Response to CQC's Strategy Consultation – closes at 17:00 on 04.03.21

Introduction to Londonwide LMCs

Londonwide LMCs represents GPs and their teams working in 27 of London's 32 boroughs. We represent approximately 1160 practices and over 6000 GPs, covering 9 million patients. We have substantial experience in supporting practices through the CQC inspection process and registration issues and have done a lot of work educating and informing practices about the CQC inspection regime. We feel we are well placed to contribute to this consultation and express views and experiences practices have shared with us.

1. **People and Communities**

The CQC's summary statement on this theme:

We want to be an advocate for change, ensuring our regulation is driven by people's experiences and what they expect and need from health and care services, rather than how providers want to deliver them. This means focusing on what matters to the public, and to local communities, when they access, use and move between services. Working in partnership, we have an opportunity to help build care around the person: we want to regulate to make that happen.

Our response:

We *mostly* agree with the proposals.

The ambitions are sensible and well placed. The issue is the lack of detail as the current proposals are very high level. While we absolutely support the focus on people and their needs, the involvement of communities and the specific intention to enable the voice of marginalised, disadvantaged etc people to be heard, we also wish to note the following:

a) People's "wants" vs their "needs" - it is important to keep in perspective the expectations from patients and the public and consider them in the context of the current health provider landscape and documented limitations of health services. Particularly in relation to GPs whom we represent, the CQC needs to be mindful of the financial and resource constraints within which GP practices operate, their continuously expanding workload, transfer of unresourced work from secondary care and the impact of these additional demands and the pandemic on the GP workforce. It is not always possible or realistic to respond to all patient expectations, nor is it required by the regulations or the GP contract.

There is also a problem for practices if as is often the case, patient expectations clash. The wish for access from some patients, for example, clashes with the wish for continuity of care from others. There is also the problem of some patients being more vocal others. This is not a simple problem and is best solved by local negotiation and communication between practices and their patients.

b) Obtaining and acting on patient feedback is paramount as this enables GP practices to better understand their patients' needs and expectations and make changes or improvements to their services as far as practically possible. However, the CQC should also make it a priority to listen to providers and their staff about the CQC's own regulatory processes, inspection regime and registration issues. It is essential for GP teams to receive written feedback from inspectors at the end of an inspection - may that be physical or remote - and there should also be a mechanism for practices to provide anonymised feedback to CQC on their inspection experience.

c) The consultation document places a significant emphasis on how providers and systems work together. While the patient journey and the interconnection between services is extremely important, the CQC needs to be clear about how it can actually implement regulation at system level when each provider is registered and regulated individually.

2. Smarter regulation

The CQC's summary statement on this theme:

We will be smarter in how we regulate. We'll keep pace with changes in health and care, providing up-to-date, high-quality information and ratings for the public, providers and all our partners. We'll regulate in a more dynamic and flexible way so that we can to adapt to the future changes that we can anticipate – as well as those we can't. Smarter use of data means we'll target our resources where we can have the greatest impact, focusing on risk and where care is poor, to ensure we're an effective, proportionate, and efficient regulator.

Our response:

We *mostly* agree with the proposals.

We fully support CQC's intention to move away from a rigid inspection regime into a more flexible, targeted and dynamic approach, which is built on positive relationships between providers and inspectors.

We wish to see regulation moving away from a tick box approach to a developmental one. As the CQC sees it as part of their role to enable and encourage quality improvement, we wish to see them offer support for learning and sharing best practice.

Specifically:

a) More frequent, meaningful and up to date ratings

Currently the regulations require a physical inspection to take place in order for a GP practice to receive an updated rating. Practices have told us that they are keen on being able to get re-rated even when they have a remote assessment, as they want their rating to reflect their current state of compliance and service delivery. The pandemic has significantly impacted the CQC's ability to conduct on-site inspections, therefore practices with Requires Improvement ratings who have worked hard to make the necessary improvements are unable to move to a Good rating until they are able to have another on-site inspection. The new proposals will enable ratings to be updated through alternative monitoring methods which do not require an on-site inspection.

Our regional CQC colleagues have told us that following inspections in November and December 2020, the vast majority of London practices in special measures were able to come out of special measures despite the pandemic, so we want our Requires Improvement practices to have the same opportunity to achieve a Good rating without the need for a physical inspection. Of course we appreciate that this means that practices whose performance has deteriorated may be at risk of getting down-rated, but the principle of current, up to date and meaningful ratings still remains.

b) Moving away from long inspection reports

We are fully supportive of this initiative and we believe that the Evidence Tables in reports are probably the best change the CQC has ever made in its report writing.

There is still quite a lot of repetition in inspection reports and also in warning notices. We wish to see Evidence Tables remaining and becoming even more targeted and concise and the narrative in the main report not being repetitive.

We also wish to see improved clarity in the ratings methodology and how the aggregation of outcomes under the different domains is used to reach a particular rating. We understand that the CQC is intending to move away from rating the 6 population groups and focus on the 5 key Domains, but we will comment on these proposals specifically as part of the other consultation the CQC is currently running on its regulatory approach.

c) Using high quality information and making smarter use of data

The intention is appropriate and welcomed, but we have concerns about its practical implementation. Practices are aware of the performance/achievement data which is publicly available about them from national sources (e.g. QOF, Patient Survey etc) or regional/local sources (e.g. CCG and hospital data) but there are issues around:

- The timeliness of data - national data sets can be up to 12 months out of date. Relying only on national and local data sources does not always give an accurate picture of the current state of play in practices. Every time we have asked CQC colleagues to consider using data directly from Open Exeter (the national payment system for GP practices) or practices' own clinical systems, we have been told that these are not "validated" data sets. This rationale and approach needs re-thinking as it is absolutely crucial that CQC makes use of the most direct, live and relevant data when assessing GP practices.
- Benchmarking - up until recently, evidence tables compared practice level data with CCG averages, national averages and also WHO thresholds. In the latest reports we have seen a move away from using WHO data, which is welcomed as it does not provide a meaningful comparative measure. Data needs to be contextualised and inspectors need to understand what lies behind the data, how each practice's patient demographics, culture and attitudes affect service delivery, as well as other practice specific factors like workforce etc.
- Public data sources are widely known, however there are other sources of information that CQC uses which provide "softer" intelligence, which may be from local commissioners, Healthwatch and other sources that practices are not always aware of. The clearer and more transparent the data sources are that CQC inspectors use, the more credibility the whole process will have and the more trust will be inspired in GP providers.
- Data needs to be triangulated and not used in isolation - we hope that this is what CQC means when it talks of "innovative use of data".

d) Appropriate registration for "future proofing"

We agree that the way providers are currently registered can be problematic, particularly in cases of at scale providers, providers holding multiple primary medical services contracts under overarching partnership structures, digital only providers etc. We would be happy to comment on specific proposals on how these different providers may be registered differently in the future.

It is also important to understand the CQC's intentions around holding systems to account. Systems are not registered as systems, individual providers within systems are registered in their own right, therefore it is important for CQC to articulate its plans for system accountability.

We also wish to see a clear process of registering providers who are being appointed as interim caretakers in practices as a result of CQC action, early retirement or death of a GP contractor etc. Speaking of caretaking providers, we also wish to understand CQC's approach in terms of inspection. For example, we know that significant changes in GP partnerships, practice relocations, or practice mergers tend to trigger an inspection, however we have not

seen the same rigorous approach being followed when it comes to caretaking providers taking over a practice whose registration was cancelled by CQC.

We also wish to see a clear, transparent and publicly documented approach to Fit Person interviews for GP partners who apply to become Registered Managers. The process of these interviews should be described in detail in a public guidance document and CQC should also provide feedback to partners who have been through this process as currently it does not.

We finally wish to see CQC encouraging, gathering and responding to feedback from providers for quality improvement and promoting the learning culture it advocates. The CQC should apply to its own organisation the values it advocates for others.

3. Safety through learning

The CQC's summary statement on this theme:

We want all services to have stronger safety and learning cultures. Health and care staff work hard every day to make sure people's care is safe. Despite this, safety is still a key concern for us as it's consistently the poorest area of performance in our assessments. It's time to prioritise safety: creating stronger safety cultures, focusing on learning, improving expertise, listening and acting on people's experiences, and taking clear and proactive action when safety doesn't improve.

Our response:

We *mostly* agree with the proposals.

We agree on the importance of an organisation's culture or ethos and the ability of staff to report concerns openly, confident that they will not be blamed. At the same time, we wish to highlight that this needs to be a genuine approach, which is implemented in the spirit it is intended and also applies to CQC as the regulator.

We have seen practices who have been open and honest about failures or challenges being criticised heavily in reports and we have also seen disgruntled staff making unfounded allegations to CQC inspectors which have not been checked and cross referenced, resulting in damning reports and adverse ratings.

The culture of learning through mistakes needs to be instilled in all parts of the NHS for practices and their staff to have the confidence to come forward about safety mistakes or near-misses.

We note the CQC's intention to address systemic safety issues and "speak out" about them. Again, it is important to understand how the CQC is going to discharge its regulatory function when it doesn't regulate systems as a whole. Systems are not just made up of providers, they also include commissioners and the CQC does not regulate commissioners. To be able to inspire trust in this process, GP providers need to have confidence that when they raise systemic issues which may involve their local hospital trust provider, local commissioners etc, that effective action will be taken by CQC. This kind of assurance will be incredibly important to GP providers.

4. Accelerating improvement

The CQC's summary statement on this theme:

We will do more with what we know to drive improvements across individual services and systems of care. We'll use our unique position to spotlight the priority areas that need to improve and enable access to support where it's needed most. We want to empower services to help themselves, while retaining our core regulatory role. The key to this is by collaborating and strengthening our relationships with health and care services, the people who use them, and our partners across health and care.

Our response:

We *partly* agree with the proposals.

We always support the need for GP practices to improve where it is necessary and in accordance with the relevant regulatory and contractual requirements they are bound by.

We also appreciate the importance of collaboration and support when it comes to quality improvement.

Having said that, we believe it is important for the CQC as the regulator to recognise that it is not realistically possible for any provider to continue to improve perpetually, for standards to continue to be raised and for expectations to continue to increase.

The consultation document states that "what was considered good a few years ago is not good enough today and what is good today won't be good enough in the near future. People have higher expectations about safe, high quality care - and so do we".

As we mentioned earlier in our response, it is important that expectations are reasonable and are managed appropriately. GP practices do not have infinite budgets, expanded workforce, state of the art premises, or manageable workloads. The demand on practices is ever increasing, the financial envelope ever shrinking and performance management more pressurising than ever. We hope that the CQC as the regulator will consider these very real constraints as valid parameters in their assessment of practices and in the standards it sets for them.

Thank you for considering our response and we look forward to seeing the outcome of the consultation.

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