Submission to the Health Select Committee
Care Quality Commission accountability inquiry

Introduction
The British Medical Association (BMA) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership in the region of 170,000, which has been growing year on year.

We welcome the Health Select Committee’s upcoming Care Quality Commission (CQC) accountability inquiry, and believe this is a key opportunity to consider the organisation’s response to the recent Public Accounts Committee (PAC) and National Audit Office (NAO) reports. It is also a valuable opportunity to explore CQC’s role and effectiveness more broadly.

Executive Summary
Through our General Practitioners Committee (GPC) we work closely to provide guidance, information and support for GPs as they undertake the registration and inspection process. This includes surveying GPs to gauge their views and experiences of the regulator. Our most recent survey was conducted in January 2016 and had over 1,900 respondents. This response to the Committee focuses on the information we have gathered as part of this process.

Key points from this submission include:

- GPs report that both the CQC registration and inspection process is unduly bureaucratic and lends itself to ‘tick boxing’ rather than addressing areas of genuine concern in relation to patient safety and care quality. The BMA support proportionate regulation and as such would like to see a reformed system based on an inspection approach that provides targeted assessments of essential quality assurance processes and addresses unreliable aggregate ratings. Such assessments should be designed not to duplicate what is already assessed by NHS commissioners.

- The inspection process, including preparation time and the wait between inspection and report, can be a lengthy process and we have concerns that preparing for inspection takes doctors away from patients, at a time when general practice is already struggling to meet patient demand. This can, in turn, impact negatively upon doctor morale. General practice is under significant pressure, yet GPs are clear that the outcomes for patients will not improve simply as a result of a CQC inspection.

- There is a lack of acknowledgement and consideration by CQC of GP practices budgetary constraints in the inspection process, resulting in those practices which receive lower funding on a per-patient basis often being provided with lower ratings. The untimely provision of the inspection reports and ratings is also of concern.

- There is huge frustration that, regardless of whether costs are covered centrally by government or directly from practices, CQC fees divert overstretched funds from frontline patient services to prop up a system of regulation and inspection in which the majority of GPs have little confidence.

Quality and ratings
1.1 Our comments come against a backdrop of 87% \(^1\) of GP practices inspected by CQC having been rated as ‘good’ or ‘outstanding’. We therefore consider that the experiences and feedback provided by GPs to be motivated by a desire to see the establishment of a more efficient regulatory system that is better suited to meet the needs of patients without unduly burdening the profession.

1.2 The CQC’s Annual Provider Survey Results\(^2\) show that nearly half (43%) of the 1,004 GP practices who responded do not believe that the way CQC inspects and regulates is beneficial to the quality of care received by people. Worryingly, two thirds (67%) of GP respondents also stated that the outcomes for those who use their services have not been (or will not be) improved as a result their inspection. Our own survey also revealed that nine in 10 GP practices believe inspection ratings are too simplistic or misleading to measure quality of care accurately\(^3\).

1.3 The BMA believes it would be beneficial for CQC to provide details of what evidence it holds that its ratings are actually being used by patients when they choose healthcare providers.

1.4 In light of this, and reflecting our member feedback, we share the PAC’s concerns, raised in its report, Care Quality Commission Twelfth Report of Session 2015–16\(^4\). The report notes that when the CQC is asking providers to pay substantially more towards the cost of their inspection it is more important than ever that it can demonstrate the quality of its work. In particular we agree that CQC should demonstrate a reduction of errors in draft reports, a reduction in the amount of time it takes to produce the reports, and that it should address variation in the quality of initial judgements.

1.5 The BMA would like to seek assurances from CQC that it is addressing these challenges and will report back on its progress.

**Impact on doctor morale**

2.1 We have significant concerns that CQC inspection preparation time is particularly burdensome for GPs and that this is having a knock on effect on patient care and doctor’s morale. Our survey showed that eight in ten practices report that the workload to prepare for a CQC inspection is ‘excessive’ and around 80 per cent of practices say the system of checking their services takes GPs away from patients and increases doctors’ stress levels. We are also concerned with CQC activity involving practices that are struggling due to system-wide pressures.

2.2 We believe that the CQC should carry out more work to reduce the burden GP practices face when preparing for inspection.

**Performance level**

3.1 The BMA supports the Nuffield Trust’s report ‘Rating providers for quality: a policy worth pursuing’ \(^5\), commissioned by the Secretary of State for Health, which recommended that “ratings should be updated regularly and made available in a timely way”. With this in mind it is worrying that the

---


\(^6\) The Nuffield Trust’s report ‘Rating providers for quality: a policy worth pursuing’, published in March 2013

\(^7\) CQC’s recent Chief Executive report to the Board (Public Board Meeting, 22 September 2016)

CQC’s recent Chief Executive report to its Board\(^6\) states that ‘overall, no directorate is meeting their objectives in the timeliness of inspection reports published to people who use services and providers’.

3.2 As one example of its performance, the (year to date) figures provided to the Board show that only 65.5% of reports for primary medical services (which includes GP and dental practices) are being published within the 50 working day target set by CQC\(^7\). We are also concerned with the long delays in re-rating practices that have quickly made the necessary improvements. It is unfair for such practices to be linked to a rating that no-longer reflects their status.

3.3 We are keen to see CQC address concerns raised by both the PAC and the NAO regarding its staffing levels and performance issues, such as continued failure to meet targets in issuing reports.

3.4 The BMA survey also revealed that three in four GPs state that the CQC inspections were more likely to make them want to leave the profession. We believe that at a time when general practice is in crisis and facing increasing recruitment challenges, it is unacceptable that a regulation and inspection regime exists which actively discourages doctors from working in general practice.

3.5 We continue to urge the CQC to fully engage with the profession in developing its plans to overhaul the inspection approach to reduce unnecessary burden on GPs, allowing them to free up time to better meet the needs of patients.

**Funding impact**

4.1 Following a Local Medical Committee special conference in January 2016, the BMA undertook a piece of work to analyse whether per practice funding levels correlated with CQC ratings\(^8\). The results from inspections carried out at 2,814 GP practices in 2015 showed there is a clear link between the amount of funding a GP practice receives and the rating they are allocated by the CQC. We are particularly concerned that CQC takes no account of resources available to practices when they rate the level of care they provide. Practice funding is directly contributing to GP practices being rated ‘inadequate’ or ‘requiring improvement’.

4.2 The BMA believes that the CQC should take into account the inequality in practice funding during its registration, monitoring and inspection process.

**Fear of intervention**

5.1 The BMA also supports the PAC report’s recommendation that CQC must improve its response to concerns raised by both staff and patients. The BMA found that almost 50 per cent of GPs say their practice is experiencing significant pressures and 47 per cent say their practice is struggling and not coping\(^9\). However, worryingly a quarter say they are less inclined to raise concerns about practice pressures for fear of CQC intervention. We are concerned that the perception of GPs is that raising genuine concerns to address and promote patients wellbeing and safety will lead to them being penalised through CQC intervention.

5.2 In the interests of patient safety we hope that CQC will work with GPs to address these concerns.

**Cost of regulation**


\(^7\) Comparing per patient funding levels with published CQC ratings of practices www.bma.org.uk/-/media/files/pdfs/working%20for%20change/urgent%20prescription%20for%20general%20practice/comparing-cqc-ratings-with-patient%20funding-16052016.pdf

\(^8\) Regulatory fees for 2017/18 – consultation http://www.cqc.org.uk/content/regulatory-fees-201718-consultation
6.1 The cost of regulating the GP sector by the CQC is high. We are concerned that, regardless of whether funding is provided centrally or directly via practices, such fees will divert overstretched funds from frontline patient services simply to prop up a system of regulation and inspection in which the majority of GPs have little confidence. Practices have seen costs recovered from them increase from £6M in 2013/14, to £21.3M in 2016/17, to a proposed £37.5M for 2017/18.

6.2 Although there has been talk of efficiency measures and a change in approach to regulation of the GP sector during this time, the overall cost of regulation will have reduced little (approx. 6%) since 2013. The proposed figure of £37.5M to be recovered from GP practices in April 2017 (compared with £37.6M in 2016) should be vigorously challenged given the cost of regulating the sector should significantly reduce as a result of proposals to diminish the frequency and bureaucracy of GP inspections.

6.3 The CQC should explore the reasons for the continued high cost of regulating the GP sector, and establish if proposals to maintain costs at this level in 2017 are justified given the expected decrease in practice inspection activity and the aim to reduce costs.

November, 2016

For further information, please contact:

Gemma Hopkins, Senior Public Affairs Officer
Tel: 020 7383 6287 | Email: ghopkins@bma.org.uk