Provider handbook

Consultation

NHS GP practices and GP out-of-hours services

April 2014

The Care Quality Commission is the independent regulator of health and adult social care in England

Our purpose

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

Our principles

- We put people who use services at the centre of our work.
- We are independent, rigorous, fair and consistent.
- We have an open and accessible culture.
- We work in partnership across the health and social care system.
- We are committed to being a high performing organisation and apply the same standards of continuous improvement to ourselves that we expect of others.
- We promote equality, diversity and human rights.

Contents

Introduction

This guidance describes our approach to regulating, inspecting and rating NHS GP practices and GP out-of-hours services. It forms part of a public consultation we are carrying out on our approach to regulation and inspection in all sectors.

Our new approach builds on our consultation, *A new start*, which proposed radical changes to the way we inspect and regulate all health and social care services.

We then published a further document in December, *A fresh start for the regulation and inspection of GP practices and GP out-of-hours services*. This set out our proposals, which included a national team of expert inspectors that include GPs and other experts, and people with experience of receiving care (Experts by Experience).

We said we would use Intelligent Monitoring to decide when, where and what to inspect, including listening better to people's experiences of care and using the best information across the system. We also said our inspectors would use professional judgement, supported by objective measures and evidence, to assess services against our five key questions.

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs
- Are they well-led?

This would include ratings to help people compare services and to highlight where care is outstanding, good, requires improvement or inadequate.

There was good support for our proposals, with a desire for us to introduce them over a reasonable timescale to allow providers time to understand the new approach. We have listened to what people said and we will continue to develop and evaluate the changes as we test our new style inspections.

At the moment there is a lack of clarity about what good care looks like in general practice. We will change this by defining what good quality care looks like in relation to the five questions. We will work with the public, people who use services, GPs and practice staff across the sector and with our partners to do this. Our definitions will drive our ratings, which will be the authoritative judgement of the quality of care provided.

We want to make sure we look at the things that matter to the people who use GP practices and out-of-hours services, and that their interests are at the heart of the questions we ask:

- **Are they safe?** This will include checking whether practices and out-of hours providers learn and improve following safety incidents, that medicines are managed properly, and adults and children are safeguarding from abuse.
- **Are they effective?** This will include checking that people are given the right diagnosis and treatment and that patients are referred properly to specialist services. We will also check how GP practices work to prevent poor health and to promote healthy living.
- **Are they caring?** This will include checking that people are treated with compassion, dignity and respect and are involved as in partners their care
- **Are they responsive?** This will include checking whether a GP practice or GP out-of-hours provider plans its services to meet the needs of the practice population and will include checking that all patients can access appointments when they need to.
- **Are they well-led?** This will include checking that a GP practice supports its staff, provides training and supervision to make sure they are able to do a good job, and has good quality governance. It will also include looking at how the practice proactively gets feedback from people and learns from this feedback to improve services.

This guidance reflects our current thinking and will be refined as we test it further from April, when we start our first wave of inspections of NHS GP practices and our second wave of GP out-of-hours services. We will continue to work with the public, people who use services, providers and organisations with an interest in our work to develop our thinking further.

We will publish an update of this guidance with our final approach in September 2014, and we will roll out our new approach from October 2014.

We will inspect and rate all NHS GP practices and GP out-of-hours services in England between October 2014 and April 2016. Once we have done this it is likely that we will inspect services that are judged to be providing poor quality care more frequently than those that we judge to be good or outstanding.

1. Key principles

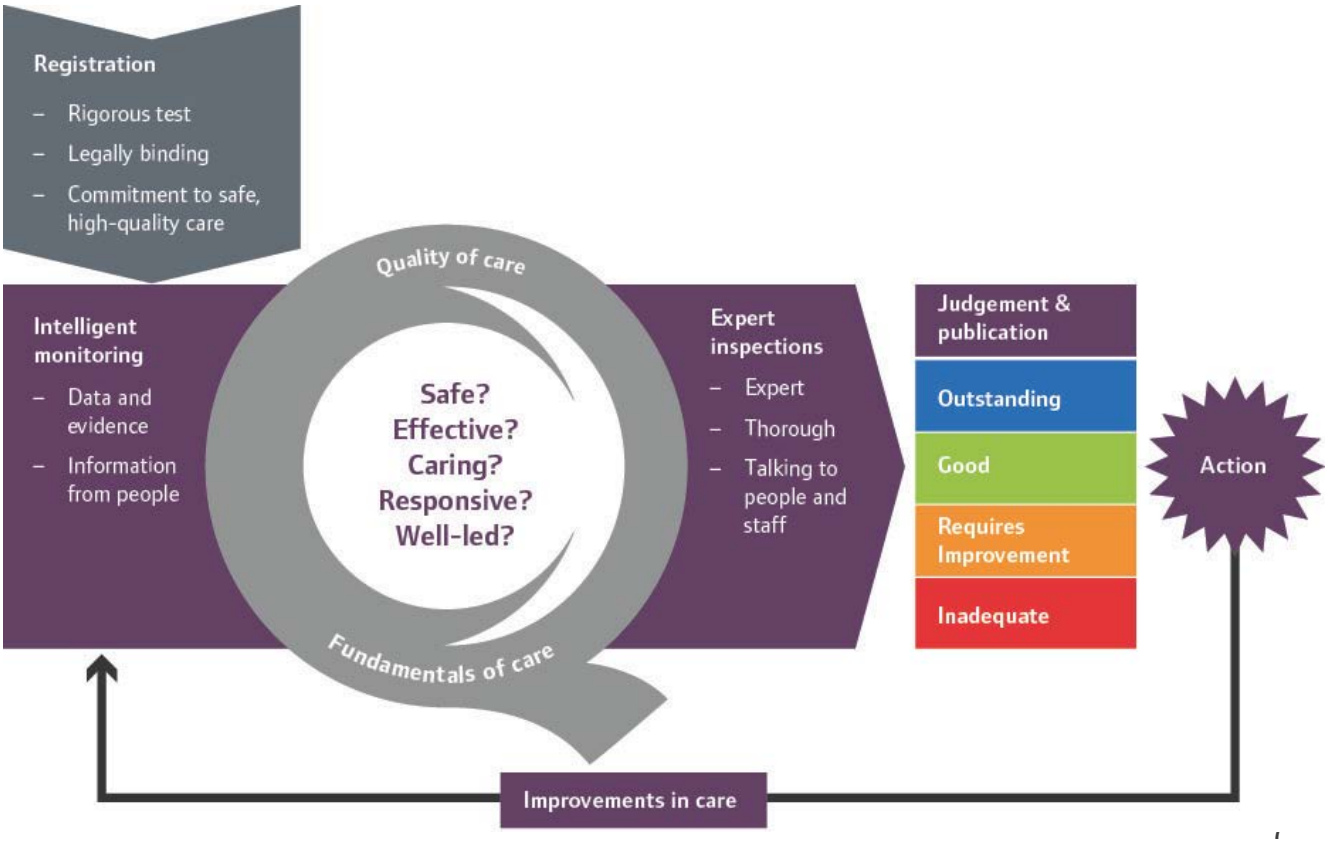
Although we will inspect and regulate different services in different ways, there are some key principles that guide our operating model across all our work.

Our operating model

The following diagram shows an overview of our overall operating model. It covers all the steps in the process, including:

- Registering those that apply to CQC to provide services
- Intelligent use of data, evidence and information to monitor services
- Using feedback from patients and the public to inform our judgements about services
- Inspections carried out by experts
- Information for the public on our judgements about care quality, including a rating to help people chose services
- The action we take to require improvements and, where necessary, the action we take to make sure those responsible for poor care are held accountable for it.

Figure 1: CQC's overall operating model



The five key questions we ask

To get to the heart of patients' experiences of care, the focus of our inspections is on the quality and safety of services, based on the things that matter to people. We always ask the following five questions of services.

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

For all health and social care services, we have defined these five questions as follows:

Safe	By safe, we mean that people are protected from abuse and avoidable harm.
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.
Caring	By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.
Responsive	By responsive, we mean that services are organised so that they meet people's needs.
Well-led	By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Population groups

As well as focusing on the five key questions, we will always look at how services are provided to people in specific population groups. For every NHS GP practice we will look at the quality of care for the following six key population groups:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

We will only do this when we inspect GP practices. It will not apply to GP out-of-hours services.

We have provided more detailed definitions of these population groups in appendix A.

By looking at services for these groups of people, we can make sure our inspections look at the outcomes of care provided for all people, including those who are particularly vulnerable. It also means we can present information to the public about local services that are relevant to them. For example, someone with a long-term condition would be able to look at the quality of care provided by a practice for all people with long-term conditions registered with that practice.

Consultation question

We have identified the population groups that we will inspect and rate during our inspections of NHS GP practices.

Do you agree that these are the right groups for us to look at?

Do you understand what we mean by these population groups? If not, what is unclear?

Do you agree that we should rate and report on each of these population groups for GP practices?

Key lines of enquiry

To direct the focus of their inspection, our inspection teams will use a standard set of key lines of enquiry (KLOEs) that directly relate to the five key questions – are services safe, effective, caring, responsive and well-led?

The KLOEs are set out in appendix B.

Included next to each KLOE is our description of what 'good' looks like in relation to that KLOE.

Having a standard set of KLOEs ensures consistency of what we look at under each of the five key questions and that we focus on those areas that matter most. This is vital for reaching a credible, comparable rating. To enable inspection teams to reach a rating, they will gather and record evidence in order to answer each KLOE.

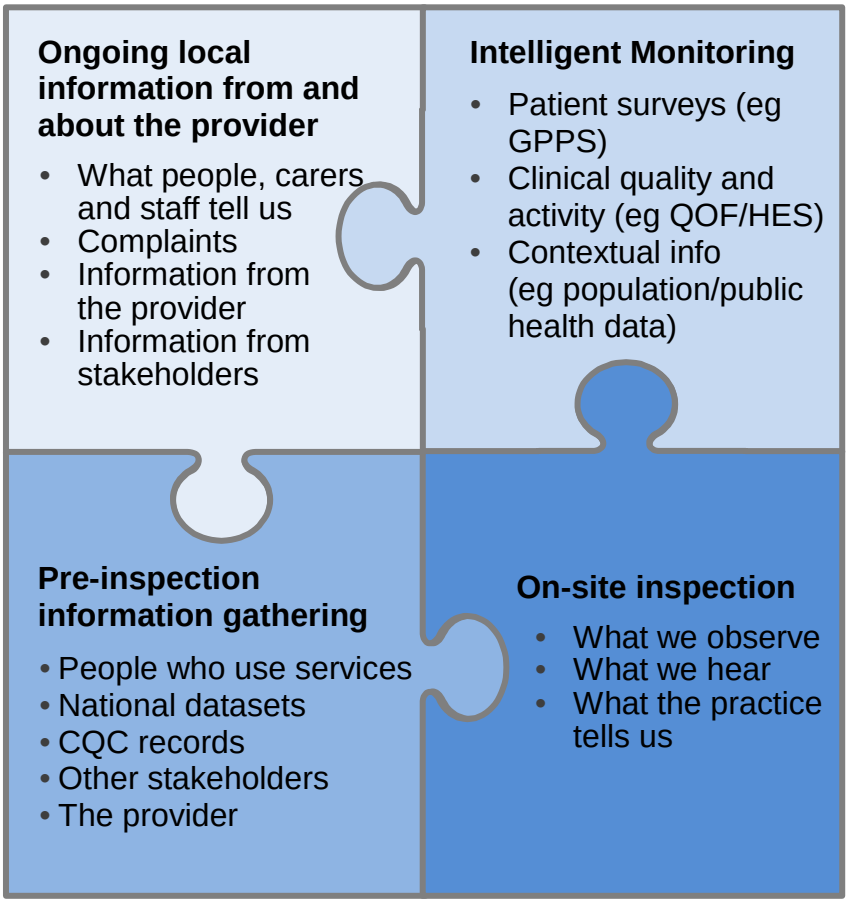
Each KLOE is accompanied by guidance on a number of particular of quality issues that inspection teams will consider as part of the assessment. We call these prompts. Inspection teams will take into account the information gathered in the preparation phase and the evidence they gather during the inspection, to determine which aspects of the KLOE they should focus on.

The prompts are included in appendix B. Note that there are some differences in the prompts for GP practices and GP out-of-hours services.

Inspection teams will use evidence from four main sources to answer the KLOEs:

1. Information from the ongoing relationship management with the GP practice or GP out-of-hours service.
2. Information from Intelligent Monitoring. This will include the data underlying 'risk' or 'elevated risk' scores, and other nationally available and local information that can form the inspection judgement. This will typically be included in the data packs described in section 5a.
3. Information from activity carried out during the pre-inspection phase as set out in section 5a.
4. Information from the inspection visit itself.

Figure 2: The four main sources of evidence



We will not, at this stage, have specific lines of enquiry for the population groups. Instead we have developed a short list of prompts for each population group, and these are linked to the most relevant KLOEs. These are set out in appendix D. We are working with internal and external specialists to develop these further. These will not be used in our inspections of GP out-of-hours services.

Consultation questions

Do you feel confident that the key lines of enquiry and the list of prompts will help our inspectors judge how safe, effective, caring, responsive and well-led NHS GP practices and GP out-of-hours services are? Is there anything we are missing?

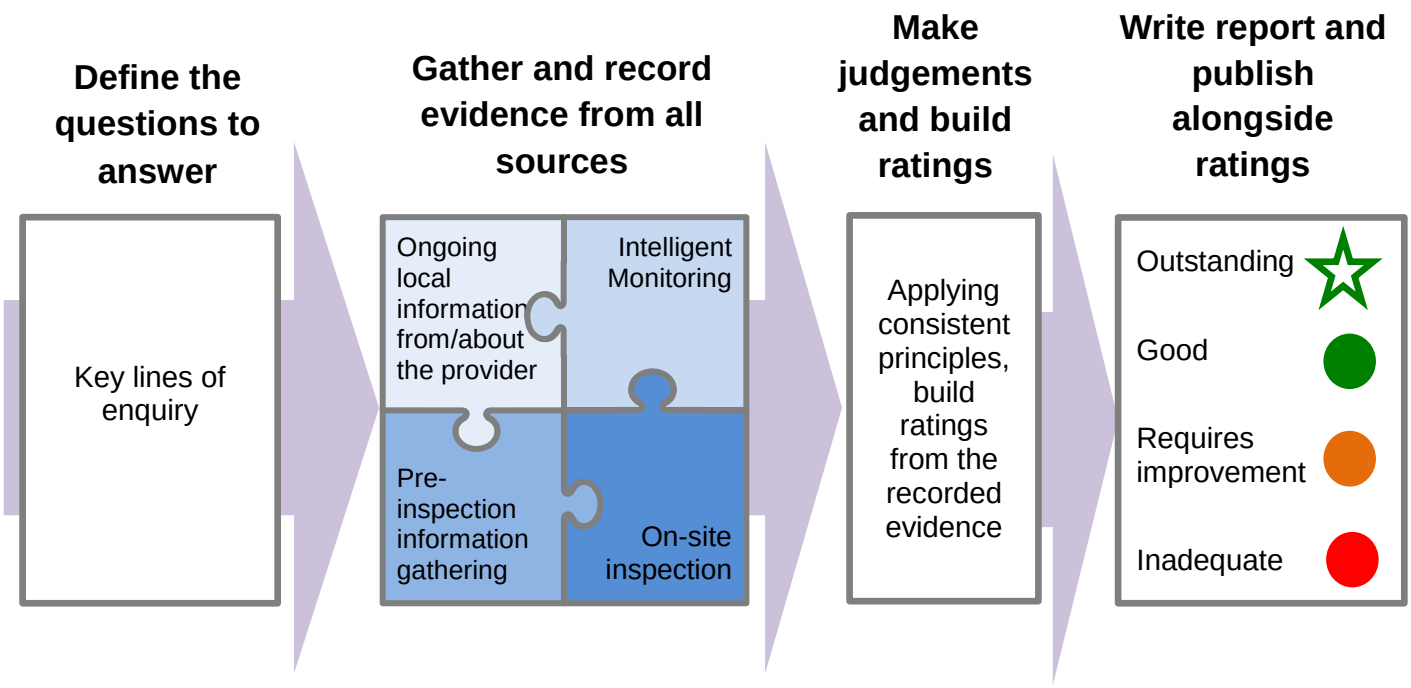
Do you agree that the key things we have highlighted for each population group are the right things for our inspectors to consider when they are inspecting GP practices?

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. We will do this in a phased way.

As set out in figure 3 below, our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding, good, requires improvement, or inadequate.

Figure 3: How KLOEs and evidence build towards ratings



From April 2014, we will start to test our approach to how we will decide ratings for GP practices and GP out-of-hours services. From October 2014 we will fully implement our approach to rating GP practices and GP out-of-hours services, including formal ratings.

We will consider whether we can award shadow ratings as we get closer to October. Shadow ratings are ratings which we will award following an inspection and will be included in the inspection report.

We have already carried out some early tests of our approach in GP out-of-hours services. From July 2014, we will provide shadow ratings for all GP out-of-hours services.

This draft handbook outlines the approach we are proposing to use once the regulations underpinning the Care Bill are in place (subject to Parliamentary approval). Until that point we will apply the principles and guidelines that we have outlined in this handbook to determine shadow ratings, but we reserve the right not to follow all elements precisely, as we will be learning from the inspections carried out and from this consultation. We will continue to evaluate and refine our approach over the coming months and years.

We have developed a description of each of the four ratings, for each of the five key questions. These are set out in appendix C.

These characteristics provide a framework which, together with professional judgement, will guide our inspection teams when they award a rating. We will be proportionate in making this judgement and will consider the context within which a practice is working, and the specific circumstances of each GP

practice or GP out-of-hours service. For example, the evidence we may gather to support our judgements might be different depending on the size of the practice. The inspection team will use their professional judgment, taking into account best practice and recognised guidelines, with consistency assured through the quality control process.

New national priorities or policy directions will also be included in these characteristics as they emerge.

Not every characteristic has to be present for the corresponding rating to be given. This is particularly true at the extremes. For example, if the impact on quality of care or on patients' experiences is significant, then displaying just one of the characteristics of inadequate could lead to a rating of inadequate. In the same way, a service does not need to demonstrate every one of the characteristics of good in order to be rated as good. Even those rated as outstanding are likely to have areas where they could improve.

Ratings are discussed in more detail in section 5.

Consultation question

Do you agree that the characteristics of 'outstanding' (in appendix C) are what you would expect to see in an outstanding NHS GP practice or GP out-of-hours service?

Do you agree that the characteristics of 'good' (in appendices B and C) are what you would expect to see in a good NHS GP practice or GP out-of-hours service?

Do you agree that the characteristics of 'requires improvement' (in appendix C) are what you would expect to see in an NHS GP practice or GP out-of-hours service that required improvement?

Do you agree that the characteristics of 'inadequate' (in appendix C) are what you would expect to see in an NHS GP practice or GP out-of-hours service that was inadequate?

Consistency

In our engagement leading up to the production of this draft handbook, one of people's concerns has been about our ability to be consistent in our judgements and ratings. Consistency is one of our core principles that underpin all our work. We have put in place an overall approach for CQC to embed consistency in everything we do. The key elements of this are:

- A strong and agreed core purpose for CQC
- A clear statement of our role in achieving that purpose
- Consistent systems and processes to underpin all our work

- High-quality and consistent training for our staff
- Strong quality assurance processes
- Consistent quality control procedures.

Equality and human rights

One of CQC's principles is to promote equality, diversity and human rights. This is a means to an end and not an end in itself. The end is good quality care for all. Respecting diversity, promoting equality and ensuring human rights will mean that everyone using health and social care services receives good quality care.

To put this into practice, we have developed a **human rights approach to regulation**. This looks at a set of human rights principles – fairness, respect, equality, dignity, autonomy, right to life and rights for staff – in relation to the five key questions we ask. Using a human rights approach which is based on rights that people hold rather than what services should deliver also helps us to look at care from the perspectives of patients.

These human rights principles are important in the delivery of GP and GP out of hours care. Everyone wants to be treated with dignity and respect when using GP practices or GP out-of-hours services. And if people do not experience this, it may make them reluctant to use these services in the future. This can lead to a negative impact on people's health, particularly as GP practices are often the way through which other health services and social services are accessed

Equality is a particularly important principle for primary care. Not only do GP practices need to address health inequalities for certain population groups - differences in health status and the social factors influencing health - but people from some groups may experience particular barriers in accessing GP services or may be at risk of experiencing prejudice or discrimination when they are using these services. Our new approach to the regulation of GP practices and GP out of hours services, based on looking at how services are provided to specific population groups, will enable us to look at both equality for patients and health inequalities.

This focus on human rights is integrated into our new approach to inspection and regulation. This is the best way to ensure equality and human rights are promoted in our work. We have integrated the human rights principles into our key lines of enquiry, ratings characteristics, Intelligent Monitoring, inspection methods, learning and development for inspection teams and our policies around judgement making and enforcement. We will be developing and refining this further between April and September 2014.

You can also read our **equality and human rights duties impact analysis** on our website. It describes in more detail:

- What we know about equality and human rights for people using GP practices and GP out-of-hours services
- What we have done to date to put our human rights approach into practice in the regulation of GP practices and GP out-of-hours services.
- And what we plan to do in the future – to ensure that we promote equality and human rights in our regulation of GP practices and GP out of hours services.

Consultation questions

We want to know whether you agree with our approach to human rights. Please see our separate **human rights approach document**, in which we are asking a number of questions.

We would also like your comments on our **equality and human rights duties impact analysis**.

Monitoring the use of the Mental Capacity Act

CQC inspects and reports on how well the service is meeting the approach required by the Code of Practice to the Mental Capacity Act (MCA). The code applies when staff are assessing whether people aged 16 and over have the mental capacity to take particular decisions, and when they take decisions on people's behalf – for example where a service works with people who may have cognitive difficulties due to dementia or a learning disability.

In particular, we will look at how and when capacity is assessed and, where people lack mental capacity for a decision, how that decision is made and recorded in compliance with the MCA. Where applicable, we will look for evidence that restraint, if used, is proportionate and complies with the MCA.

We have reflected the importance of this in our prompts and our descriptions of the ratings for safety, effectiveness and caring (appendices B and C). The Code of Practice is an important safeguard for people's human rights. We are keen to consider how we can best support that improvement and we are therefore are seeking your views.

Consultation question

How best do you think we can ensure that providers improve the way they conform with the Mental Capacity Act?

a) Make sure we give sufficient weighting to this in our characteristics of good?

b) If providers do not meet the requirements of the MCA, apply limiters (meaning a service could not be better than requires improvement) in a proportionate way to ratings at key question level?

c) In other ways?

2. Registration

Before a provider can begin to provide services, they must apply to CQC for registration and satisfy us that they are meeting a number of registration requirements.

We said in our 2013-16 strategy document *Raising Standards, Putting People First*, that we would introduce a more thorough test for organisations applying to provide care services. This would include making sure that named directors, managers and leaders of a service commit to meeting our standards and are tested on their ability to do so. We are also committed to making the application process more streamlined through the use of online accounts.

Registration will assess whether all new providers have the capability, capacity, resources and leadership skills to meet relevant legal requirements, and are therefore likely to demonstrate that they will provide people with safe, effective, caring, responsive and high-quality care.

We will focus on the robustness and effectiveness of the registration system in a way that is proportionate and does not stifle innovation or discourage good providers of care services, but does ensure that those most likely to provide poor quality services are discouraged from doing so.

We will be seeking involvement and feedback from a wide range of stakeholders as part of our engagement around this new registration framework. We will publish full details of the changes we are making to registration when we publish the final version of this handbook in September.

3. Local relationships

It is important that we maintain good local relationships with all stakeholders in our work, including the public and people who use services, their carers and their representative groups, providers, commissioning bodies, MPs and other members of the local health and care system such as Local Medical Committees and Local Education and Training Boards.

How we maintain local relationships

Our proposed model of inspecting NHS GP practices and GP out-of-hours services will only be successful if we have good, ongoing relationships with GP practices and GP out-of-hours providers and with NHS area teams as commissioners of NHS GP practices. We also need good, ongoing relationships with clinical commissioning groups, as they have a duty to support quality improvement in general practice. This will help ensure that improvements are made following our inspections.

Each registered provider of an NHS GP practice or GP out-of-hours provider will have a member of CQC's inspection staff as their 'relationship owner'. In some cases there may be a relationship owner for each location, rather than provider. Their role will include monitoring local data and intelligence continuously.

Our inspection managers will also have an ongoing relationship with NHS area teams and clinical commissioning groups.

It will be important to maintain good relationships with local organisations and community groups who represent people who use services and routinely gather their views. These include local health overview and scrutiny committees, local Healthwatch and NHS complaints advocacy organisations.

How we work with people who use services

People's experiences of care and those of their families, carers and advocates will help us to inform our inspections in three main ways:

- To design our approach to inspection
- To plan inspections.
- To inform our judgements about the quality of care and the ratings we give.

In all inspections, we will gather information about people's experiences from a number of sources, including:

- Information that CQC has available from national patient surveys and individual comments that we receive from the public.
- Information from organisations who hold information about people's views, for example, NHS Choices website.
- Information requested from local organisations, including voluntary and community organisations and local Healthwatch.
- Information from the Friends and Family Test.
- Patient satisfaction surveys carried out by service providers, with views of patients, carers and representatives.

4. Intelligent Monitoring

Our new, more comprehensive model includes ongoing Intelligent Monitoring of the risks that individual GP practices and GP out-of-hours providers are not providing either safe or high quality care.

The Intelligent Monitoring tool is built on a set of indicators that relate to the five key questions we ask of all services – are they safe, effective, caring, responsive and well-led? The tool analyses a range of information including patient experience, staff feedback and patient outcomes.

We use this information to give our inspectors a clear picture of the areas of care that may need to be followed up in practices along with local insight and other factors. This information helps us to decide when, where and what to inspect. This means that we can anticipate, identify and respond more quickly to practices at risk of providing poor quality care. We plan to create priority bands for inspection. We will use these bandings to help inform where we prioritise for inspection.

The indicators raise questions about the quality and safety of care, but they are not used on their own to make final judgements. These judgements will always be based on a combination of what we find at inspection, Intelligent Monitoring data and local information from the GP practice or out-of-hours provider and other organisations.

We are currently developing the set of indicators that we will use for GP practices. Our initial scoping work has identified the sources of information set out in table 1. We will be undertaking additional testing and engagement to determine the most useful indicators to inform our work. We will align our definitions of indicators as far as possible with those used by our partner bodies such as NHS England and Public Health England.

Table 1: Example indicators for GP practices

Outcome measures and safety events	Information from patients and the public	Information from and about staff
• Prescribing indicators – safe prescribing/ effective prescribing indicators • Safeguarding referrals and alerts • Selected QOF indicators • Secondary care activity: e.g. emergency admission rates for long -term conditions A&E attendance rates, referral rates to secondary care • Vaccination rates • Screening uptake– e.g. breast, cervical cancers • Patient safety incidents	• Responses from General Practice Patient Survey • People's experiences shared with CQC • Feedback left on NHS Choices, and other feedback sites (e.g. Iwantgreatcare) • Complaints • Feedback from local Healthwatch	• Concerns raised by staff to CQC • Fitness to practice referrals and cases

Consultation question

How confident are you that the sources of information we plan to look at will identify risks of poor quality care and good practice?

5. Inspection

Within our new approach we have two types of inspection:

Comprehensive

- Review the provider in relation to the five key questions leading to a rating on each on a four-point scale
- Assess all six of the population groups

Focused

- Follow up a previous inspection, or to respond to a particular issue or concern

We will flex our approach for those inspections where we are following up a previous inspection, or we are responding to a particular issue or concern. Section 7 provides more detail on this.

The remainder of this section describes our approach to comprehensive inspection: how we will plan our inspections, what will happen during them, how we will make our judgements and decide ratings, and how we will report our findings to the public.

We will check the quality of NHS GP services and GP out-of-hours services within each clinical commissioning group (CCG) area. Over a two-year period, we will inspect a number of GP practices in each CCG every six months as well as inspecting the GP out-of-hours service. We are not inspecting the clinical commissioning group itself.

We will be considering how we inspect practices that have merged, have become multi-site practices or have federated and where they may share common leadership or systems and processes. We will test this between April and September.

5a. Planning a comprehensive inspection

To make the most of the time that we are on site for an inspection, we must make sure we have the right information to help us focus on what matters most to people. This will influence what we look at, who we will talk to and how we will configure our team. The information we gather during this time is also used as evidence when we make our ratings judgements.

Gathering and analysing information

To prepare for the inspection we will analyse data from a range of sources including information from people who use services, information from other stakeholders, and information from the CCGs, area teams and the GP practices and out-of-hours providers.

When we begin testing our approach in April, we will collate our analysis in a 'data pack' for each CCG area. This will contain information about GP practices and GP out-of-hours across the CCG area and will be refreshed regularly. It will also contain contextual information, for example, about the population in that CCG area.

We will share the data pack with the CCG and local area team before we start to inspect practices within the CCG area. Information relating to individual providers of GP practices and GP out-of-hours services will be shared with these providers.

Gathering information from people who use services

We will gather information from people who use services in advance of the site visit in the following ways:

- We will invite people who use the service and their carers to tell us about the care they have received through our website, social media, our helpline, and where appropriate, at public meetings run either by CQC or our partners.
- Individual patients and carers will be able to speak to an inspector or fill in a comment card, which will be publicised on posters and information in the GP surgery.

We will also ask local organisations to provide information, including:

- Local Healthwatch.
- Patient participation groups, where they exist.
- Local voluntary and community groups.

- Patient and carer groups.
- Community outreach focus groups.

Some local organisations have a responsibility to gather and use people's experiences of care and we will request information they hold, for example:

- Overview and scrutiny committees.
- Quality surveillance groups.
- Local NHS complaints advocacy service.

Gathering information from stakeholders

We will also ask local organisations to provide information, including:

- CCGs and NHS England area teams.
- Local education and training boards (post-graduate deaneries)
- Local authorities
- Local Medical Committees.
- Other local health and social care services, including local authorities, hospitals, care homes, public health departments
- Local GPs and other practice staff about the quality of out-of-hours services.

We will use nationally collated feedback from patients and carers (for example, patient survey data, evidence of complaints from the Parliamentary and Health Service Health Ombudsman, NHS choices, family and friends test).

Many national partner organisations we work with hold information about people's experiences and we want to make the best use of their evidence. This includes, for example:

- The General Medical Council, Nursing and Midwifery Council and medical Royal Colleges.
- Health and wellbeing boards.

We will write to some of these other stakeholders to ask for information.

Gathering and analysing information from the practice or service

Before we begin inspecting in a CCG area we will write to practices and the GP out-of-hours provider and we may ask them for some information. We may ask for documents and examples of information that will provide us with helpful pre-inspection insight.

GP practices and providers of out-of-hours services will have at least 10 working days to respond to our request. The letter will make it clear what

information to send, where to send information and who to contact with any queries or questions.

We will publish further detail about the information we will request, but it is likely to include:

- Results from patient surveys and associated action plans.
- A copy of the provider's statement of purpose.
- A summary of any complaints received in the last 12 months, any action taken and how learning was implemented.
- A summary of any serious adverse events for the last 12 months, any action taken and how learning was implemented.
- Significant event analysis.
- Locum/agency use over the last 12 months (out-of-hours services only).
- Evidence of monitoring the quality of services provided.
- Evidence of supplying urgent/emergency medicines.

This list is not exhaustive.

Going forward, we will be asking practices and GP out-of-hours providers to include their own view of their performance. We want providers to be open and share their views with us in advance about where they are providing good care, and what they are doing to improve in those areas they know are not so good.

We will judge practices and out-of-hours providers more harshly on 'well-led' if we find that they have not been open with us about issues they already know about, and this will affect their rating.

We will provide more information on this soon. At this stage, and for our inspections of GP practices and GP out-of-hours providers between April and June 2014, there is no expectation that this happens.

Other information gathering

Throughout the year, and particularly in the weeks leading up to an inspection, we may gather additional information. For example, we may carry out case tracking of some patients. We are developing and testing this between now and September 2014. As with all of our new approach, we will evaluate the methods to determine how effective they are in reaching a comprehensive regulatory judgement. We will also be looking at the impact of these methods on practices or services, to identify any additional burden or resource implications.

Concerns from patients and staff

We use information about complaints and concerns raised by patients and staff to understand how well a practice or GP out-of-hours service listens and learns, and to highlight potential areas of concern.

The inspection team

Inspections will be led by specialist inspectors, with clinical input led by GPs.

Inspection teams visiting individual practices within a CCG area will usually include specialist inspectors, GPs, nurses and/or practice managers. The team may also include trainee GPs. The lead inspector is the main point of contact for inspections of individual GP practices. Our inspection team will vary in size, to reflect the size of the practice or out-of-hours provider.

An inspection manager will lead the inspections across a CCG area, and will be the main point of contact with the CCG and the area team throughout the inspection. We also propose to have a GP with oversight of our inspections across a CCG area to provide advice to the inspection manager and inspection teams.

Teams may also include Experts by Experience. Experts by Experience are people who use or care for someone who uses a GP or out-of-hours service. Their main role is to talk to people who use services and tell us what they say. Many people find it easier to talk to an Expert by Experience rather than an inspector. Experts by Experience can also talk to carers and staff.

Experts by Experience are recruited and supported to take part in our work through a number of support organisations. The support organisations also carry out the relevant Disclosure and Barring Service checks. Experts by Experience are trained to carry out their role, and their performance is monitored on an ongoing basis. We match their experience to the services that are being inspected. Further details on the Experts by Experience programme can be found on our website at www.cqc.org.uk/public/get-involved.

We have not consistently used Experts by Experience in our inspections of GP practices to date, but we will test how they can be used during our inspections of NHS GP practices between April and September.

Planning the inspections

Inspections are usually announced. We feel that this is the most appropriate way to make sure our inspections do not disrupt care provided to patients by the practices we are inspecting.

We will announce which CCG area we are visiting at least four weeks before we begin inspecting practices in that area. We will then announce which

practices in that area we intend to inspect, usually two weeks before the date of the inspections of individual practices. We will write to each of these registered providers notifying them that we will be inspecting when we visit that CCG area.

We will usually give GP out-of-hours providers six weeks' notice of their inspections. This is because we expect that we will ask for more information from GP out-of-hours providers before we inspect than we will do from GP practices. So more time is needed to collect and analyse this information.

We will also carry out some unannounced inspections, for example if we have concerns about a practice or if we are following up on concerns identified in a previous inspection

Following our announcement that we are inspecting in a CCG area, we may receive information about other practices in the area and decide to include these in the inspections. Where appropriate, we will notify these providers that we intend to inspect.

Timetable

Inspection teams will spend a numbers of weeks (usually two, sometimes up to four) in a CCG area inspecting NHS GP practices and NHS GP out-of-hours providers

The inspections of practices and out-of-hours services within a CCG area will go through the following stages:

- Preparation
- Briefing and planning for the inspection team
- Planning meeting with the Area Team and CCG
- Inspections of GP practices and GP out-of-hours services
- Draft reporting
- Final reporting (including quality control, post-inspection meeting with the CCG and Area Team and follow-up).

Planning meeting

Approximately two weeks before the start of the inspection period, the inspection manager, supported by a GP, will meet with the CCG and area team(s) to discuss:

- The scope and purpose of the inspection.
- Who will be involved from CQC.
- Which GP practices and GP out-of-hours providers we propose to inspect (practices and GP out-of-hours providers will have been notified before this meeting takes place)

- How the inspections will be carried out, including our relevant powers.
- How we will communicate our findings from our inspections across the CCG area.

The CCG and area team will be asked to provide an overview of the local context, what is working well or is outstanding and where there are areas of concern or risk in GP practices and GP out-of-hours services.

Making arrangements for the inspections

The inspection manager will plan the inspections across the CCG area. This involves:

- Organising and chairing the pre-inspection planning meeting with the CCG and the area team.
- Consulting with CQC's engagement and involvement teams on how to best engage with the public, people who use the service and specific communities to get a range of views and experiences about the services.
- Liaising with the named contact at the CCG and the area team to organise the logistics of the visit and to invite their help in advertising focus groups and the public listening event.
- Making the outline plan for the duration of the time spent in the CCG area.
- Setting a provisional date for the meeting with the area team(s) and the CCG at the end of the inspection period.

Inspectors will plan inspections of individual practices. This involves:

- Deciding on the areas of focus for the inspections, which are informed by the data pack and information we have gathered and analysed before the site visit.
- Identifying members of the inspection team based on the specific skills, knowledge and experience needed.
- Considering the need for specialists, including pharmacy inspectors.
- Liaising with the practice before the inspection.
- Ensuring that we follow up any outstanding compliance actions or warning notices.

5b. Site visits

Site visits are a key part of our inspection process, giving us an opportunity to talk to people using services, staff and other professionals to find out their experiences. They allow us to observe care being provided and to review people's records to see how their needs are managed both within and between services.

Inspections of individual practices or GP out-of-hours services usually last one day. Inspections of GP out-of-hours services will include inspection time during the out-of-hours period as well as during the daytime.

The start of the visit

At the start of each inspection of a GP practice or a GP out-of-hours provider, the inspector will meet with the registered manager. If the registered manager is not available then the inspector can meet with another senior member of staff, for example a partner. This introductory session will be short and will explain:

- The scope and purpose of the inspection
- Who will be involved
- How the inspection will be carried out, including our relevant powers
- How we will communicate our findings.

Gathering evidence

The inspection team will use the KLOEs and collect evidence against them using the methods described below.

Gathering the views of people who use services in advance

A key principle of our approach to inspecting is to seek out and listen to the experiences of the public, patients and those close to them, including the views of people who are in vulnerable circumstances or who are less likely to be listened to by statutory bodies. The purpose of this is to better understand the issues that are of most concern to people to guide our inspection.

In the four weeks following our announcement that we are visiting a CCG area will gather people's experiences of care through:

- Local discussions with Healthwatch, local overview and scrutiny committees, NHS complaints advocacy services, patient participation

groups and identified patient representatives at CCGs and within health and wellbeing boards.

- Holding focus groups or open public listening events in partnership with local Healthwatch and local community groups, where appropriate, to give people a chance to talk about their experiences in a group.
- Targeted focus groups with targeted population groups.
- Questionnaires and surveys – for example, surveying GPs about the out-of-hours care.
- Using local media to publicise our inspections (eg media to advertise, posters in local premises etc).

Gathering the views of people who use services during the site visit

We will gather the views of patients and those close to them by:

- Speaking individually with people who use services.
- Holding drop-in sessions for patients.
- Using comment cards placed in reception areas and other busy areas to gather feedback from people who use services, their family and carers.
- Using posters to advertise the inspection and give an opportunity to speak to the inspection team. These will be put in areas where patients and other people will see them.
- Arranging further interviews of patients not present on the day of the inspection.
- Exploring options for using other digital routes for people of all ages to share their experience, through text messaging, social media such as Twitter and through apps.
- Use the information gathered from our work looking at patient complaints and concerns

Experts by Experience will interview people using GP practices and out-of-hours services on the premises.

Consultation question

During our inspections of NHS GP practices and GP out-of-hours services, we will use a number of methods to gather information from the public about their views of the services provided.

Do you agree that the proposed methods of doing this are the right ones to use?

Will they enable us to gather views from all of the people we need to hear from?

Gathering the views of staff

The inspection team will speak to staff. On all inspections, we are likely to speak to the following people:

- GP partners
- Other GPs employed, including locums and trainee GPs
- Practice managers/managers of out-of-hours services
- Practice nurses
- Healthcare assistants
- Administrative staff.

In larger providers the inspection team may also hold focus groups with separate groups of staff.

The inspection team will offer to talk to current and former whistleblowers during the inspection period.

Other inspection methods/information gathering

Other ways of gathering evidence may include:

- Pathway tracking patients through their care.
- Reviewing records.
- Reviewing policies and documents.
- Observing care.
- Listening to how staff handle calls in GP out-of-hours services.

Continual evaluation

When inspecting practices and GP out-of-hours services the inspection team will continually review the emerging findings. This keeps the team up to date with all issues and enables the focus of the inspection to be shifted if new areas of concern are identified. It also enables the team to identify which further evidence might be needed in relation to a line of enquiry and what relevant facts might still be needed to corroborate a judgment.

Closing the visit

At the end of the inspection visit, the inspector will provide feedback to the practice or out-of-hours provider, usually to the registered manager and/or the partners. This is to give high level initial feedback only, illustrated with some examples.

The meeting will cover:

- Thanking the practice or out-of-hours provider for their support and contribution.
- Explaining findings to date, but noting that further analysis of the evidence will be needed before final judgments can be reached on all of the issues.
- Any issues that were escalated during the visit.
- Any plans for follow-up or additional visits (unless they are unannounced).
- Explain that further analysis is required before we can award ratings.
- Explaining how we will make judgments against the existing regulations.
- Explaining the next steps, including challenging factual accuracy in the report and final report sign-off, quality summits and publication.
- Answering any questions from the practice.

Unannounced inspection visits

The inspection team may carry out one or more unannounced visits of GP practice or GP out-of-hours services. At the start of these visits, the team will meet with the practice’s partner or senior manager on duty at the time and will feed back if there are any immediate safety concerns.

When we are following up concerns from a previous inspection, we will usually carry out an unannounced inspection.

5c. Judgements and ratings

Making judgements

Inspection teams will base their judgements on all the available evidence, using their professional judgement.

For each individual rating (for example,, responsiveness for people living in vulnerable circumstances), the judgement will be made following a review of the evidence under each key line of enquiry (KLOE), with this evidence coming from the four sources of information: our ongoing relationship, Intelligent Monitoring, pre-inspection work and information from the inspection visit itself. This hard link between KLOEs, the evidence gathered under them, and the rating judgements lies at the heart of our approach to ensuring consistent, authoritative judgements on the quality of care

When making our judgements, we will consider the weight of each piece of relevant evidence. In most cases we will need to corroborate our evidence with other sources to support our findings and to enable us to make a robust judgement.

When we have conflicting evidence, we will consider the weight of each piece of evidence, its source, how robust it is and which is the strongest. We may conclude that we need to seek additional evidence or specialist advice in order to make a judgement.

From April 2014, we will start to test our approach to how we will decide ratings for GP practices and GP out-of-hours services. From October 2014 we will fully implement our approach to rating GP practices and GP out-of-hours services, including formal ratings.

We will consider whether we can award shadow ratings as we get closer to October. Shadow ratings are ratings which we will award following an inspection and will be included in the inspection report.

We have already carried out some early tests of our approach in GP out-of-hours services. From July 2014, we will provide shadow ratings for all GP out-of-hours services.

Ratings

Note: This draft handbook outlines the approach we are proposing to use once the regulations underpinning the Care Bill are in place (subject to Parliamentary approval). Until that point we will apply the principles and guidelines that we have outlined in this handbook to determine shadow ratings, but we reserve the right not to follow all elements precisely, as we will be learning from the inspections carried out and from this consultation.

During the period of testing, we will engage with providers informally over any concerns they may have in relation to their shadow ratings. We will ensure a fair process for setting ratings and we will be transparent in investigating any concerns.

Our learning will feed into the way CQC awards ratings. We will review the principles and guidelines, and amend them in line with this learning.

What do we give a rating to?

For each **GP practice** we inspect, we will test our ability to rate performance at four levels.

Level 1: Rate every population group for every key question

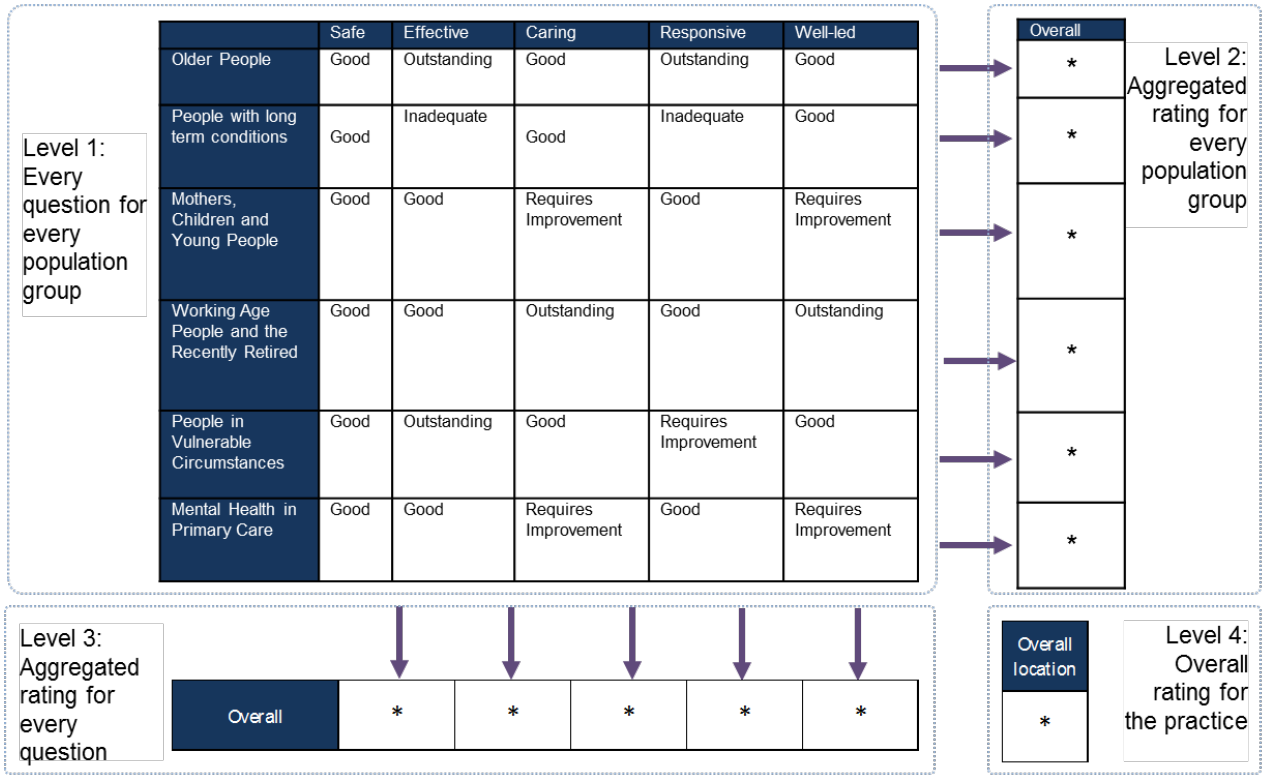
Level 2: An aggregated rating for each population group

Level 3: An aggregated rating for each key question

Level 4: An aggregated overall rating for the practice as a whole.

The following example shows how the four levels work together:

Figure 4: Rating at four levels for GP practices



* We will test our ability to aggregate ratings to these levels on our four point scale (outstanding, good, requires improvement or inadequate) using the ratings principles outlined below.

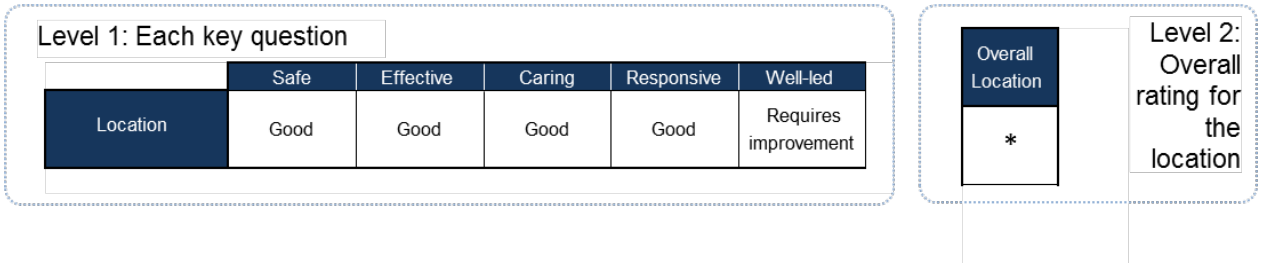
We will use the learning from the first wave of inspections to help determine the levels and methods that we use to rate GP practices and update our guidance as a result.

For GP **out-of-hours services**, we will only rate performance at the following two levels based on our learning from the Wave 1 inspections for these services:

Level 1: A rating for each of the key questions for the out-of-hours services as a whole.

Level 2: An overall rating for the out-of-hours services. This will be an aggregated rating informed by our findings at level 1.

Figure 5: Rating at two levels for out-of-hours locations



Where we have evidence about the quality of services for specific population groups, we will include this as part of our overall report following the inspection.

Sometimes, we won't be able to award a rating. This could be because:

- The service is new, or
- We don't have enough evidence, or
- The service has recently been reconfigured, such as being taken over by a new provider.

In these cases we will use the terms 'Not Sufficient Evidence to Rate' (NSE) or 'Not Applicable' (NA).

We may also suspend a rating at any level. For example, we may have identified significant concerns that, after reviewing but before a full assessment, lead us to re-consider our previous rating. In this case we would suspend our rating and then investigate the concerns.

How we decide on a rating

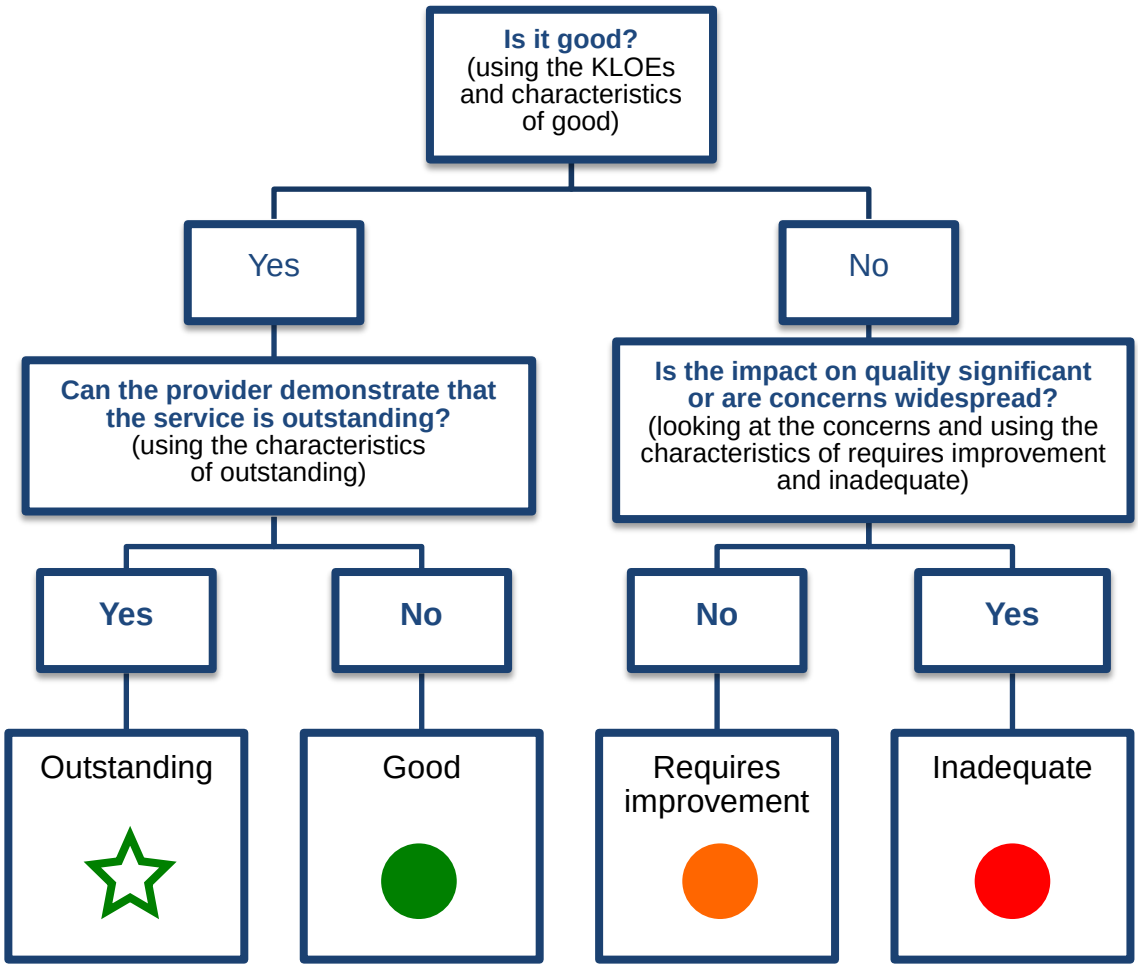
When awarding ratings of the five key questions, our inspection teams will review the evidence gathered against the KLOEs and use the guidance supplied to decide on a rating.

In deciding on a rating, the inspection team will look to answer the following questions:

- Does the evidence demonstrate a potential rating of good?
- If yes – does it exceed the standard of good and could it be outstanding?
- If no – does it match the characteristics of requires improvement or inadequate?

The following flowchart shows how this would work.

Figure 6: How we decide on a rating



Aggregating ratings

We are in the very early stages of developing and testing the new approach to inspecting GP practices and GP out-of-hours services described in this handbook. In the future we intend to use principles to ensure consistent decisions are made about ratings. We have developed some principles for this as we are developing our new approach in other sectors we regulate. Whilst we have not yet begun trying to rate GP practices or GP out-of-hours providers we are seeking feedback on these principles so we can consider how they may work in inspections of GP practices and GP out-of-hours services.

When aggregating ratings, our inspection teams will follow an algorithm –a set of principles – to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence. Where a rating decision is not consistent with the principles, the rationale will be clearly recorded and the decision reviewed by a national quality control and

consistency panel. The role of this group is to ensure the quality of every report is high ahead of it being shared with the organisation being inspected.

There are four steps that support the generation of consistently aggregated ratings. The first step, determining the individual ratings at level 1, is done first. Steps two to four are applied at the same time as each other.

1. **Individual rating judgements:** Inspection teams determine ratings at the most detailed level (level 1), based on all the available evidence.
2. **Aggregation of ratings for key questions, population groups and overall:** We apply a basic aggregation to support inspection teams, based on the key questions, population groups and ratings levels being weighted equally.
3. **Adjust overall ratings so they are consistent with specific principles about aggregation**: We apply principles to ensure ratings are consistent with reasonable expectations. This also guards against equal weighting leading to unintended results, for example where outstanding and inadequate judgements balance each other out.
4. **Apply principles about key indicators and information:** In coming to judgements we use a range of information. Using this final set of principles we double check that our ratings judgements are consistent with key pieces of information and indicators, including the views of people who use services. The rating would also be limited when we decide to take enforcement action or set a compliance action.

Appendix F sets out the principles that we propose to apply in steps two to four, with some further questions for consultation.

5d. Reporting, quality control and action planning

Reporting

The inspector will draft an inspection report in conjunction with other members of the inspection team. The report will be clear, accessible and written in plain English. When we begin rating, it will include ratings.

Quality control

For our first wave of testing we will hold a national quality control and consistency panel, chaired by CQC's Chief Inspector of General Practice, which will review reports. The panel will always include a CQC legal expert. For initial testing of our approach this will be a national panel. In the longer term this may be a regional panel due to the significant numbers of GP practices and GP out-of-hours providers we will be inspecting

Once approved by the panel, the inspector will send the report to the practices or out-of-hours registered manager to enable them to comment on its factual accuracy.

We will use our current factual accuracy policy and ask the practice to return any comments within 10 working days. However, it would be beneficial if practices could return any comments early during this period rather than at the end. All factual accuracy comments received will be checked by CQC's analysts and legal team.

We will share the draft report with area teams and clinical commissioning groups before publishing on our website, but this will always happen after the practice has carried out factual accuracy checking.

Action planning by GP practices and GP out-of-hours providers

We expect individual practices and providers of out-of-hours services to respond to areas of concern that we have identified and to make the recommended improvements. This may include developing an action plan to address these.

Action planning with local partners

The inspection findings from all inspected GP practices and GP out-of-hours providers will inform the basis of a discussion at a meeting held between

CQC, the area team(s) and the CCG. Where appropriate, we will use existing structures and meetings to hold these discussions, for example quality surveillance groups.

The purpose of this meeting is to discuss our overall findings in that CCG area with partners in the local health and social care system – organisations that are responsible for commissioning or supporting improvement of general practice in the local area. Individual practices are usually not invited to attend the meeting. The purpose of this meeting is to develop a CCG area wide plan of action and recommendations based on the inspection team's findings across the CCG area.

We propose that each meeting will consider:

- An overview of findings from across the CCG area including key themes of good and poor practice.
- Identification of practices or GP out-of-hours providers where there are concerns including a discussion about whether planned action to improve quality is adequate, or whether additional steps need to be taken. In some cases this discussion may take place separately from the broader discussion about our findings across the CCG area and will include the individual provider.
- Whether support should be made available to these practices and GP out-of-hours providers from other stakeholders, such as commissioners, to help them improve.

At least five working days before the meeting, we will publish the final reports and send these to the practices and out-of-hours provider. The area team(s) and the clinical commissioning group will be sent a letter of invitation to attend the quality Summit, along with an agenda copy of the final report(s).

The plan of action will be developed by partners in the local health and social care system and the local authority. Attendees will include:

- Inspection manager.
- CQC GP regional advisor.
- Other CQC staff involved in the inspections as required.
- Representatives from the CCG and the area team (usually Head of Primary Care).
- Local Healthwatch.
- Others as appropriate (for example, Local Education and Training Boards and local medical committee(s) representative).

We want to make our processes as open and transparent as possible so will test how we will run these meetings and who we invite between now and September.

Following this meeting, recommendations for action will be captured in a high level action plan which covers all actions across the CCG area. This will be led by the CCG and the area team. Further work will be expected by the area team, CCG and its partners to develop further detail beneath the high level actions. Action plans are owned by the area team and the CCG.

This action planning does not replace action planning carried out by individual practices to respond to any concerns we have or recommendations we make. Individual practices may have their own action plans as well. Once agreed, action plans should be shared with the CQC inspection manager and the GP regional advisor to ensure that all key areas highlighted during the inspection have been appropriately addressed.

As part of our ongoing learning, we will be reviewing how successful this approach is in driving improvement

Publication

CQC will publish the inspection reports on our website soon after the end of the inspection. We encourage CCGs, area teams and individual practices and out-of-hours providers to publish their action plans on their own website. We also aim to publish our data packs.

The Chief Inspector of General Practice will also write an open letter, aimed at the public, to describe and summarise our key findings across a CCG area.

Encouraging improvement

A vital part of CQC's purpose is in encouraging services to improve. The evidence-gathering process, post inspection meeting, publication of our reports and ratings of service are all intended to promote improvement. However, we would welcome views about whether there is more we could do to publicise where we identify excellent practice or care to enable services to learn from the example.

Consultation question

Are there ways in which we could promote learning between providers and services, particularly where we have identified outstanding care?

6. Enforcement and actions

Relationship with the registration regulations

The Department of Health is currently consulting on proposed regulations to replace the current registration requirements. This is in response to the Francis report and other findings such as the Winterbourne View Serious Case Review.

In the summer we will consult on our guidance for providers that will underpin the new regulations. We will also consult on our enforcement policy. The new regulations, our provider guidance and the new enforcement policy will be implemented from 1 October 2014, along with our new approach as set out in this document.

The table below sets out the relationship between the regulations and ratings. The regulations will continue to be central to our approach, and we will not hesitate to use them to take action where appropriate against providers where we find breaches.

Overall rating	Level of compliance with regulations	High level characteristics of each rating level
Inadequate	Non-compliant (with the exception of well led which does not all translate to regulations)	Significant harm has or is likely to occur, shortfalls in practice, ineffective or no action taken to put things right or improve
Requires improvement	Non - compliant Or Compliant	May have elements of good practice but inconsistent, potential or actual risk, inconsistent responses when things go wrong
Good	Compliant + (i.e. more than just compliant)	Consistent level of service people have a right to expect, robust arrangements in place for when things do go wrong
Outstanding	Compliant ++	Innovative, creative, constantly striving to improve, open and transparent

A fit and proper person test applied by providers will be made a requirement of CQC registration. The test will place a clear duty on health and social care providers to make sure directors and board members (or their equivalents) meet criteria set out in the test.

Organisations retain full responsibility for appointing directors and board members (or their equivalents). However, CQC will be able to intervene where it considers an individual is not a fit and proper person, and place a condition on a provider to remove the director if there is evidence that they have previously been involved in failures to deliver good quality, safe care.

A new statutory duty of candour will be placed on all organisations registered with CQC from October 2014. This means that people, and where appropriate their families, must be told openly and honestly when unanticipated things happen, which cause them harm above a pre-determined threshold. They should be given an apology, an explanation, all necessary practical and emotional support, and assurances about their continuity of care. This statutory duty on organisations supplements the existing professional duty of candour on individuals. We will be considering this statutory duty as part of our assessment.

Types of action and enforcement

Where we have identified concerns we will decide what action is appropriate to take. The action we take will be proportionate to the impact that the concern has on the people who use the service and how serious it is. Where the concern is linked to a breach in regulations, we have a wide range of enforcement powers given to us by the Health and Social Care Act 2008. Our enforcement policy describes our powers in detail and our general approach to using them.

Enforcement action can be taken under either:

- **Civil enforcement:** to protect people from harm
- **Criminal law:** to hold a registered provider or manager to account in court in relation to a significant failing.

We will also ‘recommend improvements’ where we have identified changes that could or should be made but where a regulation has not been breached.

We will include in our report any concerns, recommended improvements or enforcement action taken, raise them at the quality summit and expect appropriate action to be taken by the provider and local partners.

We will follow up any action we take. If the necessary changes and improvements are not made, we can escalate our response through a focused inspection. However, we always consider each case on its own merit and we do not rigidly apply the enforcement rules when another action may be more appropriate.

A number of legislative changes are amending the enforcement powers we have under the Health and Social Care Act 2008 and associated regulations. In most instances these changes apply to all provider types across all sectors. The key changes to our enforcement powers, which will be included in our revised policy due for consultation in the summer, are:

- An amendment to regulations to enable us to prosecute providers for breaches of regulations without being required to issue a warning notice first.
- New regulations underpinning the new standards against which we will enforce when there is a breach.

As we develop our new approach we will engage with key stakeholders and the public to ensure we reflect the key characteristics, risks and quality issues within each sector we regulate. The Department of Health hopes that the new legislation will be passed into law by October 2014. CQC will be consulting on guidance on how the new rules will work in practice. We will also consult on our enforcement policy in June 2014 in readiness for implementation from October 2014.

Working with commissioners to respond to poor performing practices and GP out-of-hours providers

CQC will work closely with NHS England area teams, as commissioners of GP practices and Clinical Commissioning Groups as commissioners of GP out-of-hours services. These organisations have a key role to play in ensuring safety and quality of GP practices and GP out-of-hours services working alongside CQC. We will work together to ensure that if there are serious concerns about the quality and safety of services in any practices, for example where a practice is rated as inadequate, our actions are joined up and that there is a clear coordinated response to this.

Ratings review process

CQC will have in place a process whereby GP practices and GP out-of-hours services can ask for a review of their rating. We want to ensure that providers can raise legitimate concerns about the way we apply our ratings process, and have a fair and open way for resolving them.

GP practices and out-of-hours providers can challenge the factual accuracy of reports and make representations about the evidence in warning notices. These steps will normally be the means by which providers will also challenge the ratings CQC has awarded, because ratings are awarded on the basis of the evidence about the quality and safety of their service.

The following routes are open to GP practices and GP out-of-hours providers to challenge our judgements. This will be amended and updated as necessary in light of responses to this consultation.

Factual accuracy check

When GP practices and GP out-of-hours providers receive a copy of the draft report (which from October will include their ratings) they are invited to provide feedback on its factual accuracy. They can challenge the accuracy and completeness of the evidence on which the ratings are based. Any factual accuracy comments that are upheld may result in a change to one or more rating. GP practices and GP out-of-hours providers have 10 working days to review draft reports for factual accuracy and submit their comments to CQC.

Warning notice representations

If CQC serves a Warning Notice it gives registered persons the opportunity to make representations about the matters in the Notice. The content of the Notice will be informed by evidence about the breach which is in the inspection report. This evidence will sometimes have also contributed to decisions about ratings. Therefore As with the factual accuracy check, representations that are upheld that also have an impact on ratings may result in relevant ratings being amended.

Under our process for factual accuracy checks and warning notice representations, unresolved issues can be escalated to managers in CQC who were not involved in the inspection.

Request for a rating review

If factual accuracy checks and warning notice representations do not resolve the issues then GP practices and GP out-of-hours providers can ask for a review of both individual key question ratings and overall location ratings. The only grounds for requesting a review is that the inspector did not follow the process for awarding them properly, as described in published policies and procedures. GP practices and GP out-of-hours providers cannot request reviews on the basis that they disagree with the judgements made by an inspector, as such disagreements would have been dealt with through the factual accuracy checks and warning notice representations.

Where a GP practice or GP out-of-hours provider thinks that we have not followed the published process properly and wants to request a review of one or more of their ratings, they must tell us of their intention to do so once the report is published. We will reply with full instructions on how to request a review.

GP practices and GP out-of-hours providers will have a single opportunity to request a review of their inspection ratings. In the request for review form, they must say which rating(s) they want to be reviewed and all relevant grounds and circumstances. Where we do not uphold a request for review, practices and providers cannot request a subsequent review of the ratings from the same inspection report.

When we receive a request for review we will explain on our website that the ratings in a published report are being reviewed. Reviews will be undertaken by senior CQC staff who were not involved in the relevant inspection and a report presented to the Rating Review Panel.

The panel will be chaired by an independent reviewer from outside CQC, who will provide wholly independent advice. The role of the panel is to provide advice to Chief Inspectors/Chief Executive about whether to uphold or reject the GP practices and GP out-of-hours provider's concerns.

The panel will consider the report and make recommendations to the relevant Chief Inspector (or Chief Executive where the Chief Inspector was part of the original rating judgement). The Chief Inspector/Chief Executive will make a final decision.

The outcome of the review will be sent to the GP practice or GP out-of-hours provider following the final decision. Where a rating is changed as a result of a review, the report and ratings will be updated on our website as soon as possible.

The review process is the final CQC process for challenging a rating. GP practices and GP out-of-hours providers can challenge our decisions elsewhere – for example by complaining to the Parliamentary and Health Services Ombudsman or by applying for judicial review.

Consultation question

Do you agree that with the grounds on which practices and services can challenge their inspection reports and ask for a review of their ratings?

Issues to consider

In responding to this consultation question it might be useful to consider whether:

- The process described is workable for GP practices and out-of-hours locations?
- The process is fair and transparent?

Complaints about CQC

We aim to deal with all complaints about how we carry out our work, including complaints about members of our staff or people working for us, promptly and efficiently.

Complaints should be made to the person that the provider has been dealing with, because they will usually be the best person to resolve the matter. If the complainant feels unable to do this, or they have tried and were unsuccessful, they can call, email or write to us. Our contact details are on our website.

We will write back within three working days to say who will handle the complaint.

We'll try to resolve the complaint. The complainant will receive a response from us in writing within 15 working days saying what we have done, or plan to do, to put things right.

If the complainant is not happy with how we responded to the complaint, they must contact our Corporate Complaints Team within 20 days and tell us why they were unhappy with our response and what outcome they would like. They can call, email or write to our Corporate Complaints Team. The contact details are on our website.

The team will review the information about the complaint and the way we have dealt with it. In some cases we may ask another member of CQC staff or someone who is independent of CQC to investigate it further. If there is a more appropriate way to resolve the complaint, we will discuss and agree it with the complainant.

We will send the outcome of the review within 20 working days. If we need more time, we will write to explain the reason for the delay.

If the complainant is still unhappy with the outcome of the complaint, they can contact the Parliamentary and Health Service Ombudsman. Details of how to do this are on the Parliamentary and Health Service Ombudsman website.

7. Focused inspection

The purpose of a focused inspection is to review and assess a GP practice or GP out-of-hours provider in one of the following scenarios:

- Where we have concerns that improvements have not been made.
- Where the GP practice or GP out-of-hours provider says improvements have been made that would lead to a change in their rating (we will set the timescale in which a practice or GP out-of-hours provider can request a focused inspection).
- Where a merger, takeover or acquisition of a service takes place. Including some instances when there is a change in partnership.

These inspections are smaller in scale, but will still involve experts and could lead to a change in rating. They may be unannounced, particularly if we have concerns about the practice.