11 December 2025

Londonwide LMCs
The professional voice of London general practice

CQC Better Regulation, better care: Consultation on improving how we assess and rate providers, Response from Londonwide LMCs

I am responding on behalf of an organisation or business
• I am completing this form as:

Other: Londonwide Local Medical Committees
Local Medical Committees (LMCs) are recognised in statute (NHS Act 2006, as amended by the Health and Social Care Act 2012) as the representative bodies for all NHS GPs practising within a defined geographical area.

• • Do we have permission to use your comments anonymously? – Yes

Consultation question 1: To what extent do you agree that we should publish clear rating characteristics of what care looks like for each rating as part of our new assessment frameworks?

Strongly agree. Clarity on each rating's characteristics is key in assisting with provider compliance. Bringing back KLOEs would be helpful in achieving this.

Consultation question 2: To what extent do you agree with our proposed approach to developing assessment frameworks that are specific to each sector?

Strongly agree. Assessment frameworks should be developed collaboratively with appropriate expertise from each sector. In general practice, this must include meaningful consultation with GP leaders, specifically Local Medical Committees (LMCs) and the BMA's General Practitioners Committee (GPC) to ensure that expectations are realistic, deliverable, and reflective of the realities faced by frontline GPs. This engagement is essential to build confidence and trust in the regulatory process.

We would welcome the publication of more detailed supporting guidance for general practice that shows the key standards and sources of evidence that CQC will consider, as this will help to clarify expectations in some areas. Prompt practical guidance from CQC (with input from the LMCs/GPC) for emerging issues where there may be uncertainty will be vital in supporting practices to reach expectations.

We recommend and expect that CQC will ensure that sector-specific inspectors with relevant experience will undertake inspections in each sector. For example, inspection teams going into GP Practices must be constituted by clinicians and non-clinicians with experience of the day-to-day running of practices, practice targets, clinical systems etc.

Consultation question 2a: Do you have any comments or suggestions on how we should develop the sector-specific assessment frameworks?

A rigid, "one size fits all" assessment framework that overlooks the local context and the roles of different organisations within new care models is unlikely to be effective. Flexibility is therefore critical to ensure fairness and accuracy, as are regular reviews of the frameworks based on feedback from providers and patients where appropriate.

The local context and roles of the different organisations in health care also include pressures on other services e.g. hospital waiting times, decommissioning of services, lack of decompression options that add further pressure to General Practices. Taking into consideration the interdependencies on other parts of the health system GPs should not be held responsible for wider system failings that impact on their patient care.

Clear and detailed guidance should be published to aid in compliance with regulatory requirements.

Particularly for GP providers, we suggest that specific evidence requirements are listed against main areas of compliance, e.g. Under the 'Safety' Key Question there are medicines management, repeat prescribing, etc. We would like to see a list of the evidence required for each of these areas, such as a repeat prescribing protocol, call and recall system etc.

It is imperative that the **Evidence Tables** are reintroduced. It is crucial for providers to have detailed feedback on the outcome of their inspection under each specific Quality Statement, whether it has been fully, partially, or not met, and the specific remedial actions they need to take to address any issues. This reduces the need for extensive and repetitive narrative within the inspection report and focuses the providers on the specific remedial actions they need to take.

Consultation question 3: To what extent do you agree with our proposed approach to making our assessment frameworks clearer and removing areas of potential duplication?

Strongly agree.

Consultation question 3a: Do you have any comments on the content of our current single assessment framework, or suggestions for how we should make our assessment frameworks simpler and clearer?

The administrative burden on individual GP practices in preparing for inspections is disproportionately higher than for larger Trusts. Therefore, a more flexible and balanced approach is needed to account for this. General Practices are lean and flexible, and can respond quickly to system changes (e.g. the short time given to set up PCNs, response to the Covid pandemic etc.) and it is important that, whilst continuing to be clinically rather than administratively led, the impact of CQC inspections on patient care and loss of capacity is minimised.

Providers should be able to demonstrate how they meet quality statements through pre-submitted examples, rather than relying solely on evidence sought on the day of the inspection.

Practices should be permitted to focus on a smaller number of broader quality statements to showcase innovation, collaboration, and excellence. Local intelligence from ICBs and relevant datasets could be incorporated to ensure that a more selective approach still meets regulatory standards.

The re-introduction of the **Evidence Tables** will help make the framework clearer and avoid duplication. Currently all adverse findings are repeated under a particular Key Question and under Well-Led. This magnifies the negative impact of a particular finding as it is mentioned repeatedly throughout the report, thus affecting the overall adverse impression and scores/rating.

We suggest that when an area for improvement is identified under any of the 5 Key Questions, a note is made in the inspection report where it first appears, to say that it also applies to Well Led or any other Key Question. This way the reports will be more streamlined and include less repetition.

Consultation question 4: To what extent do you agree that we should award ratings directly at key question level with reference to rating characteristics?

Agree. We understand the need for a more simplified ratings system. However, it is not clear how Rounded Assessments of evidence will be made with reference to rating characteristics. More detail is required here, because if providers are only able to see an aggregated rating for each Key Question with no detail on the scores of individual Quality Statements underneath it, a) they will have difficulty understanding how the aggregated rating was reached, and b) it will be harder for them to appeal against a Key Question rating as they will not have the detailed evidence sitting underneath it. This is extremely important for providers, particularly when their scores are close to the next rating up, but they cannot see those scores.
We request that the CQC provides clear detail of the methodology behind these Rounded Assessments to clarify how judgements will be made.

Consultation question 4a: Do you have any comments or suggestions on our proposed approach to awarding ratings?

As above. Clarity on the proposed methodology please.

Consultation question 5: **Do you have any comments or suggestions for how we should support our inspection teams to deliver expert inspections, impactful reports, and strong relationships with providers?**

Inspectors

- Have a sufficient number of inspectors as a large number of them were let go in the CQC's last restructure. This lack of inspectors has resulted in major delays in inspections being undertaken, with the LMC having to escalate several cases of practices rated Requires Improvement that had been waiting for two or more years to be reinspected and improve their rating.
- Ensure all sector-specific inspectors are truly experts by experience, have a proper understanding of the sector they are inspecting, understand clinical systems etc., and have regular training updates and supervision from their Operations Managers to ensure a consistent approach to inspections.
- Inspection teams should acknowledge the wider pressures facing general practice, including rising demand, workforce shortages, increasing patient expectations and prolonged underfunding. We would expect Inspection

teams to engage professionally and compassionately with providers to better understand how they are trying to meet the required standards.

- CQC should have a system in place whereby, should inspectors fall ill following an inspection and are unable to draft the inspection reports, they are covered by other inspectors within the inspection team who are able to access the data and information collated on inspection day or in interviews etc. and draft the report.
  We are aware of a practice that had to wait for over a year to receive their report because their lead inspector was unwell, and there was no system in place for anyone else to draft the report in their absence. This system would be an essential safety netting measure and reflect proper governance internally for CQC.
- Inspectors should be consistent in the evidence they require under each category. Acknowledging that each practice will be different, there must be a level of consistency in what is being asked from practices pre, during, and post-inspection. The experience of the inspectors should ensure that assessments are balanced and do not place a disproportionate emphasis on one aspect of the inspection.
- To build trust and strengthen relationships, inspectors should proactively engage with Local Medical Committees (in the case of general practice). This would support effective feedback across regions and allow emerging issues to be identified and addressed early on.

Inspection process / site visit

- When undertaking a site visit it is important that the inspection team recognises that they are visiting a working practice that needs to continue to meet the needs of its patients; and so, they should disrupt this as little as possible, which has not always been the case.
- Consistency is key here. To reiterate what we said in the previous question, there currently seems to be great variation in the pre-inspection evidence being requested by different inspectors from different practices. One practice may have 50 pieces of evidence requested, another double that amount. This is not appropriate.
- There are double standards in terms of availability, which needs addressing. Currently, when an inspector is for whatever reason unable to attend on the scheduled day, CQC will cancel the inspection even at short notice. However, if a practice has a key individual on leave or off sick on the proposed inspection day, CQC will not move the date. Equity and flexibility must be there for both parties. Interviews can be deferred to another date. CQC must ensure there are inspectors who can be

called upon if lead inspectors or GP SPAs are unavailable on the day to avoid disruption to the practice.

- If the inspector has missed a certain piece of evidence (e.g. a staff member's BLS training certificate was in their personnel file but the inspector missed it), they must highlight this clearly to the practice on the day to allow the practice the opportunity to redress this either during the inspection or immediately after it, whilst acknowledging that the practice was not at fault for any perceived omission.
- Similarly, if any evidence requested exists but cannot be located on the day, the practice must be given the opportunity to provide this information within an agreed time after the inspection.
- Feedback post-inspection – we appreciate inspectors cannot provide an indication of rating on the day, but they should be able to provide specific verbal feedback on what they have seen on the inspection day, followed by written feedback shortly after (no more than 5 working days).
- Examples of good practice should be celebrated, with learning shared across the wider system. Registration systems must be more user friendly.

Inspection reports

- Inspection reports should be timely, factual, and clearly supported by evidence.
- The absence of **Evidence Tables** (as previously used in general practice inspections) has impacted the quality and clarity of inspection reports and has led to duplication. The **Evidence Tables** are clear, simple to understand, reduce the need for excessive narrative in reports, and reduce the overall size of reports. They are an extremely useful tool for all providers to address any issues found, as they provide a clear gap analysis and remedial actions required.
- Duplication of the same findings across different Key Questions is unhelpful and can distort the overall impression of the provider's performance or compliance. Please see our earlier comments on this.
- The CQC's timeframe on producing inspection reports needs to be tight and adhered to. Lengthy delays of over a year in getting reports published are not acceptable.
- The content of inspection reports has a direct impact on practices' contractual relationship with their ICBs. In London, all Inadequate rated reports and sometimes also Requires Improvement ones, will result in the ICBs issuing remedial notices under the contract, which means that practices have a dual process running in parallel, i.e. with the CQC and

the ICB at the same time. This is why it is extremely important that the findings of inspection reports are clear, specific, and evidence based.

- Adverse ratings, particularly Inadequate ratings, can have a particularly detrimental impact on practices, e.g. on recruitment of partners, succession planning, getting a mortgage approved by the bank etc. Any extended delays in re-inspections can amplify the negative impact on practices' viability and sustainability. Timely re-inspections are key in cases of Inadequate and Requires Improvement ratings.
- External factors impacting on delivery should be noted and acknowledged without being deemed to be a poor reflection on the practice. For example, a well led and run practice may be carrying longstanding partner vacancies because they are unable to recruit suitable partners. These challenges, which are well documented, should be recognised and understood within the context of the realities of modern general practice.
- Frequency of inspections – there is no longer a schedule of inspections from CQC depending on the previous rating of the practice. We have seen practices who have not been inspected since 2016 and others who have had multiple inspections in a space of two years. We suggest that there should again be a schedule of inspections/re-inspections, as this would help CQC plan their capacity accordingly, and would also restore practices' confidence in their regulator, if they know that they will not be left with Requires Improvement or Inadequate ratings indefinitely, with all the risks this carries.

Factual accuracy reports

- The current focus is only on what is strictly factually incorrect, e.g. a target achievement being reported wrong. Often, we see that there are nuances in statements made in reports, which may not be strictly "factually" incorrect, but contain extrapolated generalisations based on a small number of patient reports, biased views, unclear findings (e.g. X piece of evidence was not available on the day without clarity on what this actually means) or statements made about evidence missing that was not even asked for on the day.

  It is near impossible for practices to challenge such statements as even when they do, CQC inspectors will most likely refuse to make the relevant changes in the final report. CQC should be more responsive to practices' "softer" challenges, ensuring that statements in inspection reports are contextualised and proportionate to the evidence provided.

Data & IT systems

- CQC will only rely on nationally published data sources to assess practice performance against clinical and other performance targets. These can be quite out of date at the time of the inspection. Repeated suggestions to also utilise real-time practice-based data directly from their clinical system/QOF etc. have been met with a refusal to do so because:

  a) CQC cannot rely on payment-related data as it can contain various exemptions and exclusions, and
  b) data from practice systems are not demonstrably collected on a comparable basis to the parameters/criteria of the national data sets and are therefore unverified.

  We are aware that the Ardens searches are linked to one of the CQC's myth busters (no.12), but not all ICBs use Ardens searches, therefore they are not universally used by practices. We would also suggest that CQC produces specific guidance on how practices can demonstrably collect data from their own live clinical systems in a way that is comparable with the national data sources that CQC uses. This way the information will be reflective of real-time achievement on all clinical areas and will therefore be more accurate and up to date.
- We request that patient satisfaction data re: access is considered proportionately and in the specific context of the practice's circumstances. CQC has assured us that all areas are weighted equally, but in our experience if a practice's uptake is low on childhood immunisations and cervical screening, and they have scored low on the national IPSOS Mori patient survey, they will be assessed much harsher, even if they have performed well in the rest of the Key Questions. Would CQC please confirm that all Quality Statements will be equally weighted, and practices will not be disproportionately disadvantaged by low scores on these particular areas as it appears to happen now.
- It is important that the CQC ensures that data reviewed is effectively interpreted with appropriate, fair conclusions drawn, applying statistical analyses and recognising the limitations of the data.
- **IT systems** – these should be improved dramatically to ensure accurate and timely publication of reports. Data from previous reports needs to be accessible to inspectors and not require manual inputting from the previous IT system.
- Currently, when a provider changes status from an individual (single-handed) to a partnership or vice versa, and their previous profile is archived. If there was an inspection before the change of registration status, that inspection report is not available on the new profile. The

extraction of that report is not available to the practice and poses legal and governance questions for CQC.
The material impact on the practice, who will in most cases have continued with some of the previous partners, can be significant as they cannot access the report from their previous profile and are therefore unable to take any remedial actions required in a timely manner. CQC must put safe and timely systems in place to ensure this issue is addressed, and that providers who change registration status are able to access previous inspection reports in a timely way. There could also be safety issues if the practice spends an entire year not being informed of the areas they need to improve and therefore not taking the required remedial actions in a timely way.

Consultation question 6: To what extent do you agree with the approach to following up assessments and the principles for updating rating judgements?

Strongly Agree. Please see answer to Q5

Consultation question 6a: Do you have any comments on our proposed approach?

Please see answer to Q5 in addition to the following:
We support ratings being updated based on current evidence to avoid reliance on outdated findings.
Notwithstanding our previous suggestion regarding the timely re-inspections of practices with Requires Improvement and Inadequate ratings, routine inspections of GP practices should not take place within five years of the last inspection, unless emerging risks or significant concerns have been identified.
For practices that consistently achieve a "Good" or "Outstanding" rating and where no concerns have been raised, a full site visit should not always be necessary. In most cases, any additional information required could be requested digitally rather than through a full on-site inspection.

Consultation questions 7a, 7b and 7c – N/A as they relate to hospitals

Consultation question 8: We'd like to hear what you think about the opportunities and risks to improving equality and human rights in our proposals. Do you think our proposals will affect some groups of people more than others (for example, those with a protected equality

characteristic such as disabled people, older people, or people from different ethnic backgrounds)?
Please tell us if the impact on people would be positive or negative, and how we could reduce any negative effects.

Suggestions:

- Feedback from individuals from the groups you have highlighted, and any relevant representative groups should inform decision making around language used and the approach taken to reduce inequalities.
- Easy-read versions of inspection reports to be made available on the CQC website
- Reduce language barriers through introducing a web-based translation facility of reports and guidance on ratings characteristics
- Sensitivity to the ethnic and cultural differences of GPs and their staff is key and is currently lacking to a significant extent. CQC needs to be more astute to these differences and accommodate them as part of their inspection process.
- GPs and practice staff are demonstrably affected by the CQC inspection process, the inconsistency of approach between inspectors, the attitude of some inspectors, the way they question practices and the decisions made. "Interrogation" and "excessive scrutiny" are terms quite often used by practices describing their experience of the inspection process. Practices report that the stress, demoralisation and general impact on their physical and mental health and wellbeing is such that some of them actually decide to leave general practice.

  We would like to highlight that GPs and practice teams are a specific cohort particularly affected by CQC inspection processes, which are often reported as being "unsupportive." There are also unacceptable delays in re-inspections and the issuing of reports which can destabilise practices, and disproportionate expectations placed on them by some inspectors, which are applied inconsistently.
  We would like to call on CQC to recognise the impact of their approach on practices and act as a fair and responsible regulator acknowledging their duty of care to their providers.

Consultation question 9: Do you have any other comments on our work, things we should consider, or suggestions for how we could improve?

N/A – please refer to our previous answers