

The state of care in general practice 2014 to 2017

Findings from CQC's programme of comprehensive
inspections of GP practices



Our purpose

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can

Contents

Foreword from the Chief Inspector	3
1. Introduction	6
2. Ratings 2014 to 2017	10
3. What drives great care?	25
4. Improvement and deterioration	39
Conclusion	47
References	49

Foreword from the Chief Inspector

I am delighted to present CQC's report of the quality of care in general practice in England, which we are able to do after completing our programme of comprehensive inspections of every GP practice in England registered with CQC at October 2014. This was the first of its kind and, in total, we inspected and gave a first rating to 7,365 practices.

For the first time, we have an unprecedented detailed view of the quality of all GP practices, which enables us to look at the sector as a whole and see where it is good – which we celebrate – and where it needs to improve.

Everyone in our society deserves high-quality, accessible primary care. Of all the health and care sectors that CQC regulates and rates, GP practices have consistently received among the highest ratings and we should be immensely proud of the fact that as at 16 May 2017, nine in 10 practices that CQC has inspected were providing good or outstanding care to their patients. This is to be commended when considering the challenges that general practice currently faces, in terms of the widening gap between the demand from a growing population of people living longer with complex medical needs, and the capacity of general practice to meet these needs.

Through our inspections we are increasingly seeing evidence of GP practices delivering care in new and innovative ways to benefit patients and the wider community. We highlight innovative practice in our inspection reports to encourage others to learn from it, to be inspired by it and to adapt what is relevant to use in their own improvement journey. There are particular characteristics at the heart of high-quality general practice: practices proactively engage with patients to identify local needs; they use this understanding to create a strategy and provide services to respond effectively to meet these needs, sometimes in innovative ways; and they have strong leadership with a good mix of skills, and good external relationships and partnership working, to share learning with others in the wider health and care community.

But, at the same time, we recognise that there are pockets of persistent poor care in general practice, which is bad both for patients and healthcare professionals themselves, including doctors and practice staff. Although these professions are regulated, historically there was no regulation of general practice as a service before CQC's inspection programme, which meant little was known about the quality of care for patients. Our first inspections found practices where care had fallen short of the quality that people should be able to expect, and which had not been addressed before: on first inspection, 13% of practices were rated as requires improvement and a further 4% were rated as inadequate.

Our inspections have helped to highlight problems and ensure that these are addressed – not only for the benefit of patients, but to improve and support the profession. Where we found concerns, we have taken action to protect the public by re-inspecting to follow up the necessary improvements. In extreme cases, where we found very poor and unsafe practice that put patients at risk, we took more serious action more proportionate to our concerns, and in a small number of cases we used our urgent enforcement powers to cancel a provider’s registration.

I know that the results of our inspections have helped to deliver improved care, which potentially affects more than 3.6 million patients. Practices that are open and willing to learn are able to respond quickly to the issues we identify in our reports and improve the quality of care. Many practices told us that their inspection provided valuable feedback on how their practice is run and that they valued our acknowledgement of what they are doing well, as well as the insight into where they could improve. The majority of practices are taking action on inspection findings and providing better care. We can see this from the percentage of practices originally rated as requires improvement or inadequate that have improved their ratings following re-inspection. From the patient’s point of view, this means that at the end of the first inspection programme, more than 3.4 million more people had access to safer and better quality care from practices rated as good or outstanding, which shows the positive impact of regulation.

But there is no room for complacency; while some have improved, as at 16 May 2017, one in 10 GP practices still needed to improve the quality of their care. Although CQC’s inspections are a catalyst for improvement, we believe that more must be done to support general practice to sustain this, as we are starting to see examples of practices that are unable to maintain improvement.

Consistent and sustainable support will enable general practice to deliver a high-quality service and play its important part in delivering care as part of the health and care system. Good and outstanding GP practices are the driving force leading to service changes and more integrated care in their local area. So we fully support the pledges made by NHS England in the General Practice Forward View to increase funding for general practice, improve leadership, increase the frontline workforce and skill mix, and invest in infrastructure. If properly targeted to meet local needs and used appropriately, investing in general practice will ensure that whole health economies remain sustainable and that outcomes for patients improve. We will continue to demonstrate the impact of these investments on the quality of care.

We will use the findings from our first programme of inspections as a baseline for the quality of general practice in England. As a regulator, we cannot afford to stand still. We must be vigilant and continue improving and adapting, enabling us to regulate in a more targeted, responsive and collaborative way.

We are using the learning from inspections to refine our approach to regulating general practice in England, which will be reflected in our Next Phase of regulation. On the ground, this will result in a greater focus on outcomes for patients and understanding of where quality of care is changing, while at the same time sharing what we know about what works well and what challenges remain.

To help ensure that the General Practice Forward View achieves its goals, we will work collaboratively with commissioners and other stakeholders to reduce duplication of what we ask of general practice and to share information effectively so we have a shared view of quality.

Going forward, CQC will continue to champion general practice, using our findings to highlight its strengths and promote innovative practice. We have seen some of the best care delivered to the most vulnerable in society, which all health and care services can learn from and aspire to achieve truly outstanding care.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

1. Introduction

Background and context

General practice is the 'front door' of the National Health Service and people's first point of contact for general healthcare. In England, there are more than 7,500 general practices registered with the Care Quality Commission (CQC). The core purpose of general practice, as set out in the national GP contract, is summarised as the services that GPs must provide to manage a registered list of patients. The majority of practices are run by GPs working as independent contractors under the terms of a national contract: the General Medical Services (GMS) contract and the Personal Medical Services (PMS) contract.

There is no official data collection, but one estimate indicated that there were 372 million general practice consultations in 2014-15^a, managing medical care from before birth to the end of life. This includes diagnosing, treating and preventing disease and illnesses, including a wide range of major health conditions, assessing risks, dealing with complex health conditions, coordinating long-term care and addressing patients' physical, social and psychological wellbeing, as well as acting as a gateway to specialists by referring patients for further care.

Challenges to the sector

General medical practice is a core part of primary care in the NHS, and therefore plays a fundamental role in the overall health of the population. A greater focus on prevention and early management of health problems in primary care should result in more appropriate and effective care leading to better health outcomes and greater equity in health. Therefore, it follows that properly investing in general practice should reduce the high costs associated with secondary care in hospitals.

However, general practice is currently facing unprecedented challenges. England has an ageing population: the number of people aged 65 and over is projected to increase in all regions of England by an average of 20% between mid-2014 and mid-2024.^b The number of people with chronic conditions is increasing, including conditions such as diabetes, cancer and heart disease and dementia, which presents an enormous challenge. The majority of these are managed in general practice. GPs are also seeing patients with increasingly complex healthcare needs.

Concerns about capacity and demand are well-documented. We know that workload for general practice has increased substantially in recent years but this has not been matched by growth in either funding or in the workforce.

In its report on pressures in general practice, the King's Fund reported that the number of consultations grew by more than 15% between 2010/11 and 2014/15, and that many GPs are choosing to retire early or work part-time.^c Without enough GPs to meet the growing demand, there is increasing pressure on general practice to manage patients' expectations about access to a consultation with a GP.

Workload also appears to be continuing to grow. In all regions across England, the number of patients registered at GP practices has been increasing year-on-year between 2013 and 2016, with an average increase of 7% and the largest rise in London at 10%. The South had the largest number of patients per practice in 2016, with an average of 8,661 patients per GP practice.^d The rise in the number of patients per practice is not only related to a growing population but also a result of practices increasing in size through mergers and federations.

In June 2017, the number of full-time equivalent GPs and GP registrars in England was 34,242.^e But there is a downward trend in the number of partner GPs in the UK, with a 400% increase in the number of salaried GPs from 2003 to 2012.^f This could be a result of the increasing pressures associated with running a practice – either as an individual or as a partnership model – and a desire to control individual workload.

In April 2016, NHS England launched the General Practice Forward View in partnership with the Royal College of General Practitioners (RCGP) and Health Education England. This recognised that primary care has been under-funded compared with secondary care, and that general practice in particular has been under-funded over the past decade.^g

As part of the GP Forward View, NHS England committed to invest an extra £2.4 billion a year by 2020/21 in a national sustainability and transformation package to support and grow general practice services to reverse the decline. The five-year programme pledges to address investment, workforce, workload, infrastructure and the redesign of care. It includes funding for 5,000 more GPs and 5,000 additional members of the practice team by 2020/21.

The workforce elements draw on a report for Health Education England, which recommended expanding the primary care workforce by using new clinical and support staff roles to address workload capacity issues.^h It is vital that this investment is sustainable and used to make a meaningful impact and bring about positive change for the benefit of patients and the wider NHS.

The redesign of general practice has already started to evolve, with many smaller providers becoming part of a larger organisation or federation and closer, more integrated working with other primary healthcare teams and practices, which follows the recommendations of the RCGP's *Roadmap for General Practice*.ⁱ The benefits of the federated approach for patients are also echoed in RCGP's *Putting Patients First*, which stated "Federations would help ensure the continued viability of primary care – and the important personal link between the patient and the GP".^j

A research study from the Nuffield Trust found that almost three quarters of surveyed GP practices are now in some form of collaboration with other practices, to deliver services at a larger scale, almost half of which formed during 2014/15.^k In the British Medical Association's 2015 GP survey, in total over a third (37%) of GPs said their practice had joined with a network or federation, and the figure for England was 43%.^l Many transformation approaches nationally also include new arrangements for general practice in primary care hubs or collaborative clusters, such as the Primary Care Home programme launched in October 2015, now serving eight million patients, across 14% of the population.^m

At the time of writing, the GP Forward View is starting to make progress in terms of funding, although the impact on frontline general practice and patient care is yet to be seen in terms of benefits to patients.ⁿ

Regulation of general practice

All people in the UK are entitled to the services of an NHS GP, and they have the right to register with a GP practice that best suits their needs. However, for some patients, the choice of GP practice and access to high-quality care can be limited.

Regulation of general practice in England by CQC was introduced in April 2013. Before this, although there was regulation of GPs and nurses as professionals, there was no regulation of general practice that assured the quality of care on behalf of patients.

The focus of our approach to inspections – across all types of services we regulate – is on the quality and safety of services, based on the things that matter to people. This enables us to get to the heart of people's experiences. We developed the approach to regulating general practice by consulting with the public, people who use services, providers and organisations with an interest in our work, and tested it in the sector.

In October 2014, CQC started a comprehensive programme of inspections of GP practices. Our inspection teams are led by specialist CQC inspectors, always include a GP, and may also include other specialist input from a practice nurse or practice manager. They sometimes include an Expert by Experience (someone who uses a GP practice or has a particular experience of this type of care). We also speak with patients and staff to understand what the quality of care in a practice is truly like. Inspections look at the quality of care and treatment of the range of services offered in a practice – for example, from healthcare teams involving nurses, healthcare assistants, phlebotomists, pharmacists, physiotherapists and counsellors. This extends to how practice managers, receptionists and other staff contribute to patient care, and how a practice works with other healthcare professionals, such as health visitors, midwives, mental health services and social care services.

We completed our programme of comprehensive inspections in January 2017. This is the first comprehensive assessment of general practice of its kind. The evidence we have collected through our inspections has given us a detailed picture of general practice and an unparalleled resource of information. It has also provided us with a baseline against which we can continue to monitor and measure the quality of general practice in England.

This report

We are now able to set out the findings from our first inspection programme. In this report, we provide quantitative data on all the ratings we have given to practices, showing the ratings on first inspection compared with those as at 16 May 2017 when all practices had been inspected. Although we completed our initial programme of comprehensive inspections in January 2017, the data used in this report was extracted on 16 May 2017 to allow time for all inspection reports and ratings to be published. The data shows a picture for England across the overall ratings, and the ratings for each of our five key questions and population groups. We can also see where there are regional variations by looking at provision of GP practices within clinical commissioning group (CCG) and government regional office areas.

One of CQC's fundamental aims is to encourage improvement. In this report, we celebrate the fact that the vast majority of GP practices in England provide good or outstanding care. To find out what drives high-quality care, we carried out interviews with senior CQC inspection staff and national professional advisors across the country, including from a GP and nursing background, who have reviewed many inspection reports as part of our quality assurance process. We also analysed a sample of inspection reports where the GP practice was rated as outstanding overall.

This report is based on the knowledge and experience that CQC has amassed during the inspection programme.

We use this to present some of the common themes and characteristics that we found contributed to a GP practice providing high-quality care, and illustrate them by drawing from wider examples of inspection reports of high-performing providers, identified in the course of the inspection programme.

We also use our findings to look at how GP practices have improved the quality of care following an inspection – particularly those that were rated as inadequate and placed in special measures, or those subject to enforcement activity. As well as protecting the public from unsafe care, enforcement activity is designed to ensure that providers take action to improve the quality of their services. To give some insight into factors that either contributed to an improved rating, or that inhibited improvement, we analysed a selection of inspection reports of practices that had improved from a rating of inadequate to good, and carried out interviews with the CQC inspectors that re-inspected them. The interviews aimed to uncover the factors that had driven practices' improvement.

2. Ratings 2014 to 2017

Key points

- Of all the health and care sectors that CQC regulates and rates, GP practices have consistently received among the highest ratings.
- On first inspection, 79% of GP practices were rated as good and 4% were rated as outstanding overall.
- At 16 May 2017, with re-inspections, this had improved to 86% rated as good and 4% outstanding overall.
- This meant that nearly three million people in England had access to care from practices rated as outstanding overall.
- But one in 10 practices needed to improve the quality of care, as 8% were rated as requires improvement and 2% rated as inadequate overall at 16 May 2017.
- Safety was the main concern as 27% were initially rated as requires improvement and 6% were rated as inadequate for the safe key question.
- Of the practices that were rated inadequate and re-inspected in the first programme, 80% improved their overall rating.

2.1 Background

Our ratings of GP practices have been designed to give a clear indication to the public about the quality of their local services. They also act to encourage improvement, as they enable practices rated as requires improvement or inadequate to understand where they need to make improvements and aspire to achieve a higher overall rating.

Ratings are based on a combination of what we find during an inspection, what the patients tell us, our monitoring data, and information from the practice itself. Inspectors use all the available evidence and their professional judgement and, following a thorough review process involving a number of checks to ensure quality and consistency, the inspection report is published on CQC's website.

As with all services that CQC rates, we ask five key questions: are they safe, effective, caring, responsive to people's needs and well-led? To decide on a rating, the inspection team asks: does the evidence demonstrate a potential rating of good? If yes, does it exceed the standard of good and could it be outstanding? If it suggests a rating below good, does it reflect the characteristics of requires improvement or inadequate?

We rate each of the five key questions and aggregate them to give an overall rating for a practice. Figure 1 shows examples of aggregated ratings for each key question and an overall rating.

Figure 1: Examples of overall ratings at practice level

Ratings	
Overall rating for this service	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Good ●

Ratings	
Overall rating for this service	Inadequate ●
Are services safe?	Inadequate ●
Are services effective?	Good ●
Are services caring?	Requires improvement ●
Are services responsive to people's needs?	Requires improvement ●
Are services well-led?	Inadequate ●

For GP practices, we also look at the quality of care provided to six different population groups:

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people with dementia).

Each population group is rated separately and this feeds in to the overall aggregated ratings.

2.2 Overall ratings for GP practices

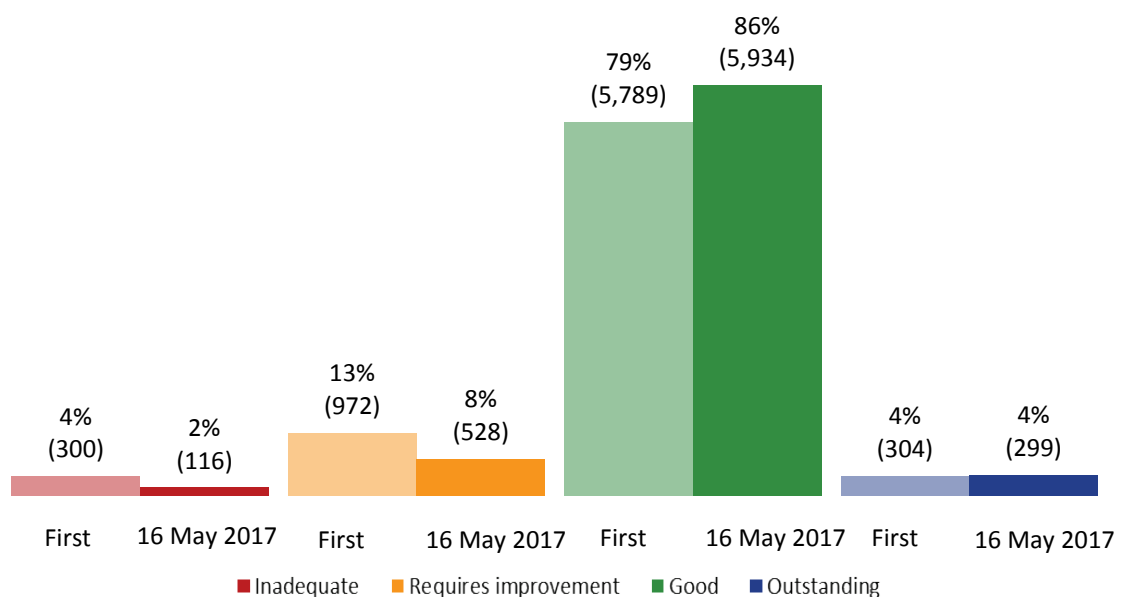
Of all the health and care sectors that CQC regulates and rates, GP practices have consistently received among the highest ratings.

It is important to compare the profile at the end of the first programme of inspections with the picture when practices received their first rating following an inspection, because the position has improved over time and the proportion of practices rated as good or outstanding has increased throughout the programme.

The quality of care in general practice overall is good. Of 7,365 first comprehensive inspections of GP practices, 79% were rated as good and 4% rated as outstanding. At the end of the first programme of inspections when a number of practices had been re-inspected (data from 16 May 2017), this increased to 86% rated as good and 4% rated as outstanding overall (figure 2).

We also found some poor care. When we carried out first inspections, a higher proportion of GP practices were initially rated as requires improvement or inadequate overall (13% rated as requires improvement, and 4% as inadequate). Again, these compare with figures from 16 May 2017, which show that 8% were rated as requires improvement and 2% rated as inadequate overall. This means that one in 10 practices still needed to improve the quality of care for patients.

Figure 2: Overall ratings of GP practices (at first inspection and at 16 May 2017)



Source: CQC ratings data (figures in brackets show the number of rated practices).

Where CQC rates a provider as inadequate, we will re-inspect it within six months. Of the practices that were re-inspected in the first programme, 80% improved their overall rating. We provide more details in the [section on improvement](#) in this report.

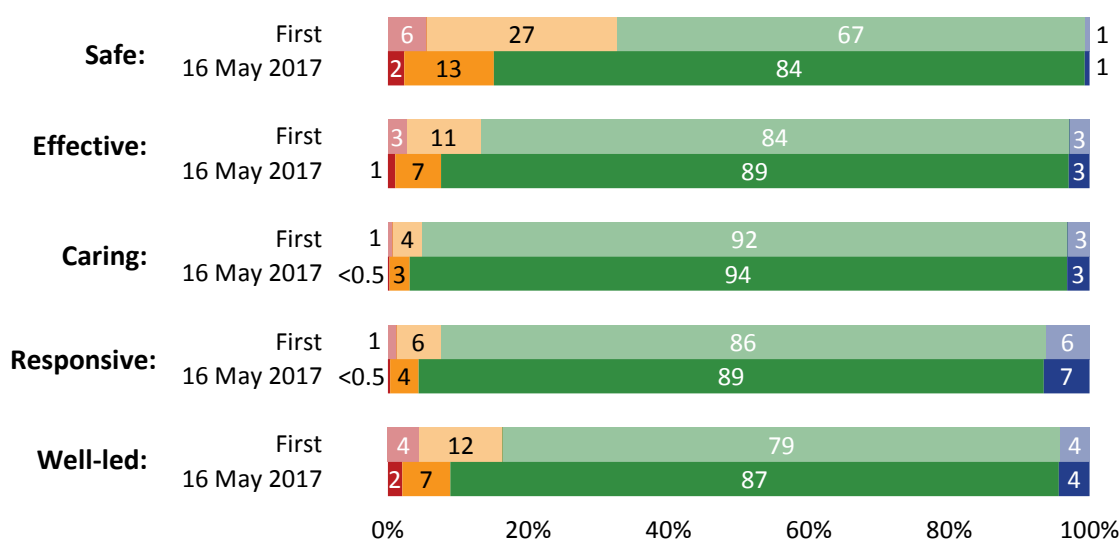
For most people, a GP is the first point of contact when they need healthcare and the place where they have an ongoing relationship with the NHS. At 16 May 2017, nearly three million people had access to care from practices rated as outstanding overall. But, while we are pleased with the high levels of good and outstanding care, there is still work to do as not everyone benefits from high-quality general practice. At the same time, more than 650,000 people in England were registered with practices rated as inadequate overall.

2.3 Ratings by key question

The vast majority of practices are caring, responsive and effective. Where we find problems, they are more frequently related to the practice’s approach to safety and how well it is led and managed.

In the first inspections, 38% of practices were rated as requires improvement or inadequate in at least one of the five key questions. Although these ratings exposed a gap in quality, the sector has responded well and the picture at 16 May 2017 showed improvement (figure 3). We discuss this in more detail later in this report.

Figure 3: GP practice ratings by key question (at first inspection and at 16 May 2017)



Source: CQC ratings data (figures in bars are percentages).

Safe

Delivering safe care is essential. Patients can be protected from abuse and avoidable harm when a practice has robust systems and processes, creating a strong foundation to enable staff to be proactive about risk, assess and mitigate risk, and see problems before they happen. A safe track record, a willingness to report safety incidents and be actively involved in learning from them to drive improvement – both within and outside the practice – is a key indicator of its safety.

Overall performance for the safe key question continues to be the poorest of all the five key questions, as it shows the largest percentages of ratings of requires improvement and inadequate.

On first inspection, 27% of practices were rated as requires improvement and 6% were rated as inadequate for safety. This improved to 13% and 2% respectively, but still only 1% of practices were rated as outstanding for safety at 16 May 2017.

From our experience of the first inspection programme, the main issues we found included problems relating to poor systems and processes to manage risk so that incidents are less likely to happen again. These apply to many areas, such as safeguarding, effective administering of medicines and vaccines, managing serious incidents, and having appropriate equipment and medicines for emergency use. We found many practices had no arrangements for acting on patient safety alerts.

Having consistently safe care can be achieved partly by having the proper processes, formal training, and guidance for staff. Being able to easily access and follow up-to-date and relevant policies and guidance enables staff to be confident that they are acting in the right way for patients.

What may seem like simple day-to-day process issues can often be indicative of problems with overarching systems and governance. This is about having a culture that puts safety as a top priority and one that values ongoing learning from safety incidents. We have seen that a good safety culture within a practice is a result of leading by example, with partners and managers instilling this within the team. However, as well as lack of basic systems of management and out-of-date systems or processes, we have seen cases where a lack of governance around recruitment could have resulted in patients receiving unsafe care from a member of staff who was unqualified for their role. Where we found inadequate care that put patients at risk we took the appropriate enforcement action.

Although we have been concerned at the overall performance in safety, we have found significant improvement generally as individual practices have taken their inspection findings on board, and taken steps to improve. At 16 May 2017, although we had rated 15% of practices as inadequate or requires improvement for safety, this is an improvement from the overall figure of 33% found on first inspection.

Effective

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence. An effective GP practice routinely reviews the effectiveness and appropriateness of its care as part of quality improvement. When care and support is effective, people have their needs assessed and their care and treatment delivered in line with current legislation, standards and evidence-based guidance. This is particularly important as patients are increasingly living longer with multiple, long-term and complex conditions.

On first inspection, 84% of practices were rated as good for the effective key question and 3% were rated as outstanding. This improved to 89% of practices rated as good and 3% as outstanding at 16 May 2017.

To support our judgements we look at existing data, including data from the Quality and Outcomes Framework (QOF), which is an annual reward and incentive programme detailing GP practice achievement results. We consider how QOF data compares with local clinical commissioning group (CCG) and national averages. Although QOF targets are a good indicator of meeting needs, reaching them all is not in itself an indicator of outstanding care.

Our qualitative analysis showed that the practices rated as outstanding for the effective key question went above and beyond QOF targets; they were proactive in identifying patients' needs and meeting them, and could demonstrate a positive effect as a result of their care. Importantly, we saw that those rated as outstanding could quantify the significant impact they were having on outcomes for patients. The interviewees point out that increasingly, these practices used non-traditional roles such as advanced nurse practitioners, care coordinators or healthcare assistants to support GPs and reduce referrals to secondary care or avoidable hospital admissions. This reflects the importance of having a multidisciplinary team and mix of skills in general practice. Outstanding practices also carried out more annual reviews for patients with long-term conditions by creating care plans or booklets that patients could use to better self-manage their conditions.

Where performance was poor for this question, our experience is that it was because practices had not carried out any clinical audits (in some cases for two years) or other quality improvement activity to demonstrate that they reviewed their own performance with national and local standards to ensure safe outcomes for patients. We have also seen practices with large backlogs of patient correspondence that had not been reviewed or filed onto the record system – for example, records of hospital, out-of-hours, walk-in centre and A&E discharge reports, and test results and prescription requests that had not been followed up for weeks. In the worst cases, referral letters for cancer opinions had not been followed up, which not only means that care may not be effective, but may also be unsafe. We acted in all cases of this nature to make sure that patients were protected and the practice made improvements.

Caring

Compassionate care has a lasting impact on people's experience of their GP practice. Our analysis of interviews and inspection reports found that practices with good and outstanding ratings got to know and understand their patients as individual people, and were sensitive to their preferences and requirements.

As well as observing how staff interact with patients, we base our judgements on patient feedback from comment cards, information from the patient participation group, data from the GP patient survey as well as the practice's own surveys, and to a lesser extent from Friends and Family Test results.

We found that, as with most other healthcare services, an overwhelming proportion of GP practices provide caring services to their patients, with caring being the best performing key question.

On first inspection 92% of practices were rated as good, 3% were rated as outstanding and 1% rated as inadequate. This improved further to 94% rated as good and fewer than 1% rated as inadequate at 16 May 2017.

This means that the vast majority of practices and the staff working in general practice treat their patients with compassion, kindness, dignity and respect. An example of this is by making sure they respect patients' privacy both in reception areas and in consulting rooms and explaining to patients what their care involves.

Other examples that our interviewees spoke of include providing 'extra special' end of life care and bereavement care, and practice staff responding to more vulnerable people from the moment they walk in – from receptionists to GPs. We found that another important aspect of caring is what practices do to identify and support patients who are carers. Where practices have identified a high percentage of carers on their patient list, we have seen some excellent outstanding practice, for example arranging special appointments for carers and having a coordinator within the practice to provide links with carers' organisations. Good and outstanding practices are also proactive in terms of carers' health, offering flu vaccinations and flexible carers' clinics.

However, where care could be improved, this related to a lack of continuity – where practices used multiple locums to address persistent staff shortages, with the result that their care was not person-centred, and also where patients had problems accessing an appointment.

Responsive

Good quality care is organised so that it responds to, and meets, the needs of the practice's local population. This includes access to appointments and services, choice and continuity of care, and meeting the needs of different people, including those in vulnerable circumstances. As well as face-to-face consultations, a responsive practice will carry out consultations by telephone or online by Skype, and offer tailored appointment lengths, home visits and extended opening hours.

On first inspections, we awarded the highest proportion of outstanding ratings for the responsive key question (6%) and rated 1% of practices as inadequate. These improved to 7% as outstanding and less than 1% as inadequate at 16 May 2017.

Our qualitative analysis showed that responsive practices go 'the extra mile' for vulnerable patients, for example, holding surgeries in other locations and providing free taxi services to help patients. We found that flexibility in providing care for patients is a central theme of outstanding services. The practices we rated as outstanding understood their patient population and their needs, and responded by adapting services and adopting different ways of working around these needs in a way that suited patients.

Practices that provide high-quality, responsive care also demonstrated that they have been proactive in engaging with their patients by 'including them in the conversation' and acting on feedback, complaints and concerns.

Being responsive is reflected in ratings for different population groups, for example, practices with a specific interest in care for homeless people. Practices that respond well to the needs of a particular demographic group have received the highest ratings for responsiveness for that population group.

However, throughout the inspection programme access to appointments remained an issue both in terms of what we found on inspection and what patients have told us. While this is a contractual requirement, poor access to appointments has a direct impact on quality and effectiveness of care. We have also found cases where practices had not responded to letters of complaint or discussed complaints within the practice so that trends were not identified and action could not be taken to improve.

Well-led

Good leadership, management and governance are essential in providing good quality care. They were the most common factors in practices that we rated as good or outstanding.

On first inspection, we rated 79% of practices as good and 4% as outstanding for being well-led. This improved to 87% and 4% at 16 May 2017.

Across the interviews with senior inspection staff in particular, participants shared the view that being rated outstanding for the well-led key question was an important driver for practices' performance across the other four key questions. We reflect on some of the underlying reasons that we have found for this in the next section.

In outstanding practices, we found that the leadership was clear about where they were going. They had a clear business plan, developed with the involvement of practice staff, which identified where they might be weak and had a strategic plan to address weaknesses.

Our qualitative analysis found that good leadership instilled a culture where staff work together so that everything they do is about the good of patients' health. These staff are thinking about the future and carrying out succession planning; for example, medical students that previously trained with the practice are now working there as GPs. Practices know what they will do if things go wrong. They plan for the future and may look to diversify.

From our inspections, we saw that where the quality of leadership was poor there were gaps in safe systems and processes and failures in communication between the leadership team and staff. Sometimes there were no regular practice meetings, which meant that there was no sharing or learning from significant events with staff.

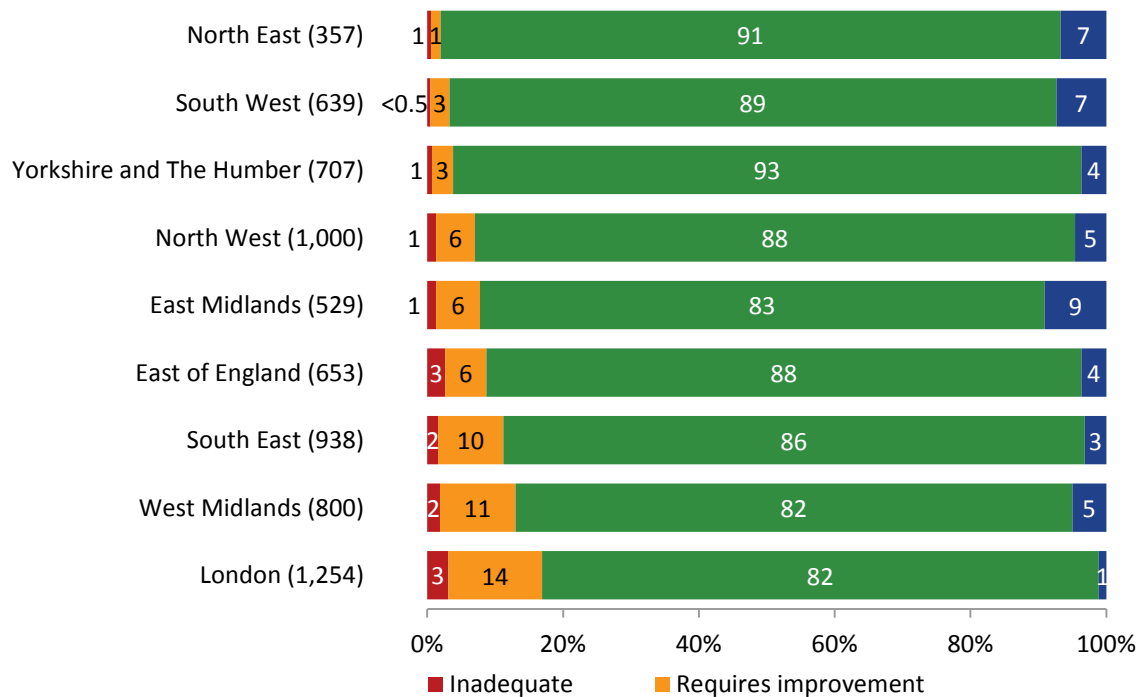
At 16 May 2017, overall ratings for the well-led question showed an improvement since first inspection. The proportion of practices rated as requires improvement reduced from 12% to 7% and ratings of inadequate reduced from 4% to 2%. However, 9% of practices still needed to improve the quality of their leadership. In these practices, GPs, partners and practice managers need to improve the way they lead the whole practice by continually improving, sharing their values and offering development opportunities to their clinical and non-clinical staff.

2.4 Ratings by geographical area

There is a clear regional variation in overall ratings for GP practices in England. Looking at the nine government regions, the North East had the largest percentage (98%) of practices rated as good (91%) and outstanding (7%), closely followed by Yorkshire and the Humber and the South West areas (figure 4).

In the London region, we inspected 1,254 practices and rated only 14 as outstanding. The London region had the largest number (17%) of practices rated as inadequate or requires improvement (14% rated as requires improvement and 3% as inadequate). We are also concerned about the numbers of practices in the West Midlands and South East that are rated as requires improvement or inadequate.

Figure 4: GP ratings by geographical area (at 16 May 2017)



Source: CQC ratings data (figures in bars are percentages).

There is a higher proportion of outstanding ratings in rural areas and a higher proportion of inadequate and requires improvement ratings in urban areas. We found examples of practices that have responded well to the challenges of having a low population density in a very rural area and have adapted their practices to meet people’s needs. But similarly, in good and outstanding practices in urban areas, we have found the reasons for higher ratings may be down to how they address local challenges.

The variation in ratings may also be a result of clinical and professional isolation, depending on whether practice leaders are linked or isolated from their peers. There are many examples of outstanding practice in both rural and urban areas, as shown in the following excerpts from inspection reports.

Example of a caring small rural practice

“The surgery was embedded in and was an essential part of the local community. Staff regularly liaised with the local primary and secondary schools and were first on call for any health concerns. This helped to avoid unnecessary ambulance call outs and A&E attendances. Arrangements had been made to carry out joint home visits with district nurses and carers. This provided patients with a more co-ordinated care service. The practice offered a range of compassionate services to address social isolation among its patient population... Many people lived outside the village in very rural areas, for example on isolated farms. Some of the patients had been reluctant to engage with healthcare services in the past. The GPs had overcome this and spent time getting to know these patients. They carried out home visits and provided care and support where necessary.”

Coniston Medical Practice, Coniston, Cumbria

Example of responding to homeless patients in a city

“The practice had a significant homeless and hostel dwelling population with drug and alcohol dependent needs. Access to services for these patients was good. The practice ran a combination of open, same day access clinics, along with booked appointments, as this flexible approach best suited the needs of people who often found it difficult to keep to rigid timetables and appointments. The practice had experienced clinicians including two dedicated homeless nurses, an alcohol nurse, shared drugs workers, two specialist GPs and close links with local homeless organisations. During the inspection we observed a flexible, sensitive, confidential and responsive approach when dealing with patients with complex health and mental health needs. We found the practice had good links with a local homeless hostel, and daily support was given by a support worker who acted as a waiting room mentor to support patients when they first and subsequently attended the homeless clinic.”

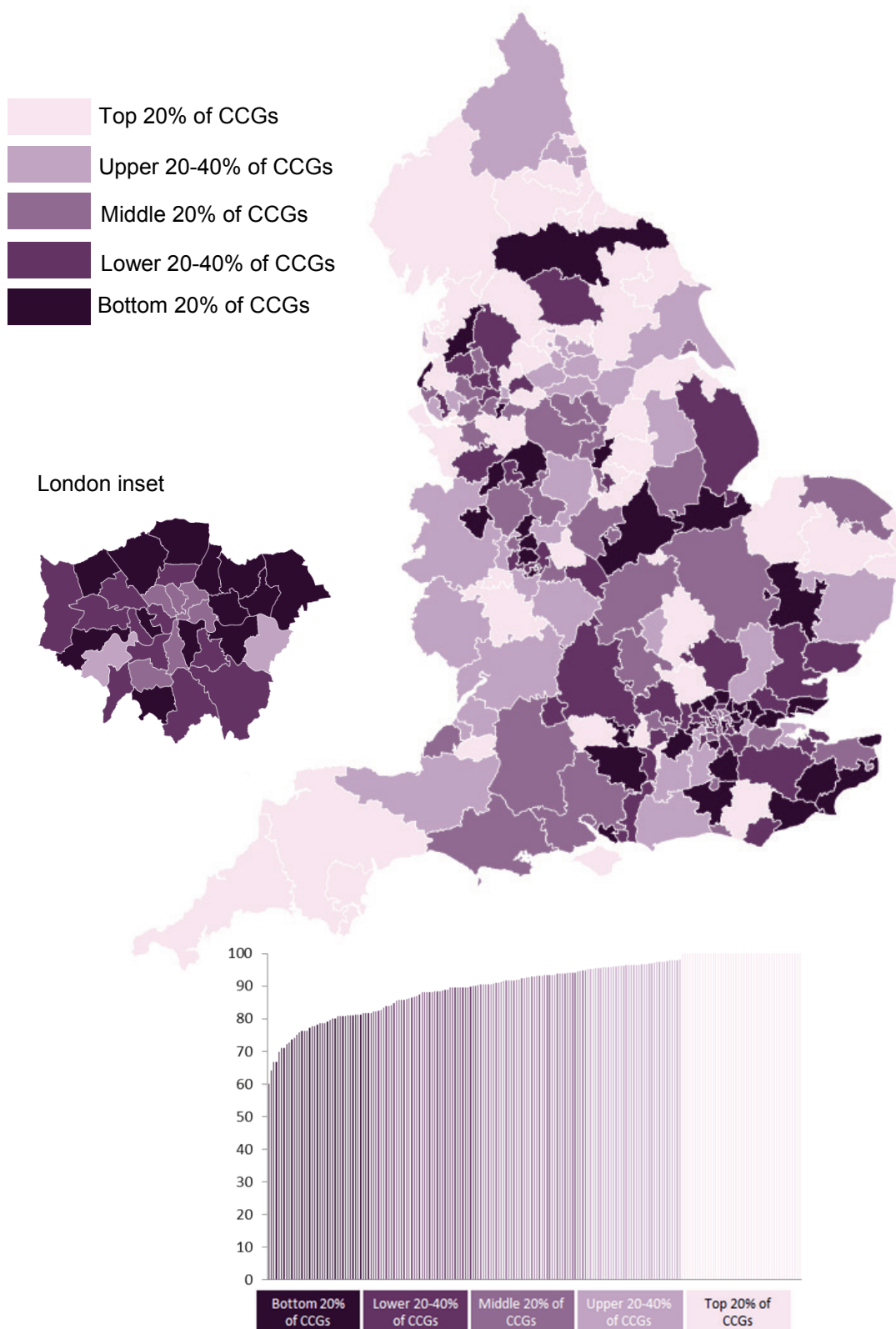
Brownlow Group Practice, Liverpool

Now that we have a more complete picture than ever before of the quality of general practice across the country, it is possible to map the variation. Although we have found the general standard to be high, we are continuing to explore the possible reasons for the geographical variation of ratings.

Figure 5 on the next page shows the percentage of practices with ratings of good and outstanding in each CCG area. The lighter areas on the map show where we found the highest rated practices.

It is important to note that CCGs in the lowest quintile still have between 60% and 82% of practices that are rated as good or outstanding.

Figure 5: Percentage of GP practices rated as good and outstanding by CCG (6,877 locations)



Note: Quintiles are based on the percentage of total number of GP practices rated as good and outstanding for each CCG. Source: CQC ratings data 16 May 2017.

2.5 Ratings by population group

As well as looking at practice-wide evidence that applies to everyone who uses the service, our inspectors look at specific evidence relating to six population groups. For example, we look at how a practice cares for older people, by offering proactive, personalised care from named GPs for patients who are aged over 75. And we look at the extra support for patients with mental health needs or dementia and whether the practice offers proactive screening and care plans. Our inspection reports highlight where we have found particularly innovative, high-quality or poor quality care for people in the different population groups.

We have learned that the most significant differences in quality between the population groups are highlighted in ratings for the effective and responsive key questions. This is because variation in practices' approach to safety and quality tends to affect all people using the GP practices and therefore impacts on all population group ratings in the same way.

Figure 6: Examples of variation in ratings for population groups within and between GP practices

Practice A (overall practice rating: good)		
Older people	Good	●
People with long term conditions	Requires improvement	●
Families, children and young people	Good	●
Working age people (including those recently retired and students)	Good	●
People whose circumstances may make them vulnerable	Outstanding	☆
People experiencing poor mental health (including people with dementia)	Good	●

Practice B (overall practice rating: inadequate)		
Older people	Requires improvement	●
People with long term conditions	Inadequate	●
Families, children and young people	Requires improvement	●
Working age people (including those recently retired and students)	Requires improvement	●
People whose circumstances may make them vulnerable	Requires improvement	●
People experiencing poor mental health (including people with dementia)	Inadequate	●

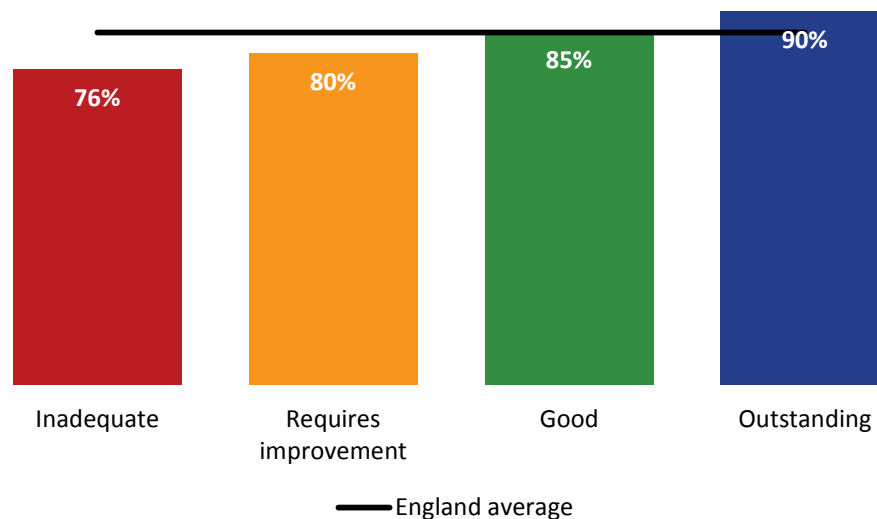
Because of the way our ratings are decided, there does not appear to be much difference between ratings for the population groups and the overall profile of ratings. Although we can see variation between practices (figure 6), it is difficult to see a national picture. We consulted on how we can improve and simplify the approach to rating population groups in our Next Phase of inspections, and will adapt our approach going forward.

2.6 Comparison with GP patient survey results

NHS England runs an independent annual national survey of patients registered with GP practices in England. This is sent to more than a million people and the results show how people feel about their GP practice. CQC's approach to inspection focuses on the importance of patients having a good experience of care and the overall quality of the service. It is therefore very useful to compare the results of the GP patient survey with our overall ratings.

Using results from the 2017 GP patient survey, figure 7 shows the total percentage of good experiences (responses as 'very good' and 'fairly good') for practices that we have rated. This shows that there is a link between people's experiences and CQC's ratings.

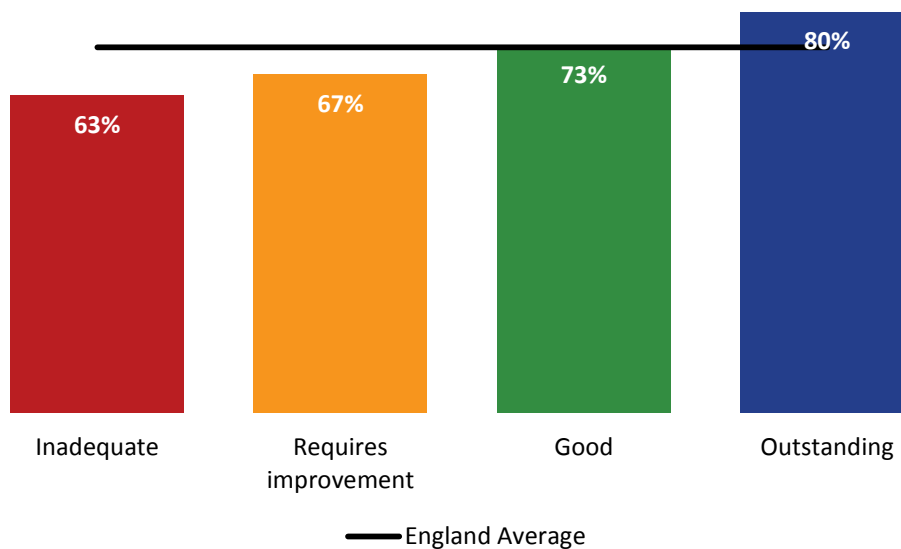
Figure 7: Overall good experience at the GP surgery (GP patient survey July 2017)



Source: GP patient survey July 2017 and CQC overall ratings 16 May 2017. Note: Based on all rated GP locations for which GP Patient Survey data is available. A small number of locations have no survey data.

The GP patient survey shows a similar link when looking at people's overall experience of making an appointment with their GP (figure 8). Again, where the survey shows a greater percentage of total 'good' responses, CQC's overall rating for a practice is better.

Figure 8: Overall good experience of making an appointment (GP patient survey July 2017)



Source: GP patient survey July 2017 and CQC overall ratings 16 May 2017. Note: Based on all rated GP locations for which GP Patient Survey data is available. A small number of locations have no survey data.

3. What drives great care?

The ratings from our programme of comprehensive inspections of GP practices show that the majority are providing good care. Furthermore, approximately 300 GP practices were rated as outstanding at 16 May 2017, delivering care to almost three million people.

This section of the report is based on interviews with senior CQC inspection staff and national professional advisors across the country, including from a GP and nursing background, who have reviewed many inspection reports as part of our quality assurance process. We draw on their reflections and experience of our first programme of inspections to understand the key factors and characteristics that drive truly excellent care. We also draw on an analysis of a sample of inspection reports where the GP practice was rated as outstanding overall. These themes are illustrated by drawing from wider examples in inspection reports of high-performing providers.

3.1 Proactively identifying and effectively responding to local needs

A GP practice can't deliver high-quality care that meets its patients' needs if it doesn't know what those needs are.

We found that GP practices providing high-quality care were proactive in identifying the needs of their patient population as well as people's health and care needs in the wider local community. Typically, they identified these needs by engaging effectively with patients, for example by working with their patient participation group (PPG) in a meaningful and constructive way and developing their own patient surveys. They worked in partnership with patients, which empowered and involved them meaningfully by designing services and developing the practice together. In these practices, our qualitative analysis found that patients and their feedback had often influenced care in the practice, including the strategy for the practice.

Once needs are identified, we found that practices providing high-quality care developed and implemented services in a way that responded to the identified needs. There were many examples of this for practices rated as outstanding, as in the following example of a practice that implemented initiatives not just to improve the health and wellbeing of patients, but also to reduce their reliance on primary healthcare or medication.

“The surgery was instrumental in setting up various social and community groups to suit the needs of the patient population as they had recognised that the high cost of joining social groups potentially made them unaffordable for patients. The groups included:

- BLISS (Believe Love Inspire Self-worth Support), for young isolated mothers, initiated by reception staff. A counsellor from the practice attended the group once a month.
- Mucky Monkeys, a group for young children and their parents, initiated by the Salvation Army and run by members of the reception staff.
- Inspire, a social group for older patients and the retired.

The practice employs in-house counsellors so they are easily accessible to patients. A focused care practitioner looked after a wide range of needs including family issues, alcoholism, sexual exploitation and sleep problems. The focused care practitioner saw patients on a regular basis when this was needed and put plans in place involving other organisations, such as the job centre or housing department, to ensure individual needs were met.”

Hill Top Surgery (Hope Citadel CIC), Oldham

We often see excellent examples where GP practices are responsive to specific needs, for example, when there are more vulnerable people, such as homeless people or asylum seekers, or where there is a large student population. But being responsive to needs is also about being flexible and offering appointments for working people outside of normal working hours, longer appointments or using online appointments by Skype or telephone. The following practice was rated as outstanding for providing responsive care and rated as outstanding overall.

“There are innovative approaches to providing integrated patient-centred care. For example: The practice deals with the highest HIV rate in the county and worked closely with the local sexual health or genitourinary medicine clinic based in the same building as the practice, and an HIV service was provided at the adjacent pharmacy. The practice identified and provided additional support for children at risk of female genital mutilation, trafficking and radicalisation... The practice worked with a local women’s refuge providing primary care and counselling support to women and their children.”

Acorn Surgery, Huntingdon, Cambridge

Although there are recognised challenges to general practice from a local population and geographical context, this is not always a barrier to providing high-quality care and we have seen many examples of practices providing good and outstanding care in this context.

Our ratings showed that a larger proportion of services in cities were rated as inadequate, yet we have seen many examples of high-quality care in inner city areas, including some practices rated as outstanding. At the same time, we have seen outstanding care in rural practices in small villages.

In the interviews, our senior inspection staff spoke of outstanding practice in deprived areas with more social challenges, where practices have clear strategies to deal with these challenges and have committed practice teams that are values-driven and passionate about improving care for people. These staff wanted to ‘make a difference’ to people’s lives and this, in turn, has had a positive impact on the culture of the practice and the quality of care. This included salaried GPs, GP partners, nurses, and receptionists. For example, we have seen high-quality care provided to homeless people and refugee populations.

Practices can face different challenges when delivering care whether they are an inner city practice or a rural practice. What matters is the way in which they identify and respond to local needs.

3.2 Innovative approaches that deliver real impact

Our analysis identified many examples of GP practices providing care in innovative ways that went beyond what they needed to do in terms of core services. This tended to be driven where they had tried to meet needs in a way that hadn’t been tried before.

Many of the practices that we rated as outstanding have developed innovative working styles that have led to a direct improvement on patients’ experiences and/or their outcomes of care, as well as indirect improvements, such as improving the working environment or developing new ways of working to use practice staff to their best potential.

However, innovation itself does not guarantee an outstanding rating. To be outstanding, our qualitative analysis found that innovation must be evidence-based and developed in response to a real need – either within the practice or within the local population, with evidence that it has had a positive, tangible impact on care. Some services are doing innovative work but they don’t evaluate or measure it, therefore they cannot demonstrate its impact.

In the best practices, we saw clear evidence of the impact that the changes had made and the improvement over time. Inspectors noted that practices had made use of analytical tools and there was leadership capability to use available tools and techniques to drive continuous improvement and measure the impact.

Having evidence that an initiative has made a real impact on patient care is important and, in awarding our ratings, can elevate a rating to outstanding. Many practices have initiatives that are potentially outstanding because, for example, they have reduced rates of admission

to hospital, improved support for people with dementia by using dementia cafes, or organised fundraising events.

“The Bradford Bevan Pathway Team is a dedicated group of health and social care professionals that help patients who are homeless or vulnerably housed. The team attends regular meetings at the local hospital to review its patient group and any discharge plans. The Bevan team worked with the Bradford Respite and Intermediate Care Support Service (BRICSS), which is run by a social housing provider and provides accommodation, with Bevan Healthcare providing medical care for residents. It offers respite accommodation for homeless patients who need medical care after they are discharged from hospital. Bevan’s Street Medicine Team also held mobile outreach clinics in city centre locations to enhance access for vulnerable patients and also offered advice and healthcare to people who were not registered with the practice.

These initiatives led to an increase in the number of homeless people registering with the practice, a reduction in the use of acute health care, A&E admissions and days spent in hospital.

A review conducted by an external agency of BRICCS, the Street Medicine Team and the Pathway Team found that for every £1 invested in these services the savings were from £1.50 to £8.00. The Bevan Pathway team was noted to have reduced acute health care costs by 62% by supporting homeless patients in primary care settings.”

Bevan House, Bradford, West Yorkshire

In the following example, we saw evidence that the practice had been successful in reducing antibiotic prescriptions and that this effort was being maintained by using technology.

“Another audit looking at antibiotic prescribing showed that the practice had reduced its antibiotic prescribing by almost two-thirds despite an increasing list size. For example, the practice had prescribed the equivalent of 188 broad spectrum antibiotics (cephalosporins, quinolones and co-amoxiclav) per 12,000 patients in September 2014. This had reduced to the equivalent of 61 such prescriptions per 12,000 patients in June 2016. A computerised system was in place to alert a clinician if they were trying to prescribe an inappropriate antibiotic.”

Cestria Health Centre, Chester Le Street, County Durham

But the interviews with CQC’s senior inspection staff and professional advisors show that not all practices were able to demonstrate the impact that innovation has had on patient care, because they failed to measure the impact on wider system and health outcomes.

A holistic approach is also important in providing high-quality patient care, in particular achieving (and having evidence to prove) a positive impact on patients’ all-round health

and wellbeing. The inspection programme has shown that good and outstanding practices proactively support people to live healthy lives, recognise social aspects such as employment, housing and finance, and then target support at people who are particularly vulnerable.

Our qualitative analysis found that as well as engaging with patients, meeting local needs is also achieved by engaging with external agencies and networks, including the voluntary sector.

3.3 Sharing learning internally and externally

The qualitative analysis found that a good practice constantly learns from positive and negative experiences, using the learning to improve services for patients. Some practices go further and share their learning with partners in the local health economy and with their patients. This particularly includes learning from safety incidents and serious events, so that they can prevent these from happening elsewhere. Where we had rated practices as outstanding for the safe key question, a key characteristic was evidence of a willingness to share learning externally with other GP practices and wider stakeholders. These practices got people involved by sharing learning across the health community through newsletters, and with the CCG. The inspection programme has shown that practices that had the foresight to pool and share resources were also able to respond more appropriately.

Conversely, the interviews with senior inspection staff and professional advisors found that practices rated as requires improvement or inadequate tend to be more inward looking and less responsive and keen to learn, and this can restrict their ability to learn, adapt and change.

If staff were able to share learning, it supported their own continued professional development, as well as the practice's contribution to the wider health economy. For example, a nurse who was designated 'nurse lead' may attend meetings and forums to share learning and reflect and maintain their clinical knowledge. They would then bring back ideas that could benefit patients by applying their learning to practice. When staff kept on top of latest evidence regarding treatment, this new evidence translated into practice, such as reviewing medication based on guidance.

The interviewees noted that GPs often have special or academic interests or are engaged outside of the practice in local or national roles with the CCG, NHS or Royal College of General Practitioners. They may bring the learning back into their own practice, but what makes it outstanding is whether there is evidence to demonstrate that this knowledge and experience is having an impact on the GP's practice and its patients. In practices that are rated as requires improvement or inadequate, we saw GPs with outside interests that took them away from the day-to-day business of the practice and had no direct impact on the care for their patients.

In the following example, the practice was participating in a research study and had been recognised for its contribution.

“The practice participated in local audits, national benchmarking, accreditation, peer review and research. At the time of our inspection the practice were involved in the East London Gene Study (aimed to improve health among people of Pakistani and Bangladeshi heritage by analysing the genes and health of local people) and had recruited over 600 candidates... and the HepFree Study aimed to identify patients with unknown chronic active hepatitis. The practice was awarded star GP practice of the month in May 2016 by the ‘HepFree’ team for high rates of testing and identification.”

St Andrews Health Centre, Bromley-by-Bow, London

Some practices are also proactive in encouraging learning among their patients.

“Quorn Medical Centre took a lead role in organising a learning event for patients in the South Charnwood locality, conducted by pulmonary rehabilitation specialists for patients with asthma and chronic obstructive pulmonary disease. It was attended by 93 patients and feedback was 100% positive, indicating they had an increased knowledge in managing their condition and use of inhalers.”

Quorn Medical Centre, Leicestershire

Throughout the first inspection programme, we have also found examples of high-performing practices that shared their learning with others in the local care system, as shown in the following example.

“The practice analysed its emergency admissions for patients and identified that many had been admitted from a care home with dehydration and worsening infections. The practice provided training to care home staff on recognising worsening illness and had developed protocols for situations such as what to do after falls, head injuries and weight loss pathways. Emergency admission rates for these conditions had reduced since 2014/15.

“The practice was an early adopter and innovator using computer tablets and mobile technologies to provide high quality care to patients in their own homes or in care home settings. The practice had committed to working with the CCG to share this knowledge and experience to help other practices implement new technologies.”

Brinsley Avenue Practice, Stoke on Trent

3.4 Multidisciplinary working

The role of healthcare professionals other than GPs and practice nurses is becoming increasingly important in many GP practice teams. Most practices carry out some multidisciplinary working, but our inspections have found that a feature of high-quality general practice was where the work was driven by patient need to enhance care and overcome traditional organisational barriers, and was regularly planned and discussed.

Internally within practices, our qualitative analysis found that a larger team size, with a mix of skills encompassing staff from a range of professional backgrounds, contributed to high-quality care. In these practices, roles were clearly identified, and can include for example nurses, phlebotomists, counsellors, pharmacists, occupational therapists and physiotherapists. Having a broader skill mix in a practice could also be a solution to recruitment problems. Our findings echo those of the report by the Primary Care Workforce Commission for Health Education England, which recommended expanding the workforce in primary care by using new clinical and support staff roles and more multidisciplinary working to address workload issues within general practice.^o

From our experience of general practice inspections, we found that those rated as good or outstanding tended to have invested in, and valued, their nursing teams. General practice nurses (GPNs) have a crucial and expanding role in delivering high-quality care, for example in the areas of long-term conditions, wound care and the success of the childhood immunisation programme. The role of GPN can sometimes be isolated, and we found that a larger nursing team presented several advantages. For example, in a larger team it is easier to develop expertise in specific areas and divide responsibilities that would often be the sole responsibility of a single GPN; this can cause practices to perform poorly in the safe key question, for example in the governance systems for monitoring medicines, equipment and infection control. Although we found a growth in the role of nurses providing care for patients with acute conditions, some providers could not always demonstrate sufficient clinical oversight and support for this advanced level of practice. We found the role of nurse manager was more common in large practices and is valuable in developing the nursing team with professional support and appraisal, including for Nursing and Midwifery Council revalidation and skill mix.

Providers have reported widespread problems in recruiting GPNs, and the General Practice Nursing Workforce Development Plan, which is part of the GP Forward View, aims to address this by improving training in GP practice settings and raising the profile of the role to help retain and expand the general practice nursing workforce.^p

The findings from our interviews with senior inspection staff show that multidisciplinary working also contributed to high-quality care where teams worked out of the practice and with professionals from other services in the local community. We have seen evidence from practices rated as outstanding of multidisciplinary team meetings that were having a positive impact on care.

“Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients’ needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Monthly meetings took place with other health care professionals including the GPs, healthcare assistant, the practice manager, the local hospice, district nurses, health visitor and members of the local health and social care team. Care plans were routinely reviewed and updated for patients with complex needs. Vulnerable patients were identified and their needs discussed.

“The practice was involved in setting a community hub operating centre (CHOC) within the town. This involved bringing together a team from different disciplines such as mental health, social care, community nursing, voluntary organisations and GPs to help make sure that the identified patients had a joined up care plan, which met their needs, and focused on keeping them well at home.”

The Butchery Surgery, Sandwich, Kent

3.5 System-wide engagement

The interviews and inspection report analysis indicate that the majority of practices rated as outstanding are involved in their local area in a very active way, both in terms of planning services and in working with individuals to provide care with multidisciplinary teams as an externally focused activity. These practices welcome other services into the practice, engage with them, involve them in patient care, share learning and have a real sense of collaboration.

The interviewees noted that outstanding practices are not insular, but are proactive and outward-facing with excellent external relationships. This includes effective links with the wider health economy, including other GP practices, providers in other sectors such as care homes, community or acute trusts and hospital consultants, and the voluntary sector.

We saw many examples of this joint working and where this had had a positive impact on patient care. For example, they might be working with a local hospital trust with patients that repeatedly attend A&E, planning alternatives that involve district nursing, and they are aware of patients being discharged from hospital who may need more support. They adopt an individualised case management approach to reduce impact on the wider system for patients who have conditions that are better served elsewhere.

3.6 Thinking strategically and planning ahead

Having a clear strategy and vision is a key factor in providing quality general practice. Our inspection report analysis found that when practices have a strategy they plan for the future and recognise that how they deliver services, and the skills they need to deliver care, will change over time. In the following example, the practice successfully demonstrated that it was planning for the future and, furthermore, was involving patients through its patient participation group (PPG) in the process.

“The practice acknowledged the challenges they faced with an increasing and ageing population with multiple health needs, coupled with limited finances. There was a documented five-year strategy to meet the challenges, which included succession planning. The practice was planning to extend their premises to accommodate more consulting rooms and office space. Patients and staff have been involved in the discussions and the PPG was actively involved in seeking planning permission.”

Quorn Medical Centre, Leicestershire

Planning for the future effectively includes considered succession planning with regard to staffing and recruitment and staff development, and aligning this to the strategy to ensure that patients have sustainable access to services. The analysis of inspection reports showed that this was sometimes achieved through regular meetings between GP partners and the management team, as in the following example.

“The partners and management team met every two weeks to discuss key business issues and the long-term strategy of the practice. Succession planning had been implemented as two partners were to retire over the next 14 months and a salaried GP had already been recruited to maintain a good level of access for patients in the long term.”

Dr Young and Partners, Spondon, Derbyshire

From the sample of inspection reports of GP practices rated as outstanding, we saw that practices supported and encouraged their staff in all types of roles (including both clinical and administrative) to continue in their professional development and enhance their career. We also found that a non-hierarchical culture is important for ensuring that staff feel valued. In outstanding services, staff are actively engaged, feel able and supported to say what they feel, and are comfortable suggesting or leading improvements and saying when things went wrong. There is also high staff and patient satisfaction and staff are proud to work for the practice. This level of staff engagement is highlighted in the following outstanding example.

“The practice had a culture of encouraging staff to take ownership of tasks and we saw that staff were empowered. There were high staff satisfaction rates. Following staff suggestions, the practice had a communication board in the administrative area that highlighted areas for action. This highlighted where the staff needed to concentrate their efforts in order to improve the running of the practice and patient care. Staff told us they felt involved and engaged to improve how the practice was run.”

Shinwell Medical Centre, Peterlee, County Durham

We saw that outstanding services had a shared and often values-based vision for the practice. This characteristic was also mentioned by our interviewees, who found that staff in these services worked together and everything they did was about the good of patients' health, particularly in a disadvantaged population.

However, we also have a contrasting experience of inspecting practices that were rated as inadequate, where we received negative feedback when talking to staff. Staff have told us that there was no engagement with GP partners to gather their views and they did not feel involved in discussions about how to run or develop the practice.

3.7 Size of practice

The size of a GP practice does not dictate whether it can provide good quality care (or is rated as good or outstanding), but there was a link. Findings from our interviews suggest that in a larger practice it is easier to have staff with defined roles, and there is a greater likelihood that there will be well-functioning nursing teams where nurses focus on particular areas, such as diabetes or chronic obstructive pulmonary disease (COPD), and junior nurses take on task-oriented roles.

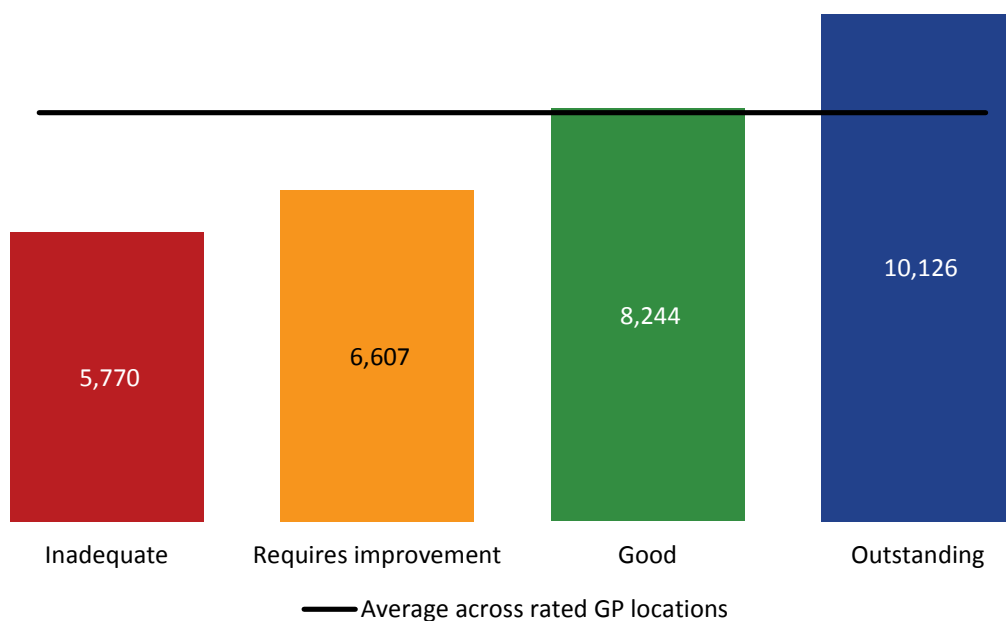
Our qualitative analysis indicated that the factors that inhibited a higher rating for a smaller practice could be related to financial pressures and professional or clinical isolation. Although patients value single-handed GPs, it can be harder to deliver high-quality, innovative services as a team of one. Where there are more people working in a practice, and a larger patient list, it is easier to deliver a wider range of high-quality services and be innovative.

We are seeing various routes to working at scale, such as the formation of super practices ranging from 10 GPs up to 60 or more GPs, and covering much larger geographical areas. But we are also seeing working at scale, where there has been no change to the provider status, through alliance agreements and collaborations. For example, the Primary Care Home programme run by the National Association of Primary Care is an innovative approach to strengthening and redesigning primary care by bringing together a range of health and social care professionals to work collaboratively to provide enhanced personalised and

preventative care for their local community.⁹ Staff from GP practices, community, mental health and acute trusts, social care and the voluntary sector, focus on local population needs and provide care closer to patients' homes. There are now approximately 180 sites delivering this model across England covering eight million patients.

There is some relationship between the size of the practice and the rating. Figure 9 shows that where the practice is bigger – seen by having a bigger patient list – the rating is better.

Figure 9: Average number of registered patients per rated GP location by overall rating



Source: NHS Digital, 12 May 2017 and CQC overall ratings 16 May 2017. Note: 215 locations could not be Organisation Data Service code-mapped or did not provide list size data and so are not included.

However, CQC's inspection programme has shown that being outstanding is not necessarily about the size of the practice; rather it's about knowledge of the population and the provision of a service that meets their needs. We have seen some smaller practices that provide really caring and responsive services. For example, in some rural areas, a practice may be small out of necessity because it serves a small population spread out over a large area of countryside. Some single-handed practices also provide an excellent service because they are supported by good clinical networks. It is therefore important to support clinical networks for practice leaders to avoid clinical and professional isolation and enable practices to deliver high-quality care.

3.8 Influence of effective practice management

Investing in clinical and non-clinical staff is important. A highly motivated, experienced and knowledgeable practice manager has a picture of the business and clinical care, providing background support, and coordinating the whole running of the practice. Our inspections found that those practices rated as outstanding had proactive and committed practice managers who worked well with the GPs to ensure effective leadership across general as well as clinical management. Where the GP leaders handed over ownership and authority, the practice managers were able to flourish.

But we also found that they need to be valued as part of the team and have authority, which needs a good leadership culture and support from the partners, otherwise their efforts did not have any impact on patient care. Where we found poor performance around governance in the inspection programme, there was lack of clarity between the practice manager and GP partners.

For example, in one practice that was rated as inadequate, we received conflicting information on who had responsibility for managing and overseeing recruitment processes, which meant that the practice recruited inappropriate staff, potentially leading to unsafe care. But we have seen examples where the practice manager has become a partner in the organisation and this has sometimes been a key factor in driving a practice towards becoming outstanding. The following example shows how investing in training for a practice manager helped with motivation and continuity of staff.

“The GPs and leadership team had invested in their staff over a long period. This had led to a happy, loyal workforce with low staff turnover. Staff were supported both financially and with protected time to develop personally and professionally in addition to the required updates. For example, the practice manager had started at the practice as a sixth form school leaver. They started in the administration team and were sponsored to obtain a dispensary qualification, followed by a national vocational qualification (NVQ) in business and administration and Level 4 management NVQ. The practice then funded her foundation degree in Management and Leadership prior to promoting her to practice manager.

“There had been effective succession planning... the previous practice manager had spent six months coaching and supporting the new practice manager in their role to ensure competency and continuity of service during the transition of management.”

Kingskerswell and Ippelen Medical Practice, Newton Abbott, Devon

3.9 Leadership

Underpinning the delivery of high-quality care and the delivery of the approaches set out above relies on strong leadership. Our expert interviews found that, where there is strong leadership from GPs, nurses and practice management, there is a positive impact on the quality of care. The culture that leaders create within the practice is important: where we saw high-quality general practice there was a non-hierarchical structure and a culture that valued the input of staff, with a balanced team that respected and valued all professionals with mutual respect and connection.

The following example from the outstanding report analysis shows where a practice had strong leadership and governance embedded in its culture.

“The leadership, governance and culture were used to drive and improve the delivery of high-quality, person-centred care. The practice had undertaken training on personality testing, which they offered to all staff and used to plan team working. Teams within the practice were set up using the results, by ensuring that personality types were as important as skill mix in deciding who should work together. The practice believed that this method increased productivity and reduced workplace conflict. Staff told us that the personality tests had given them a better understanding of why people worked the way they did, and also about how they worked themselves, and felt that it had improved working relationships at the practice.”

Distington Surgery, Workington, Cumbria

Because good leadership is a fundamental driver for practices’ performance across all areas, when leadership is poor it has a detrimental effect on safety, effectiveness and responsiveness. We found examples in practices with a poor rating where, although practice staff knew who to go to with concerns, they were not confident that these would be addressed and they reported feeling demotivated, demoralised and disillusioned with the lack of management support.

The following example is from a practice rated as outstanding and shows that the leadership contributed to the overall safety of care.

“The practice had used the Manchester Patient Safety Framework as a basis for developing [its] error reporting protocol and facilitating “a team based self-reflection and educational exercise on improving patient safety culture”. As a result, staff were fully committed to reporting incidents and near misses, as well as improving the safety culture within the practice. Every opportunity to learn from internal incidents and significant events was used by staff to improve patient care and outcomes. Improvement work had been undertaken in respect of medicines management and error reporting to ensure patients received safe care. The processes in place for monitoring safety and risk management were comprehensive and had been improved when needed. This included infection and control practices, use of equipment and arrangements to deal with emergencies and major incidents. Suitable recruitment procedures were in place to ensure fit and proper staff were employed. There were enough staff to keep patients safe.”

Bakewell Medical Practice, Bakewell, Derbyshire

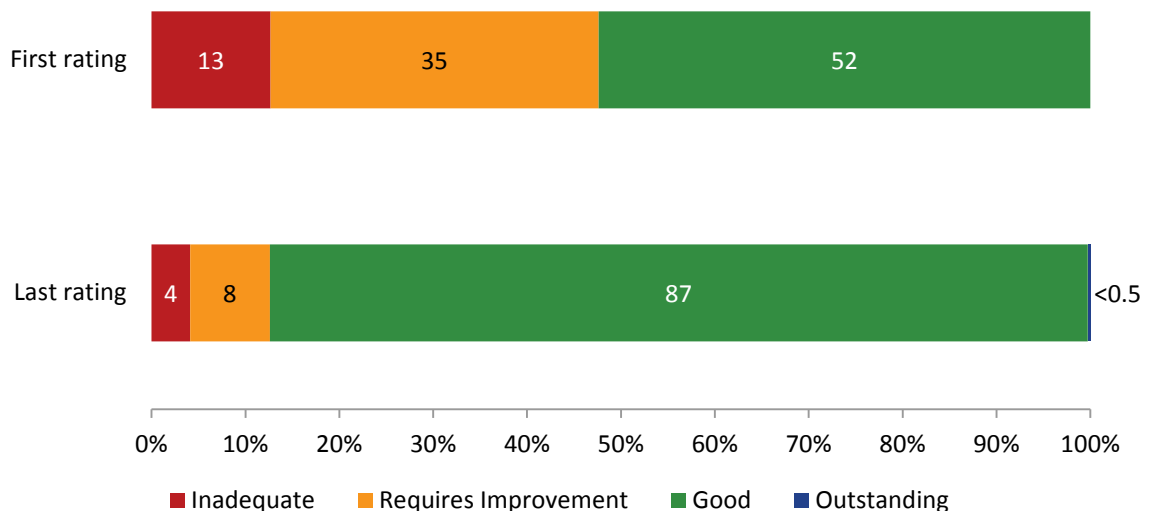
4. Improvement and deterioration

Key points

- Of the practices rated as requires improvement or inadequate on first inspection and re-inspected, 82% had improved their rating by 16 May 2017.
- Over half (53%) of the practices that were rated as inadequate on first inspection and re-inspected were rated as good on the latest inspection.
- At the end of May 2017, 138 practices had come out of special measures because they improved (71% of practices re-inspected).

Between the beginning of the inspection programme and 16 May 2017, we returned to re-inspect 1,333 practices (figure 10). Of these, 635 practices had been rated as requires improvement or inadequate for their first overall rating; following re-inspection, 520 (82%) had improved their performance and rating overall.

Figure 10: Overall ratings for GP practices before and after re-inspection

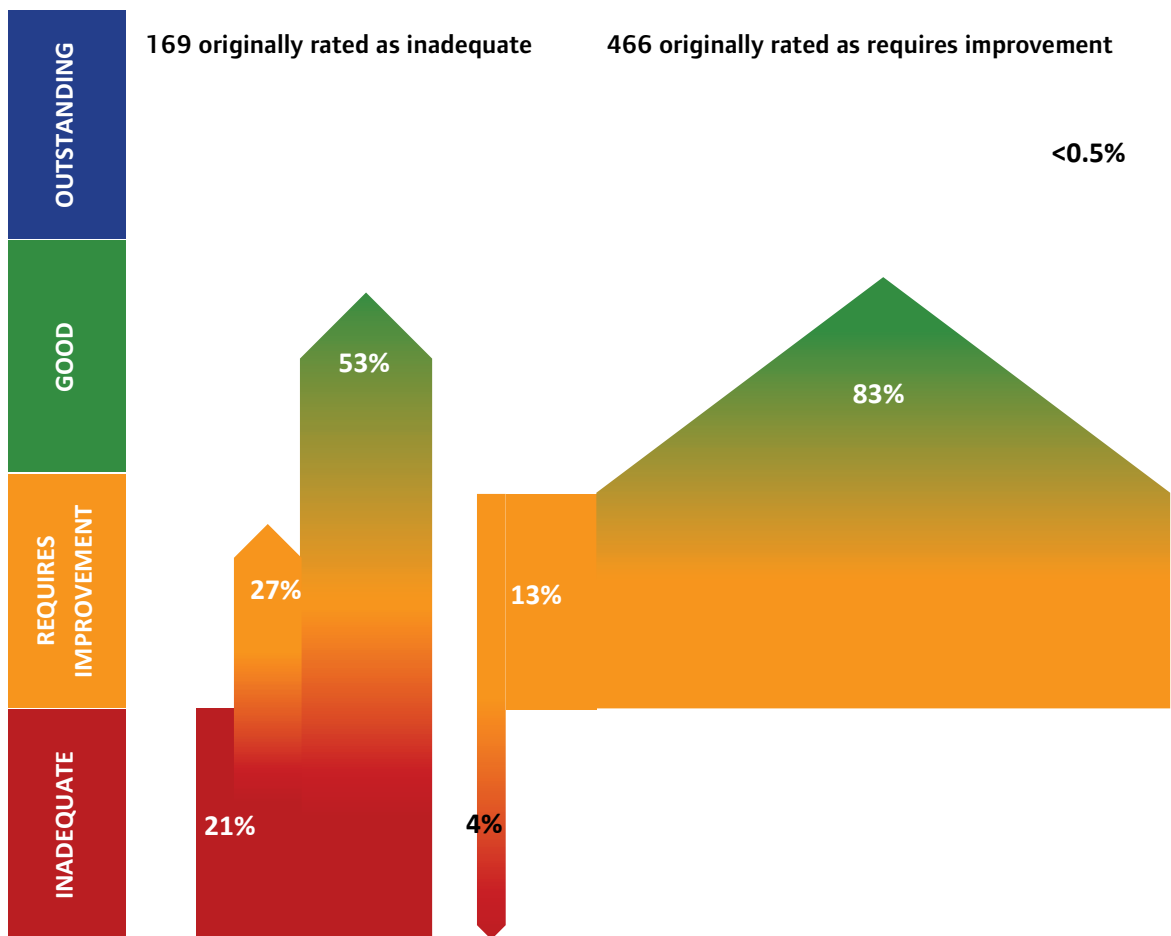


Source: CQC ratings data, based on 1,333 re-inspected locations, as at 16 May 2017 (figures in the bars are percentages).

Of all the practices that we re-inspected, 90% have improved in at least one key question and not deteriorated in any others. However, 4% have deteriorated in at least one key question and 6% have stayed the same.

Of those practices rated as inadequate on their first inspection and re-inspected, over half (53%) were rated as good on their latest inspection. However, 21% of those rated as inadequate remained inadequate. Of those rated as requires improvement on their first inspection, 83% improved to good on their latest inspection (figure 11).

Figure 11: Improvement in ratings on re-inspection (for practices rated as inadequate or requires improvement on their first inspection)



Source: CQC ratings data 16 May 2017. Note: The width of each cluster of arrows is relative to the number of re-inspections carried out.

4.1 Special measures

People who use GP services have the right to expect high-quality, safe, effective and compassionate care. Where care falls below this standard and we judge it to be inadequate following an inspection, we place the GP practice into special measures. This is because we want to ensure that practices found to be providing inadequate care do not carry on doing so and that they get the support they need to improve.

Under our current policy, a practice is automatically put into special measures if it is rated as inadequate overall, or if it is rated as inadequate in one or more key questions or population groups in two successive inspections. Such practices would normally be re-inspected after six months in special measures.

The purpose of special measures is to:

- ensure that providers found to be providing inadequate care significantly improve
- provide a framework within which we use our enforcement powers in response to inadequate care and work with, or make providers aware of, other organisations in the system, to ensure that the practice makes improvements
- provide a clear timeframe within which a practice must improve the quality of its care, or we will take further action, for example to cancel its registration
- open the way to a package of support from NHS England or the Royal College of General Practitioners to help the practice improve.

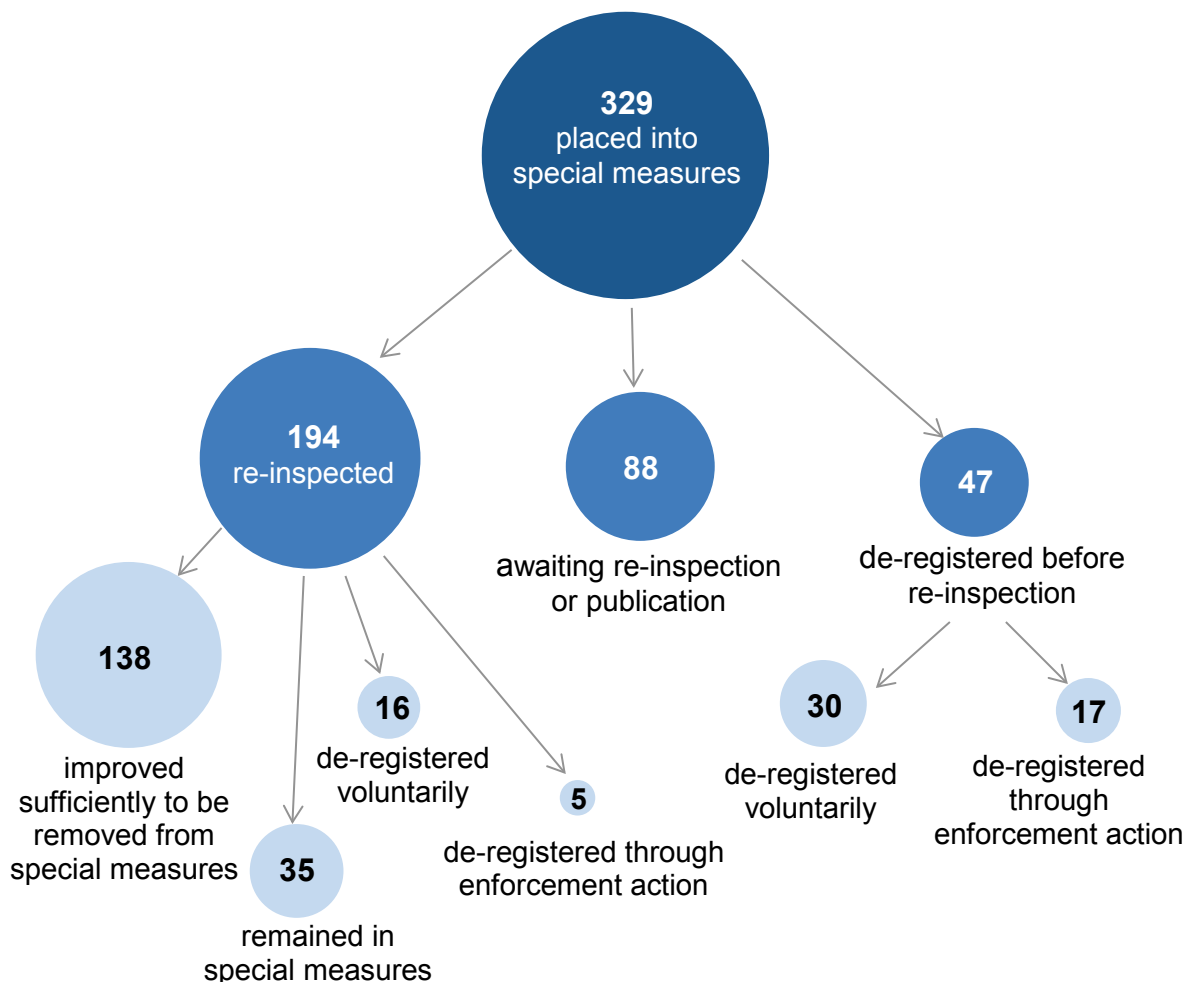
The strength of our regulatory action is always in proportion to the risk to the safety of patients. When we place a GP practice into special measures, we will re-inspect it within six months. At this inspection we expect to see improvements to the quality of care: if the practice continues to be rated as inadequate and has not made sufficient improvements by complying with the legal requirements in the warning notice, we will take action in line with our enforcement policy. In some cases, this can mean cancelling the practice's registration.

To come out of special measures, a GP practice needs to have an overall rating of requires improvement or better. In our re-inspections of practices that have been in special measures, the majority have made improvements and many are now providing good care.

From the start of the programme in January 2015 up to 31 May 2017, 329 practices entered special measures. Of the 194 practices that were re-inspected, 71% improved their rating and exited the regime.

At the time of writing, some practices had not received their second inspection, or had not shown enough improvement to exit special measures. A proportion of practices that had been put into special measures had their registration cancelled – either voluntarily or as a result of enforcement action by CQC (figure 12).

Figure 12: Journey of practices in special measures at



Source: CQC special measures data 31 May 2017.

4.2 What drives improvement?

In this section, we reflect on the factors that have enabled GP practices to improve from a rating of inadequate to a rating of good, drawing on findings from case studies. To develop the case studies, we analysed a selection of inspection reports and interviewed the inspectors that visited practices to carry out the re-inspection. The interviews aimed to uncover the factors that had driven practices' improvement.

Acknowledging the problems

A finding from the case studies was that acknowledgement of problems was important to improvement. Practices that improved had acknowledged that there were problems in the practice that needed attention and they were willing to learn from the findings of the inspection. They were motivated to change, keen to learn from what was wrong and were keen to access support to try to improve.

We saw that key members of senior staff, including GP partners and practice managers, needed to embrace the findings from the inspection as an opportunity to improve. These people were the driving forces behind the changes that were made. If there is a culture of owning problems and reflecting on the things that haven't gone well, then there is more likely to be improvement within the practice. They recognise that it is a whole staff effort, not just down to one person.

The case studies showed that an initial rating of inadequate can be a shock to the practice, but this can be channelled into making improvements. Some practices were eager to protect their reputation, and were motivated to improve to 'lose' the inadequate rating.

We found that a negative attitude towards the inspection meant that the findings from the inspection were dismissed and this was a key internal barrier to their improvement. In particular, practices that rejected the findings and rating, rather than focus on making changes, were less likely to improve as they had not recognised that they needed to change and lacked appreciation of the severity of the issues raised.

Governance

Our case study analysis found that a key driver of improvement was to address and resolve governance issues – the clinical and corporate systems and processes that underpin how practices assure their practice and the care they provide. Practices may improve by refreshing systems and processes through governance and appraisals. An example of this is a practice that had employed a reception manager to ensure a consistent set of policies across sites following concerns about the behaviour of receptionists; in turn, when the CQC inspector re-visited the practice, they saw that this had freed up time for the practice manager to focus on the governance concerns.

“The practice manager and partners had been able to develop new systems of governance by engaging with the staff and empowering them, by delegating responsibilities and action from governance meetings. The hiring of the reception manager freed up the time for the practice manager to do this.”

(CQC inspector)

In other examples, practices had recruited operations managers to deliver a unified strategy and policies that aligned with it, and created new roles to share some of the responsibilities for governance with a GP partner. This helped to establish clearer roles and responsibilities. To be successful in driving improvement, the practice manager needed to have authority and be empowered to make the necessary changes.

Our case study analysis also identified that clinical partners were particularly important across the practices, as improvements were made when clinical partners engaged more with the business side of the practices and had a better understanding of the governance around safety, safeguarding and risk assessment.

Where practices failed to improve, we identified a lack of recognition of the importance of good governance. Many systems and processes such as patient record-keeping or clinical audits were absent or inadequate. When they were addressed, it was sometimes via a ‘tick-box’ approach, which was insufficiently embedded or monitored. It could be as a result of an ‘old-fashioned’ view of general practice and not keeping up-to-date with the vital role of clinical governance in quality services.

Leadership

In practices that had improved on re-inspection, leadership was particularly important. In some cases it was the leadership role performed by the practice manager that was a key driver of improvement. In the following example, the CQC inspector highlighted the dismissal of the practice manager as impetus for a positive shift in culture within the practice when they re-inspected.

“The management team ‘got a grip on things’. The practice manager left after CQC’s inspection team brought to light serious concerns. GP partners had previously left the running of things to the practice manager but, after the inspection, there was a shift in culture across leadership. They embraced the findings of the inspection and worked through the action plan set out for them. The departure of the practice manager and the change in culture allowed staff to learn new roles and become empowered. Going back in to the practice, it was like seeing a different group of people.”

(CQC inspector)

Poor leadership emerged as the strongest message from practices that had failed to improve.

The case study analysis identified that there were barriers around ownership of improvements. In one practice, the lead GP had outsourced the improvement process to an external consultant, who had come in to drive through changes in the practice. Elsewhere, the GP lead nominally gave the lead to the practice manager, but undermined decisions that would have led to improvement. In a third case, the GP lead left improvements to an over-stretched practice manager and a one-day-a-week locum GP. This undermined the sustainability of any changes made.

The lack of an effective practice manager was also a factor in practices' failure to improve. If practice managers were either absent, temporary, or overstretched across multiple services, they were not empowered to drive change, or did not have the time or the clinical background to fully address or monitor improvements. Therefore, effective clinical and management leadership are important if ratings are to improve.

Internal staffing issues and dysfunctional working relationships within the practice, which are often longstanding, stifled improvement. Difficulties in recruiting staff from all professional backgrounds – not just GPs but nurses – particularly following a rating of inadequate, limited practices from improving because of a perceived poor reputation. However, the interviews identified that some practices had overcome this challenge through having nurse-led services and creative recruitment strategies.

Support from external bodies

The case studies identified that practices that had improved from a rating of inadequate to good needed varying degrees of external support to deliver improvements. The Royal College of General Practitioners (RCGP) currently runs a peer support programme, commissioned and funded by NHS England. This is aimed at helping practices rated as inadequate and placed in special measures, and allows them to apply for funding. The scheme offers struggling practices up to six months of turnaround support including advice, mentoring and improvement plans. In some cases, we have seen strong support for practices from their clinical commissioning group (CCG) or local medical committee (LMC).

In some cases analysed in the sample, the input provided by the RCGP, CCGs and LMCs had an influence on practices' improvement from inadequate to good. In some examples, with refreshed leadership, practices were able to drive the improvements on their own, and in others, improvement came through working with another practice or forming a larger federation.

Where practices failed to improve on the second inspection, the case study analysis found that improvement was inhibited because practices were unwilling to accept that they needed support or to access the support that may be available to help them improve. This included support from other GP practices as well as the RCGP programme, which is optional.

Although access to external support can be a driver for improvement, we have seen that there is a lack of a system-wide coordinated programme of support for practices, rated as both requires improvement and inadequate.

We have not found any causal relationship between the funding that practices receive from the NHS and our ratings. This is a complex area that may benefit from further work.

4.3 Maintaining improvement

While most GP practices have improved since being rated as inadequate, there are a number that have failed to improve. Where a practice fails to improve and is rated as inadequate at the second inspection, we take further action in line with our enforcement policy and, in some instances, this is to begin the process of preventing the provider from operating the service.

Looking at practices that were rated as inadequate overall on their first inspection, which was more than six months before the ratings picture was extracted on 16 May 2017, we are able to track what has happened to them. There were 229 practices: 26 of these became inactive before we could re-inspect them. Being inactive means that the provider that was registered with us had either left the market entirely, or had at least changed a material aspect of its service and then re-registered with us. At 16 May 2017, 35 practices were either awaiting inspection or publication of their inspection report and rating.

This meant that we re-inspected 168 practices: of these, 133 improved their overall rating and 35 remained rated as inadequate. Of the 35 that remained as inadequate, 18 subsequently became inactive.

It is still too early for us to have a good overall picture of the sustainability of improvement. However, we have seen a small number of cases of practices whose rating had initially improved, but which then deteriorated. This shows the importance of a consistent and sustainable programme of support to help practices improve and to maintain that improvement. Implementing the pledges in the GP Forward View, and ensuring that practices are fully aware of available support, is therefore a key element of improvement.

Maintaining improvement in GP practices is particularly important for all health services in a local area, as we know that good and outstanding practices are a key driver for good integrated models of care for patients.

Conclusion

This report shows that the majority of people in England receive good quality care from general practice. It also shows that there are pockets of poor practice, which CQC has identified and highlighted so that care can improve for the benefit of patients, and the profession.

We want to support general practices in England so that everybody receives good quality care. To do this, we will continue to work with NHS England, NHS Clinical Commissioners, the professional regulators and other national bodies to develop a shared view of quality and reduce duplication of reporting and, as a result, the administrative impact on GPs more widely. Our inspections have found a number of internal and external factors that contribute to high-quality care, and factors that may inhibit it. We recognise the need for more multidisciplinary working to enable patients to see other healthcare professionals to reduce pressure on GPs. We also believe that sustainability in general practice can be achieved if practices work collaboratively.

The information we now have about the quality of care in general practice provides a valuable baseline. From this, we can share what we know about how practices are delivering high-quality care, at the same time as identifying those practices that need further support. In this respect, the funding from the GP Forward View must be targeted appropriately to ensure that struggling practices are able to sustain improvements. Delivery of the GP Forward View is critical to address the challenges that the sector faces and ensure that it gets the investment it needs to continue to play a key role in a sustainable local health economy and ensure that patients get access to the high-quality care they need.

We intend to look at how this investment has had an impact on the quality of care. We also intend to delve deeper into some of the factors identified in this report that enabled practices to improve, as well as the reasons for deterioration.

Going forward

As a learning organisation, CQC recognises what aspects of the first programme of inspections have worked, and those that we need to improve. We are now using the learning to refine our approach to how we regulate general practice in England. For example, where services are rated as good or outstanding our approach will be more proportionate, and we will work collaboratively with commissioners and other stakeholders to reduce duplication of what we ask of general practice and to share information effectively so we have a shared view of quality. But we will always continue to ensure that patient safety remains paramount through monitoring and taking action where we believe patients to be at risk.

We will use our monitoring information to follow up any potential changes in the quality of care and, in light of what we have found through our first programme, will always inspect the leadership, governance and culture of the practice.

As part of our monitoring of practices, we will still be looking for evidence of outstanding care, and where we think somewhere has improved beyond good we will inspect so that we can understand the reasons why and share the learning. We have consulted on our proposed changes and, after considering the feedback, will implement them in our Next Phase of regulation of general practice.

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