Leicester City Clinical Commissioning Group

Report on Care Quality Commission (CQC) inspections of GP practices

January 2018

Summary

1. Fifty-one out of fifty seven general practices in the city have received a CQC inspection under the current CQC inspection regime.

2. The current situation is that 1 practice is rated as outstanding, 43 practices rated good, and 7 practices require improvement. The CCG is pleased with the results to date, which benchmark well against other ‘peer’ areas with England.

3. The CCG has a process in place to support practices that may require improvement and to share learning across all city CCG general practices. This has helped a number of practices make significant improvements where needed.

Background

4. GP practices have been part of the CQC inspection regime since 2013. Following a review of inspections carried out, the CQC introduced a new higher level inspection regime for GP practices during 2015. To date over 900 GP practices across England have been visited under this enhanced level of inspection.

5. There are 57 practices in Leicester City and so far 51 have been subject to an inspection.

6. Registration with the CQC is a mandatory requirement for any provider of primary medical services, underpinned by legislation, as well as being contractually mandated.

7. Practices are required to register the services they provide and to nominate a registered manager who is responsible for ensuring that CQC standards are met and maintained.

8. If practices fail to maintain registration, or fail to notify CQC of any changes to the registered manager or clinicians, they are liable to legal action or fines.

9. The CQC has the ultimate power, if services are found to be sufficiently poor, to close a practice down.

Inspection regime

10. Where inspections are announced practices will usually be given two weeks’ notice. During this time the practice will be asked to complete a Provider Information Return (PIR). This includes information such as their statement of purpose, and information about complaints received from patients or any serious incidents. The CQC will send the practice a supply of ‘comment cards’, which they need to make available to patients so they can also share their views with the inspection team.

11. Unannounced visits will take place if the CQC has any concerns about a practice or if they are responding to a particular issue or concern. As the name suggests, practices have no advanced notice of this type of inspection.

12. Each inspection team is led by a CQC inspector or CQC inspection Manager and may also include additional expert advisors. This can include a clinician (either a nurse or doctor), experts by experience or other specialist advisors, e.g. practice managers.

13. The practice is asked to ensure that at least one clinician and the registered manager are available on the day of the inspection. The practice will generally present an overview to the inspectors first. Following this, the individuals then continue with the inspection with each looking at specific areas with the relevant nominated member of staff.

14. The inspection days are normal days for the practice. This means that they continue work seeing patients during the visit. The clinical practice staff, such as GPs or practice nurses, should be available for an in-depth interview with inspectors if needed, and this can be up to an hour long. The inspectors will also often ask to speak to non-clinical staff (such as receptionists or administrative staff) for a shorter interview.

15. The CQC will usually ask to meet a representative from the practice's patient participation group. This individual will be interviewed by either the expert by experience or inspector in order to give a patients' perspective of the practice and the services that it provides. Patients attending the practice on the day may also be asked for their views of the surgery.

16. Once they have concluded the inspection, the inspector will offer the practice some initial informal feedback on what they have found. However, this is not necessarily representative of the final report as the CQC will consider further findings and information.

17. A draft report will then be written by the CQC which will go through its quality control and assurance mechanism. Following these quality assurance checks, the CQC will send the practice a draft report for a factual accuracy check. Once this is completed the final report is published on the CQC website. This can take a number of months from the date of the initial inspection.

18. The report may have a number of actions identified. If so, these are contained within the report and are defined either as areas the service *must* improve or areas the service *should* improve. If the areas of concern are sufficiently serious and may cause harm to patients then the practice is issued with an improvement notice. This means that the practice is legally required to undertake the improvement within the stipulated timescales. Timescales vary depending on the nature of change and improvements required but are typically in the region of two to three months.

What is assessed?

19. There are five key questions that the CQC asks about services at an inspection visit. These are:

    - Are services safe?
    - Are services effective?
    - Are services caring?
    - Are services responsive to patient needs?
    - Are services well led?

20. These questions are then broken down during the visit to form key lines of enquiry, or KLOEs. These focus on those areas that may need further investigation. Generally these are determined on a case-by-case basis and depend on any issues uncovered during the course of an inspection.

21. In addition the inspectors look at services for six population groups and rate those as well. The six population groups are:

- Older people
- Families, children and young people
- People with long term conditions
- Working age people
- People whose circumstances make them vulnerable
- People experiencing poor mental health.

22. It is important to recognise that any inspection is undertaken at a point in time with inspectors assessing what they see and hear on the day. Additionally, the CQC has powers under the Health and Social Care Act 2008 to access medical records for the purposes of exercising their functions (which includes checking that registered providers are meeting the requirements of registration).

Assessment and practice ratings

23. Practices are rated Outstanding, Good, Requires Improvement or Inadequate against each of the five key questions as well as for services provided to each of the population groups. These scores are then aggregated to provide an overall rating for each practice.

24. The following table provides a numerical break down of the overall ratings for practices so far inspected within the Leicester City CCG area. Appendix A provides a breakdown for all general practices that have been inspected and for whom the results are currently publicly available.

Rating	Number of practices
Outstanding	1
Good	43
Requires Improvement	7
Inadequate	0

25. It should be noted that this number is not static and does fluctuate as practices are re-inspected, CQC inspection reports are archived by the CQC or there are contractual change within the general practice. For example, this may include if a new provider takes over the running of the practice as has been the case with a number of city practices over the course of the last three months.

26. It is recognised that the vast majority of GPs do their utmost to provide the best possible care and, whilst there is always room for improvement, we are pleased with the outcomes of inspections to date. It is reassuring to note the high percentage of practices rated as ‘good’ and the increase in a good rating at re-inspection for those practices that required improvement or were inadequate. The CCG will continue to support practices to provide high quality services for patients.

27. The following table highlights the overall rating at first inspection for Leicester City general practices compared to the national data. While the city has slightly fewer

outstanding and good rated practices than the national average, it also has fewer inadequate practices. It should also be noted that the city benchmarks well against other similar cities in the country in which health need is likely to be higher and services in greater demand than in more rural and affluent areas.

First inspection	Outstanding	Good	Requires Improvement	Inadequate
National (May 2016)	4%	79%	13%	4%
Leicester City CCG	1.96%	74.5%	21.5%	1.96%

28. There are currently 6 general practices which have not yet been inspected. These are:

- Asquith Surgery
- Leicester City Assist practice
- Shefa Medical practice
- Bowling Green street surgery
- Walnut Street Surgery
- Heron Medical Practice/St Matthews Medical Centre.

29. No inspection date is yet known for these practices. It is worth noting that three of these practices have recently undergone a procurement process and are under new management as of 1st October 2017, while a further practice will be under a new provider from 1st February 2018.

Supporting general practices following CQC inspection

30. The CCG has a process in place to review all general practice CQC inspection reports when they are issued. Key Governing Body members are provided with a summary of all reports issued and they are also on the agenda at key CCG meetings such as its Risk Sharing Group. Appropriate and proportionate action is determined following review by the CCG teams at an operational group. This may include a meeting with the practice to explore particular issues or, where the inspection has been successful, sending a letter of congratulations.

31. Where themes are identified from the reports these are highlighted to all practices in various ways. This includes, for example, at protected leaning time events (which bring together all City GPs), in our practice level newsletters or other appropriate meetings. This process also includes the sharing of identified areas of good practice.

32. Themes from CQC inspection reports in the city have changed over time. For example, two years ago a common theme was around risk assessments and in particular lack of risk assessment for legionella.

33. Following an intensive awareness campaign by the CCG, we now rarely see the lack of a legionella risk assessment as an area for improvement. More recently themes are around the need to improve systems for the identification of carers, the need to establish effective systems to review and update procedures and guidance with a view to ensuring that information reflects the current requirements of the practice, and to continue to monitor patient satisfaction results in relation to the issues highlighted in the national GP patient survey.

34. Some reports show that processes do exist but are inconsistent in implementation. For example, reports highlight systems in place to identify the training needs for staff but these were not effective as there were gaps found in some staff training records. Inconsistent record keeping has been identified as an issue and this includes maintaining records of staff training, staff immunity status and emergency equipment checks. Overall the themes are reasonably similar to the national picture.

35. For practices where the CQC has identified some form of improvement the CCG will utilise a range of mechanisms to support a practice proportionate to the nature of the actions and the risk to patients. This involves a range of CCG teams including board GPs, nursing & quality team, health needs neighbourhood managers, medicines management team and commissioning contract teams coming together to work with the practice on interventions based upon the improvements required.

36. The CCG has a specific process in place to support practices which receive an overall rating of inadequate or enter special measures – the instigation of an oversight group. This group, chaired by the Director of Nursing & Quality and attended by the CQC, covers the initial review of the report to understand the level of risk and what this means to patients and the public. This group will work with the practice to develop a remedial improvement plan and risk mitigation strategies, along with an agreement of a process to monitor and oversee the implementation of the improvement plan itself.

37. For all general practices the CCG will monitor progress, working with and supporting the general practice until the identified actions are completed. There is a process of reporting and escalation in place via the CCG's Risk Sharing Group and from there to the CCG's Primary Care Commissioning Committee (which has overall board level oversight of the commissioning of general practice in the city).

38. CQC inspection reports form one part of the quality assurance process of general practices used by the CCG. The overall process is currently under review, but essentially consists of a number of levels of assurance monitoring and support. The first level is around routine assurance and evidence monitoring and practices would move up in stages if there was increasing risk or lack of assurance to, ultimately, the final stage of regional escalation and monitoring.

39. At a level one stage information and intelligence is reviewed and triangulated to identify if there are any potential risks/concerns or unwarranted variations. The CQC report would be reviewed alongside other data including prescribing information, complaint and serious incident information, performance and activity data such as emergency admissions, outpatient appointments, Quality & Outcomes Framework data and public health information such as childhood vaccinations. Additionally, general practice contract information is also reviewed. This would include opening times, appointment information and patient experience information from NHS Choices or the national patient survey.

40. Where concerns are identified further examination would take place including practice visits and specific quality and contract reviews. Where issues are more widespread and/or more prolonged and/or diverse in their nature a formal enhanced monitoring and support improvement plan would be required. If performance has not improved, despite a period of support and intervention, formal contractual actions may be considered. As already alluded to there is a process of reporting, monitoring and escalation in place via the CCG's Risk Sharing Group and from there to the CCG's Primary Care Commissioning Committee.

41. It is important to note that if the concerns relate to specific individual practitioner performance this will be the responsibility of NHS England. Where the CCG becomes aware of an issue that is related to an individual practitioner this will be escalated to NHS England.

42. A public and confidential report is on the agenda at each Primary Care Commissioning Committee which highlights all CQC reports and any actions agreed.

Informing commissioning decisions

43. The CCG takes the inspection ratings of practices very seriously, and is always keen to support practices to attain the best possible quality of care for its patients.

44. The information gained from the CQC reports provides a good indicator of practice quality and is used in triangulation with other information. This can include things such as Patient Experience Scores, Quality and Outcome Data and other quality markers (prescribing rates, ED attendances and screening uptake rates, for example).

45. CQC information is also used when considering whether practices would be suitable for providing additional or enhanced services, or whether practices need enhanced support through resilience or other funding streams that may be available to them.

Future CQC inspection regimes

46. There has been some criticism of CQC inspection regimes, particularly around the bureaucracy of visits, and the time impact it has for practices. With this in mind the General Practice Forward View describes a revised inspection regime that is less bureaucratic and focusses on certain service areas, as opposed to a full and comprehensive inspection.

47. In October 2017 the CQC issued a document entitled *How CQC monitors, inspects and regulates NHS GP practices*. This describes the how they will monitor general practices going forward. A summary formed part of the general practice exception report at the Primary Care Commissioning Committee at its December 2017 meeting, and is attached for your information as appendix B. This information is being discussed with practices in a variety of ways including at the protected leaning time event in January 2018.

Conclusion

48. We are pleased with outcome of CQC inspections so far however we are not complacent. We recognise that there is still much work to be done to improve the overall quality of primary care services in the city.

49. There is a process for monitoring CQC inspection reports and for supporting practices to make any identified improvements. This includes sharing learning from each other and ensuring any risks to patient and the pubic are minimised so patients receive as high quality standard of care as is possible.