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Inspecting General Practice in England: Outcomes from the First 2000 Practices

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Abstract

England is the first country in the world to be comprehensively inspecting General Practice. The Care Quality Commission (CQC) has been independently inspecting and rating General Practice in England with a new comprehensive methodology, including out-of-hours services, since October 2014. The CQC have so far inspected over 2000 GP practices in England, amounting to a quarter of all practices. We have found that the vast majority (83.6%) are providing good or outstanding care, 12.2% require improvement and 4.2% have been rated as inadequate. Whilst poor quality care is an exception, the practices rated so far as inadequate we have estimated to have responsibility for over 441,000 patients. Although the data demonstrates some geographical variation, particularly in London, the trends are similar across the country. We discuss the findings of the first 25% of comprehensively inspected GP practices in England.

Keywords: Health care; Care quality; Outcome research

Introduction

England is the first country in the world to be comprehensively inspecting General Practice. The Care Quality Commission (CQC) has been independently inspecting and rating General Practice in England with a new comprehensive methodology, including out-of-hours services, since October 2014. By the end of 2016, the CQC will have inspected every registered GP practice in England.

In 1997, The Government's White Paper, The new NHS (1997) [1] concluded that the NHS was providing care of variable quality and had been slow to respond to poor standards of care. Until then, there had been no national policy spanning all aspects of quality and safety of health care provision. The Commission for Healthcare Improvement (CHI) was established by the Health Act, 1999 [2] to provide guidance on clinical governance to NHS providers. In 2003, together with the National Standards Commission and the Audit Commission, the CHI was incorporated into the Healthcare Commission. The Healthcare Commission inspected NHS providers by assessing their performance against national standards and made recommendations where performance was poor.

In a bid to improve consistency in regulating health and social care services, and reduce the number of regulatory bodies, further reforms took place. The CQC became operational in 2009, which brought together the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection. It is now a legal requirement for certain providers of health and social care in England (including NHS providers, foundation trusts and independent providers) to register with the CQC. Although the CQC started inspecting primary care in April 2013, they dramatically changed their methodology to comprehensive inspections in October 2014, after a period of piloting. The drive for this change was to shift the focus from being purely compliance-led to making informed, evidence-based, proportionate judgements about the overall quality of care provided by a GP practice.

The CQC's purpose is to ensure that services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve. They deliver this by monitoring, inspecting and regulating services to ensure they meet fundamental standards of safety and quality. As guided by legislation set out in the Care Act 2014 [3], they publish what they find so that patients are fully informed about the standards of care of their local services.

To date the CQC have inspected over 2000 practices, or a quarter of all primary care providers in England. They intend to have inspected every practice in England by the end of this year.

Defining out-of-hours

GP out-of-hours services are primary medical services offered for patients with urgent needs that cannot wait until their GP practice is open again. The out-of-hours period in England covers:

- Weekdays, from 6.30 pm to 8 am the following day.
- Weekends, starting at 6.30 pm Friday through to 8 am the following Monday
- All bank holidays

GP out-of-hours care changed substantially when a new contract introduced in April 2004 allowed GPs to opt out of responsibility for providing out-of-hours care to their patients, transferring responsibility instead to their local primary care trust (PCT). Whilst some GP practices retained responsibility, the majority opted-out. GPs working in other out-of-hours services are usually GPs from local GP practices, dedicated out-of-hours GPs and locum doctors. When the CQC refers out-of- hours providers, they are not referring to GP practices providing out-of-hours appointments (referred to as extended-hours) to their own patients.

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Methodology

Inspecting teams use professional judgment, supported by well-established objective measures and evidence, to assess GP practices against five key questions, i.e., are they

- Safe?
- Effective?
- Caring?
- Responsive to people's needs?
- Well-led?

For every NHS GP practice they also look at the quality of services provided to people in six specific population groups outlined in Figure 1.

When awarding ratings for the five key questions and the six population groups, inspection teams review the evidence gathered against key lines of enquiry [4] (KLOEs) and use guidance to decide on a rating. The evidence comes from four sources: local feedback and concerns from the local Clinical Commissioning Group (CCG) and other local services, CCG-level and national data such as Quality Outcomes Framework (QOF), pre-inspection information gathering and the on-site inspection visit.

Inspection methodology

An inspection visit usually lasts one day and is made up of an inspection team. The team is led by an inspector and almost always include a GP. It may include other specialists such as practice managers or nurses. Teams often also include "Experts by Experience", who are people who use (or care for someone who uses) a GP service. Their main role is to talk to people who use services and feedback to the team.

Throughout the day the team gathers the views of people who use services as well as staff working in the practice. Other methods include pathway tracking patients through their care and reviewing patient records, operational policies and supporting documents.

To direct the focus of their inspection, the inspection team uses a standard set of key lines of enquiry (KLOE) that directly relate to the five key questions – are services safe, effective, caring, responsive and well-led? Each KLOE is accompanied by a number of questions that the team will consider as part of the assessment, called prompts. The inspector will take into account the information gathered in the preparation phase and the evidence they gather during the inspection to determine which aspects of the KLOE they should focus on.

Population Group	Description
Older people	This group includes people in the practice population who: • are aged 75 and over • have good health or those who have one or more long-term physical or mental health conditions • are living at home, in a care home or a nursing home, where a practice provides general medical services to these people. For this population group, an inspection will focus on the role of the GP practice in developing a proactive and personalised programme of care and support, which is tailored to the needs and views of older people registered with the practice.
People with long-term conditions	People with long-term conditions are those who have an ongoing health problem that cannot be cured, such as diabetes, cardiovascular disease, musculoskeletal conditions, COPD, long-term neurological disorders, HIV, and cancers.
Families, children and young people	This group includes babies, children and young people (aged under 18). It also includes services for new and expectant parents, such as prenatal and antenatal care and advice.
Working age people	This includes all people in the practice population who are of working age and those recently retired (up to the age of 75). Working age includes adults up to the age of 75 regardless of employment status and includes students aged 18 and over. Inspections focus on how people in this group are able to access appointments and services at the practice.
People whose circumstances may make them vulnerable	A number of different groups of people may be included in this group because they live in particular circumstances that may make it harder for them to access primary care, or mean they are more at risk of receiving poor care. The focus during an inspection will depend on the practice's population, however this always includes: • People with a learning disability. • People who are homeless. It may also include travellers, vulnerable migrants and sex workers. The focus is likely to include registration with a practice, and the ability to book appointments and receive services for people in these groups.
People experiencing poor mental health	This includes the spectrum of poor mental health, ranging from depression to severe and enduring mental illnesses, such as schizophrenia. It also includes people who have dementia.

Figure 1: Population groups and their descriptions. Amended from the CQC's GP Provider Handbook appendices [4].

Rating judgement methodology

Practices are given an overall rating of either "good", "outstanding", "requires improvement" or "inadequate". The CQC has developed characteristics [4] to describe what these judgements look likes for each of the five key questions. The characteristics provide a framework which, together with professional judgment, guides the inspection teams when they award a rating. Practices are also rated at three other levels (Figure 2).

By rating at these levels the CQC intends to reflect the complexity of general practice, creating a matrix of 42 ratings for each practice. They use this to aggregate a rating for each of the five key questions, each of the six population groups, and provide an overall aggregated rating. An example of what this matrix looks like has been demonstrated in Figure 3. When aggregating ratings, inspection teams follow a set of principles [5] to ensure consistent decisions. An example would be where two key questions have been rated as inadequate the aggregated rating is normally limited to inadequate. Whereas the aggregated rating is normally limited to requires improvement where one of the underlying ratings is inadequate.

The links between KLOEs, the evidence gathered under them, and the rating judgements are central to an approach that ensures consistent judgements on the quality of care.

Any practice across the country that has been rated as inadequate or outstanding in any population group or key question has its report reviewed at a National Quality Assurance Panel to ensure consistency of judgements.

Special measures

Practices that are rated as inadequate overall are put in "special measures" which is a framework designed to allow practices to access support to improve and to make patients, providers and commissioners aware that we have serious concerns. The special measures framework allows the CQC to work together with other organizations in the system to ensure a coordinated response to inadequate practices. It also provides a clear timeframe (6 months) within which providers must improve the quality of care they provide or the CQC will use their enforcement powers to seek further action. Rarely this has meant cancelling their registration.

A risk-based approach

It is important to note that during the first year of inspection (October 2014 to October 2015), the CQC prioritized inspecting practices for which they had some data suggesting there were more likely to be concerns or risks about the quality of care provided. It was therefore predicted that as the inspection programme continued, we would see the distribution of ratings change. However, interestingly since the approach became no longer risk-based, the proportion of outstanding and inadequate ratings has not changed significantly on a month-by-month basis.

Results and Discussion

On 20 November 2015, the CQC had published 2119 (of 8365) comprehensive GP and out-of-hours inspection reports with ratings in England. This represents one quarter of total providers. The breakdown of ratings is displayed in Figure 4.

The vast majority (79.5%) have been rated as good overall, with 4.1% outstanding, 12.2% requiring improvement, and 4.2% rated as inadequate. The 90 providers rated as inadequate are estimated to have responsibility for over 441,000 patients.

Figure 5 illustrates the aggregated ratings for each key question (Level 3 in Figure 2). As for the overall ratings, the majority of practices are rated as good in each key question. Practices are most likely to be rated good for "caring" (94%), and least likely for "safe" (66%). Similarly, practices are most likely to be rated inadequate in "safe" (6%), and least likely for "caring" (0.6%). There could be many factors that explain these trends. Safety is high on the priority list during inspections. Many of the regulations that inspectors review during an inspection are directly related to safety, and if there are any significant breaches on these regulations, the practice is unlikely to be rated as good for the safe key question. Although the caring key question is assessed in many ways on inspection, the inspection team will always collect the views from patients, who often experience their practice as caring, even where safety and quality of care might have been raised as significant issues.

As per previous analyses, the highest prevalence of outstanding practice was in the "responsive" key question, which may reflect the fact that practices can be particularly innovative in how they address issues specific to particular patient groups [6]. It is hardest to receive an outstanding rating in safe, which largely reflects the difficulty for practices in demonstrating that they are going above and beyond what is expected in this area.

The key question which is most closely associated with the overall rating is "well-led". By well-led, the CQC means that the leadership, management and governance of the organization assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture. Indeed all the practices rated as inadequate overall, were rated inadequate in well-led [7].

Figure 6 breaks down the ratings by four geographical areas in England, the borders of which are largely historical but also represent the areas of responsibility of the four Deputy Chief Inspectors at the CQC. This has been illustrated in graph format in the map in Figure 6.

Although fewer providers have been rated so far in London compared to the rest of the country, the CQC are seeing proportionately more ratings of inadequate and requires improvement in the capital, as demonstrated in Figure 7. There is statistically significant geographical variation in provider ratings across the four regions (Chi-square contingency test: χ^2=34.7, P<0.0001). In particular, in London there were significantly more than the expected numbers of practices rated inadequate (Observed=20, Expected=12) or requires improvement (Observed=52, Expected=35) using Chi- square contingency test. There were also significantly fewer than the expected number of practices rated as requires improvement in the North region (Observed=51, Expected=82).

At this point, the results from the London region do deviate from the rest of the country. The CQC are not the first to describe significant variation in the quality of care and outcomes in London [8].

Level 1	Rate each population group for each key question
Level 2	Aggregated rating for each population group
Level 3	Aggregated rating for each key question
Level 4	Aggregated overall rating for the practice as a whole

Figure 2: Levels of rating.

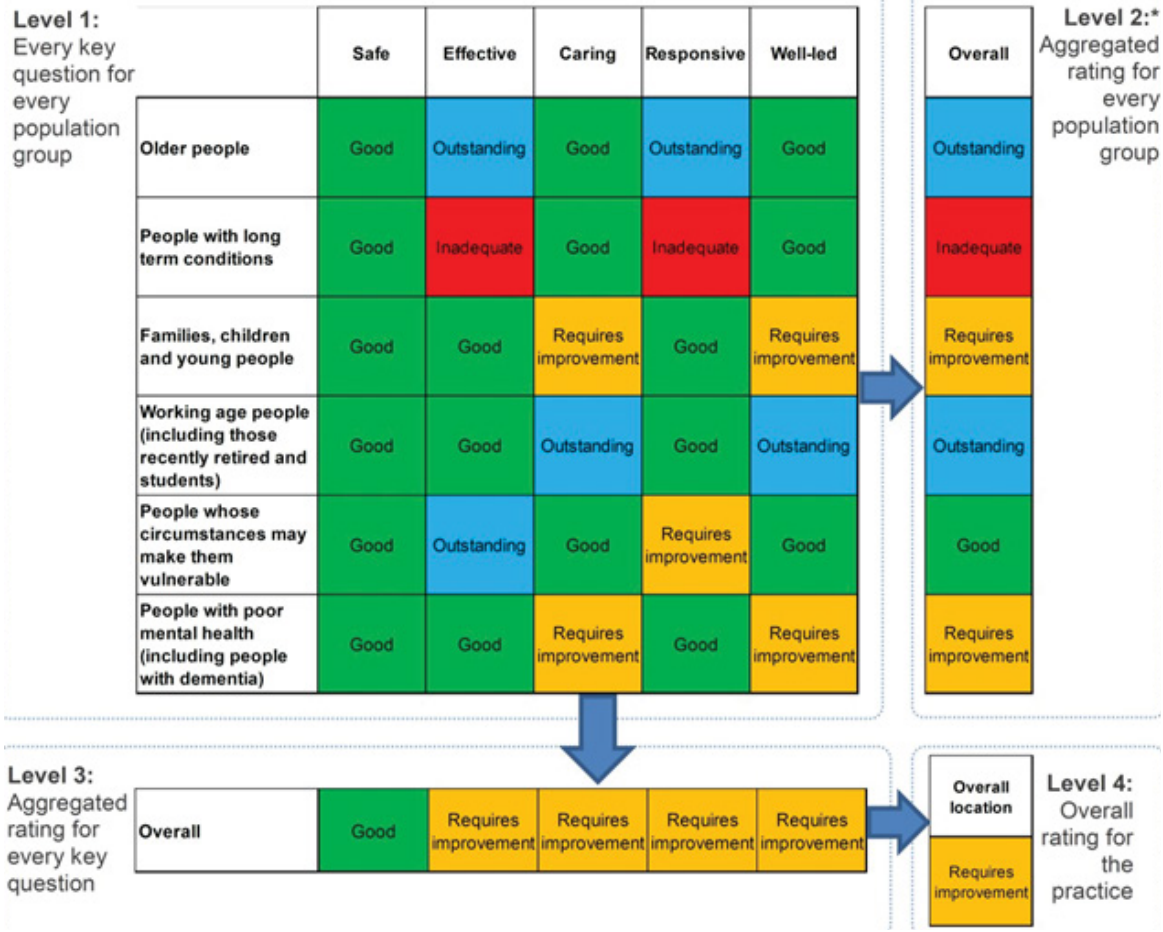

Figure 3: The 'matrix' of ratings and how ratings are aggregated. This is an illustrative example only from CQC's GP Provider Handbook [5].

Inadequate	Requires Improvement	Good	Outstanding
90	258	1658	86
4.2%	12.2%	79.5%	4.1%

Figure 4: Summary of ratings (1st October 2014 to 20th November 2015).

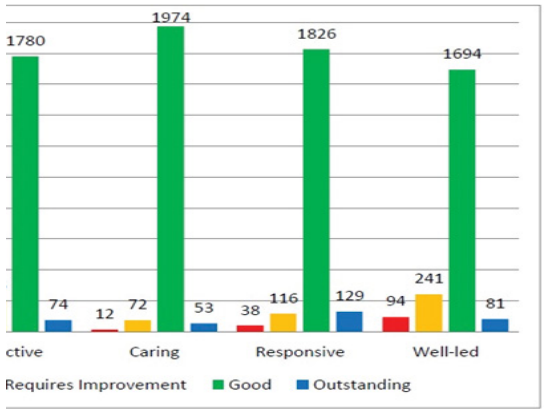

Figure 5: Overall rating by 'key question' for all providers (1st October 2014–20th November 2015).

	Total	North	South	Central	London
standing	86	30	21	27	8
Good	1685	570	434	477	204
Requires ovement	258	51	74	81	52
dequate	90	24	19	27	20
TOTAL	2119	675	548	612	284

Figure 6: Table of ratings by geographical area (1st October 2014 to 20th November 2015).

General Practice in London has long been considered to face more challenges than elsewhere in the country: its population is more diverse, more transient and is growing faster than anywhere else in England. However, it is important to note that the CQC are early in their inspection programme, so the picture is far from complete. We will be able to say more about the quality of primary care in the capital once all practices have been inspected later this year. Additionally, the

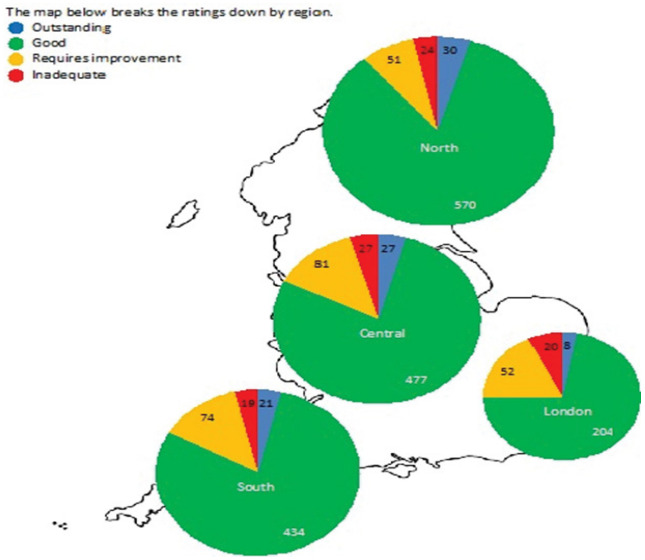

Figure 7: Geographical representation of 2119 overall inspection ratings over 4 regions in England (1st October 2014 to 20th November 2015).

CQC have not yet inspected all practices in other large urban cities in England that face similar challenges to London, or analyzed how their performance compares with the capital.

Special measures and cancellation

There are currently 81 practices (3.8% of those inspected so far) in England in special measures. The discrepancy between this number and the 90 inadequate practices rated so far reflects the change in the entry criteria after the new model of comprehensive inspections began. Initially practices with only very significant concerns entered special measures, whereas since January 2015 all practices rated as inadequate are put in special measures. So far 3 practices have demonstrated improvement in the quality of care they provide and have been removed from special measures. They are now rated as either requires improvement or good. The majority are yet to be re-inspected. The hope is that the CQC will continue to see significant improvements when they return to re-inspect practices in special measures.

The CQC have had to take action to urgently cancel or suspend the registration of 12 GP practices since October 2014 to protect patients from the very worst standards of care. This accounts for just 0.14% of providers inspected so far, a very small proportion of providers.

Conclusion

The CQC are a quarter of their way through comprehensively inspecting all of General Practice in England. Their new methodology involves rating practices, the vast majority of which are providing good or outstanding care. However a minority have been rated inadequate, most of which are still in special measures which allows practices access to support and gives transparency to the public.

There has been a larger proportion of poorer care seen in London compared to the rest of the country, but with 75% of practices still to be inspected, this picture is evolving. It will be important to analyze the extent to which applies to other urban-rural comparisons across the country.

Once the CQC have the ratings from all of general practice (including out-of-hours) providers in England, we will have a comprehensive picture on the state of primary care in England. In the meantime the CQC continues to identify the poorest level of care, champion examples of good and outstanding care [9], and encourage improvement right across the spectrum of quality of care.

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