephone triage. In fact, 63% of GPs now believe that telephone consultations can be an effective replacement for face-to-face appointments.

Innovation in how primary care is provided is developing rapidly. We are increasingly seeing new channels opening up, such as Skype, providing access to a medical consultation through an online video chat facility. Three social enterprises are leading the way in terms of new models of provision to improve the health of vulnerable and excluded groups. They work closely with services across their locality and are generally very responsive to the specific needs of their patients.

Well-led

GP practices are generally well-led, with 85% of practices rated good or outstanding. The typical examples of outstanding leadership we see relate to the culture that practice leaders create, which manifest in excellent staff development and support.

When practices are well-led, their patients are placed right at the centre of their developments. As a result, these practices often have effective patient participation groups that are involved in multiple aspects of the practice's business, including influencing practice development and coordinating services.

Innovative and proactive

St Thomas Medical Group, Devon

St Thomas Health Centre is one of four practices in a group and is rated outstanding overall.

The practice provides primary medical services to approximately 15,500 patients living in Exeter – it is well-led and responds to patient need and feedback, showing innovative and proactive ways to improve patient outcomes.

For example, some patients with leg ulcers no longer have to travel to the other side of the city for treatments, because practice nurses have worked with the dermatology department at the local hospital, and they can now perform more complex dressings. This is over and above what is expected.

Patients also have access to a headache clinic and a vasectomy clinic on Saturday mornings. Patient feedback is consistently positive.

The health centre has nine GP partners plus four additional salaried GPs, 10 registered nurses, four healthcare assistants, a practice manager, and additional administrative and reception staff. They show mutual respect and teamwork is evident – and there are systems in place to monitor and improve quality and identify risk.

Strongly performing healthcare organisations place high importance on staff development. Many of the outstanding practices we inspect demonstrate their effective leadership by implementing special programmes to develop or support staff in their role.

Practices that are rated poorly for well-led tend to lack clarity in the roles and responsibilities for the day-to-day running of the practice. There are also often poor relationships between groups of staff and a lack of visibility of senior staff.

The role and capability of the practice manager appears to play a role in a practice's overall rating. The level of training and support for practice managers is important, as is supervision and good line management. We see examples of poor working relationships between GPs and practice managers and isolated working when trying to make improvements.

In our ratings of GP practices, where well-led was rated inadequate or requires improvement, there was on average a lower proportion of patients who, when surveyed by the 2014 GP Patient Survey, said they would recommend the practice to others (figure 2.28).

Other primary care services

Dental care

We carried out 714 inspections of primary dental care services in 2014/15. Over several years, we have found that, compared with other sectors, dental services present a lower risk to patients' safety. Our stakeholders also agree that the majority of dental services are safe and that the quality of care is good. Therefore, from 1 April 2015 we are carrying out comprehensive inspections at 10% of all practices based on a model of risk and random inspection, as well as inspecting in response to concerns.

Unlike other sectors that we regulate, we will not be rating primary care dental services. It would be unfair and a disadvantage to other providers to rate only the 10% of providers that we inspect. We are working jointly with the General Dental Council, NHS England, NHS Business Services Authority and Healthwatch England on the future model from 2016 onwards.

Figure 2.28 GP practice ratings and whether patients would recommend the practice

Source: CQC ratings; GP Patient Survey 2014
Note: We have so far rated only a minority of services. We have produced 95% confidence intervals for the average values by rating, as these values will fluctuate until all services have been inspected. The error bars in each chart show the width of these confidence intervals. If the confidence intervals do not overlap then the differences between the values are statistically significant.

Inadequate Requires improvement Good Outstanding

Health and justice

People in the criminal justice system have a higher rate of ill health than the general population and are reliant on authorities for their safety, care and wellbeing. In secure settings there is no choice of service provider. This makes monitoring, inspecting and regulating even more important.

We have recently introduced a new approach to inspection alongside HMI Prisons. We published our new inspection handbook in July 2015 after a period of consultation and piloting. Our pilot inspections included three prisons, a youth offending institution and an immigration removal centre. The new approach is now used for all inspections in these settings.

In August 2015, we published new registration guidance for healthcare providers in police custody suites (PCS) and sexual assault referral centres. The guidance helps providers understand when registration is required. The current regulations allow an exemption for services that are commissioned by police authorities. It is expected that, from April 2016, commissioning for PCS will transfer to NHS England and providers will need to register with CQC. We will work with the sector, HMI Probation and HMI Constabulary to develop the approach to inspection for these services.

Pilot inspection of an immigration detention centre

Yarl's Wood Immigration Detention Centre, Bedford

In April 2015 we piloted our inspection method with Yarl's Wood Immigration Detention Centre during an unannounced inspection by HMI Prisons.

Of all the areas in the centre, health care had declined most severely. There were severe staff shortages and women were overwhelmingly negative about access, quality of care and delayed medication.

Our inspection indicated that care planning for women with complex needs was so poor it put patients at risk. Also, the available mental health care did not meet women's needs and this made it particularly unacceptable that a number of women with enduring mental health needs had been detained.

The small enhanced care unit was located in health care and used to isolate women. It was effectively used as an inpatient unit although it was not commissioned, resourced or registered to be so.

Pregnant women had prompt access to community midwives and reasonable antenatal care, but inspectors saw two instances where abdominal pain in early pregnancy was not managed appropriately.

Pharmacy services were chaotic. We issued three requirement notices immediately following this inspection and will be checking that improvements have been implemented.

Source: HMI Prisons and CQC

Children's services

We review how health services keep children safe and contribute to promoting the health and wellbeing of looked-after children and care leavers. In 2014/15 our children's inspection team has done this in three ways:

- Over a two-year period the team has inspected the health service provision in 41 local authority areas. Inspections have been based on the identified risk within the health services in those areas and we have visited at short notice. At the end of each inspection we publish a report that makes recommendation to individual providers of services and the clinical commissioning group. We are reviewing all the reports to draw out the national findings and learning for services.
- During 2015 we have developed joint targeted area inspections with other inspectorates that will examine how well local authorities, health, police and probation services work together in a particular area to safeguard children. The new inspections will include a more in-depth look at elements of practice, with the first six inspections to focus on children at risk of sexual exploitation and those missing from home, school or care.
- The team also works with other parts of CQC to provide advice and expertise in relation to safeguarding children and services to looked-after children. This has included contributing to hospital inspections, responding to concerns at GP inspections and conducting a local area inspection jointly with the hospital team. This year we are extending our work in this area under the banner of Think Child, an initiative to integrate the inspection of children's safeguarding into the wider inspection of health services provided to children.

In 2015/16 the children's team will also be starting a five-year inspection programme with Ofsted looking at how local areas are meeting the needs of children with special educational needs and disabilities.

Continuous improvement

Windsor Surgery, Lancashire

Windsor Surgery in Garstang, Lancashire was rated good overall by CQC and inspectors found evidence of outstanding work in the way the practice meets patients' needs and strives for continuous improvement.

Staff and patients were involved in local forums to drive up standards. Changes in national best practice were shared and agreed between staff and supporting community teams.

In particular, the practice held meetings every week to improve how it delivered services. Many meetings included external professionals – and where appropriate, patients were invited.

Inspectors saw audits on care delivery and outcomes for patients with long-term conditions – the aim is to improve services. The practice nurses worked with community teams to avoid hospital admissions.

For any GPs returning from long-term leave, mentoring is available. This involved a named GP mentor, who provided reviews and consultations around any issues or concerns, and regular meetings to discuss progress and any additional breaks that might be needed.

Our challenge to the primary healthcare sector

- We want primary healthcare services to become the safest, the most effective and the most compassionate in the world. We need clinicians, whether in their own practice or if they work in a leadership position, to speak out and not tolerate care that is unsafe, ineffective or lacking compassion.
- We encourage all healthcare professionals to avoid professional isolation and work with colleagues in and out of their practice.
- We encourage providers to work together across organisational boundaries to reduce variation and improve the quality of care and the provision of more joined-up health and care services. We demand investment in strong, credible leadership at all levels in primary healthcare services.
- At practice level, we need visible leaders, both clinical and managerial, to oversee the running of their practice and develop plans in response to the needs of their local patients. The vision and values of a GP or dental practice are important as they highlight the organisation's strategic objectives. These have a powerful influence on the behaviours of staff at all levels. Leaders within practices must ensure the vision and values are shared by all staff.
- Safety incidents, both within the GP practice and externally, should be reported using the e-form for the National Reporting and Learning System, and a culture of learning embedded among staff.
- Practices should become active learning organisations, encouraging all team members to be engaged in quality improvement activities.
- GP practices should improve patients' access to their services. They should encourage and facilitate self-care, and respond to the needs of their patients by improving appointment systems and looking at different ways to make contact with healthcare practitioners available for different patient groups.

An inspector's view

"One recent practice that was very well-led. One of the reasons for this was staff engagement by setting up task groups – one for patients' services, one for finance, and one for HR and training, each group had one GP, one admin person and one nurse or healthcare assistant. They talked about ideas for the future, feedback from the whole team, and how they could improve in those areas, and they showed how they implemented those ideas."

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