Care Quality Commission PPG Sounding Board Meeting, 18th March 2014 Birmingham

Report

1. Introduction

In March 2014, 22 representatives from Patient Participation Groups attended a workshop run by the Care Quality Commission (CQC) and the National Association for Patient Participation (N.A.P.P.). Many of those present had advised CQC previously on the methodology used by CQC teams to inspect GP practices and had helped CQC write its "Guide to Working with PPGs" in 2013.

The purpose of the day was to:

- Update PPGs on our work in primary care and tell you about our latest plans for inspecting GP practices
- Ask colleagues in PPGs how CQC should judge quality for people who use primary care services – how to distinguish good and outstanding care
- Discuss how we should take forward our work with PPGs and how CQC can better gather local views about primary care services.

Below is a summary of the key points from the discussion.

2. What does a 'good' GP practice look like?

The meeting heard from Vickie Priest, Primary Care Policy Manager about CQC's new plans for inspecting GP practices and then looked in detail at proposed 'Key Lines of Enquiry' to be used by inspectors. The group also commented on the proposed system for rating GP practices.

The meeting agreed that a 'good' GP Practice:

- Has appointments easily available and good opening hours, including on a Saturday
- Provides a named GP for all routine appointments
- Can provide quick easy consultations when urgently needed, over the phone where necessary
- Can demonstrate measurable, effective patient care
- Has staff who are considerate and friendly
- Provides quick access to all results – blood tests etc.
- Is responsive to concerns
- Provides clear information and is open and transparent with its patients.

Participants commented that the five overarching questions were easier to understand than the previous standards – generally these areas are the right ones for monitoring quality and safety in GP practices. However, it was agreed that the lines of enquiry needed to be focused on the patient perspective: each question should be framed according to what this would mean to be a patient here.

The group were broadly supportive of rating services as this would lead to improvement and encourage good practice. However, people told us it was difficult to see how an overall rating of 'good' would be achieved – would you have to be good for each area to receive the rating? It was suggested CQC published detailed results for each sub-question as well as for the overall question areas. Others were concerned about judging a practice according to each specific population group – as each practice serves a different type of population. Also, it was difficult to see how the public would use this information to make decisions.

PPG members present discussed how CQC would identify whether a practice was adequately serving all members of the local population – "*Is the practice cherry picking some kinds of people?"* One suggestion was to include a specific question on registration policy: to identify whether the practice was prepared to register everyone from the local population, regardless of their background.

A key overarching concern was how inspectors would find out about people's views and experiences – would they attend consultations, sit in on appointments? There were concerns about this being inappropriate….

How would the views of people who lacked capacity be measured?

3. Draft Key Lines of Enquiry – gaps and areas to strengthen

3.1 Safety

This area should include how well the practice listens to families, patients and carers when things go wrong.

"*The key lesson from Francis was that patients weren't being listened to – this is an integral part of safety as well as responsiveness"*

Inspectors should ask whether a patient or their family *feel* safe – what are the elements of their care which make them feel safe?

S2 (learning when things go wrong) is key and should be strengthened – to reflect performance over time as regards safety.

Openness and transparency is missing from this area – safety is about telling people when things go wrong and being open so that everyone knows how problems are being dealt with.

The entire environment should be considered – take a holistic approach to safety – from the car park through to the doctor's surgery.

3.2 Effective

These descriptors contain imprecise language making them open to dispute*: "what exactly do we mean by 'timely', what is meant by 'nationally accepted norms' "*

E3 (patients being seen, diagnosed and referred) needs to refer to flexible appointment times where necessary.

E3 : must also include issues of communication about discharge – how does the GP practice follow up discharge/ chase for lack of notice? Poor discharge practices, late letters from trusts are a common block to patients getting effective care – what are GP practices doing about this?

How can patients be reassured that there is consistency of practices across locality group? How is this being monitored?

Bereavement and palliative care: must be explicitly referred to in this area - How is information relayed around deaths of patients? How does the practice support the bereaved family?

E5: Must also refer to locum GPs – how does the practice ensure that not too many shifts are being covered by doctors from outside the practice?

Care plans are difficult to measure but fundamental – this is an integrated tool owned by many agencies and by the patient.

3.3 Caring

C2: Some of the wording needs qualifying: People should be involved in their own care, but many don't want to be.

C2: An outstanding practice would have patient champions in place to make sure people are fully involved in their own care.

C2: Make more specific referrals to language interpretation services- being able to speak to a doctor in a language you can understand is key to being cared for. However, some people at the meeting pointed out that a practice serving a population with many different languages should not be penalised for lack of interpreters.

C3: Transgender issues need to be considered here.

C4: Providing for grieving relatives: strengthen this element: a good practice has a recognised plan for each bereaved family and is connected into support networks, has staff appropriately trained around bereavement.

3.4 Responsive

Some references are unclear: this mentions a patient survey – is this the National Patients Survey or a survey led by the PPG?

R4 describes how a 'good' practice must have a Patient Participation Group – this could be strengthened to describe the elements of an effective PPG: face: face meetings, an independent chair, support from the practice. NAPP are developing a quality assurance and development framework sponsored by NHS England around setting up and running an effective PPG.

R2/R1 must include an emphasis on language and translation – providing services for people who do not speak English as a first language.

Include numbers of appointments made and met and waiting times for appointments here – this might indicate whether the practice has enough GPs for the population served.

R3 – is too vague – 'reasonable adjustments': A good practice must be fully accessible to people with disabilities including access to the entire building, not just getting into the front door and through the ground floor. Often, external doors open automatically, whereas internal doors do not.

3.5 Well-led

The reference to the Duty of candour is welcome, but it must sit firmly with senior managers – that leaders can demonstrate they understand the duty and act it out.

W4: The group questioned whether CQC could give guidance about acceptable levels of feedback to patient surveys. When is a practice survey not good enough?

All good practices should have a PPG with a defined independent mechanism for working – see above reference to N.A.P.P. assurance framework

4. CQC and Patient Participation Groups

The meeting discussed how CQC currently contacted PPGs on an inspection and looked at how this might be improved as CQC changes its approach. Two of the PPGs present had experienced a CQC inspection, others had feedback from other local groups.

Some members were concerned about CQC contacting the PPG through the Practice Manager as not all PPGs had good relationships with their Practice Managers. CCGs hold lists of PPG chairs – this might be a better way to contact them.

The group suggested that the extended notice period might allow for more contact with the PPG – the PPG could possibly call a meeting at the practice and invite inspectors? PPGs can often do more to support an inspection – encourage feedback, carry out an assessment of complaints.

CQC should work with networks of PPGs which are emerging in many areas. For instance some CCGs are developing Patient Congress. Some are formed independently of GP practices which is important.

Some PPGs have their own websites, some are using facebook and social media. Inspectors should always gather information to prepare for a visit from practice websites and from the PPG pages.

CQC needs to ascertain whether practices have a functioning and effective PPG rather than a virtual patient reference group – inspectors need to understand the difference. The 'best practice' model is where a practice has a face to face group supplemented by a virtual PPG.

5. Gathering local views about the quality and safety of care in GP practices

The meeting suggested a number of ways of gathering local views prior to each CCG-wide inspection:

Run focus groups with patients two weeks before the inspection to determine which areas to focus on – use common questions across the country to allow for comparison

PPGs can help run these and the membership should be a mixture of PPG members and members recruited from the virtual PPG group or from people who have visited the practice in the last year

It is important to reach patients who are using the practice and those who are on the practice list and in the wider community. The meeting was concerned that CQC was not getting appropriate representation of views, or that it did not always understand the local population.

Work with Local Healthwatch. This was seen as key – they have a seat on the Health and Wellbeing Boards and also work with local groups such as CVS, Age UK, Diabetes UK, local mental health charities who can all provide useful views about local care.

Reach out to those groups who are less likely to attend meetings/ be a member of the PPG - young people/ teenagers – those that don't get ill very often.

Use online text messages to gather views. It is important to have a confidential way of feeding back views.

CQC must also do more to publish its findings and to tell people how we have listened to them – work through PPG bulletins or newsletters as well as local media and through N.A.P.P. communication channels.

6. Next Steps

CQC is launching its consultation on the new Handbook for GP practices, the key lines of enquiry used by inspectors and its approach to ratings on April 9th 2014. www.cqc.org.uk. A similar workshop will be run at the NAPP conference in June 2014 and CQC is keen to involve the sounding board and others in revising the Guide for PPGs and supporting our inspectors to work with PPGs.

Clare Delap, CQC, 4th April 2014