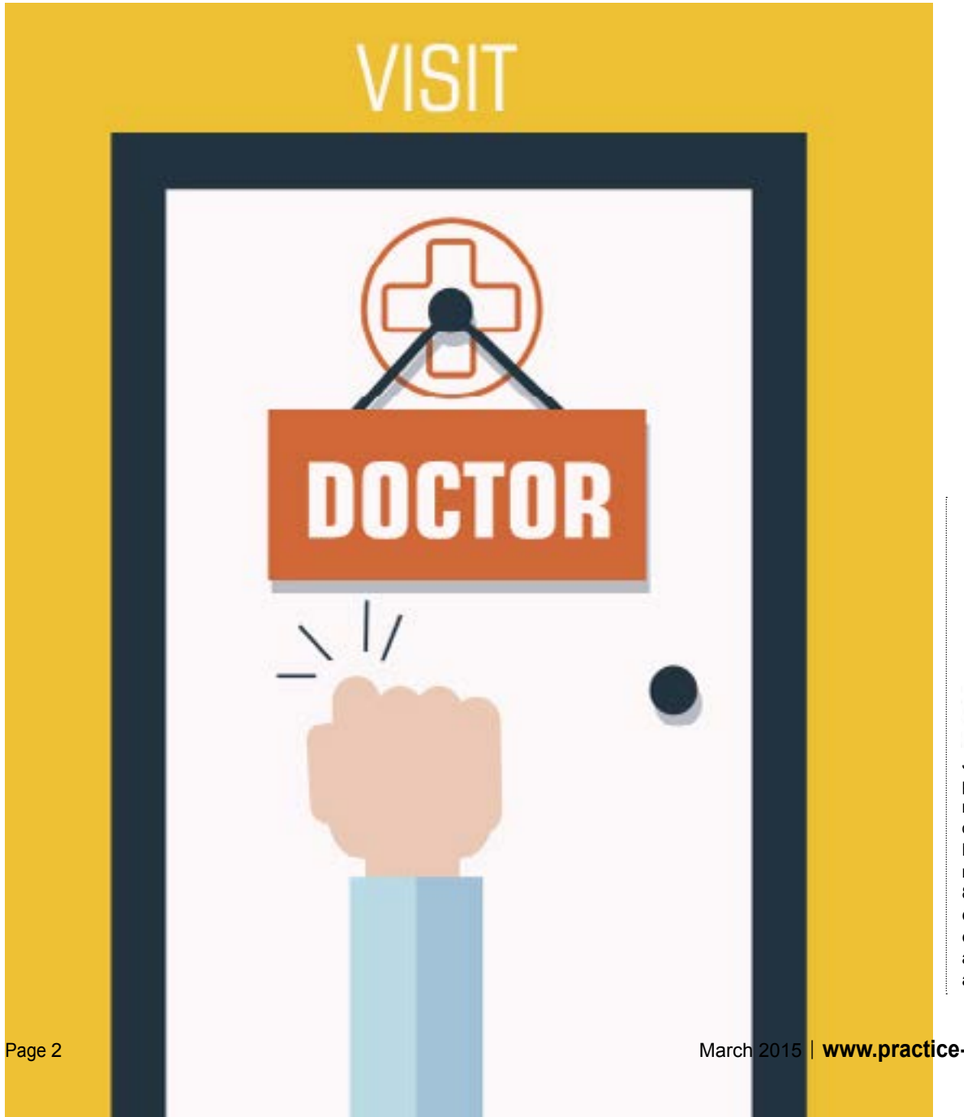
An inspector calls

Jeanette Brown flags up some surprising issues shared by CQC reports and the practice accounts

Over the last few months, I have had cause to read a number of CQC reports. This has been for a whole variety of reasons over and above my role as a specialist medical accountant. Two things have struck me. First, the numerous challenges faced by every practice in being seen to be 'getting it right'. It seems the contents of the report cover every aspect of a practice's operation. If managers choose the route of taking advice on every non-clinical issue, then they could end up spending a small fortune in professional fees. As I see it, you'd need an IT specialist for computing issues, an HR consultant for staffing matters, with a solicitor thrown in for good measure on governance and contractual matters!



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Overlap

The second and, arguably, more surprising thing I noticed was the amount of overlap there is between the matters the CQC reports on and how many of these issues we come across when preparing the practice accounts. I clicked through to a random selection of reports from all over the country and found accounting-type issues in each of the key areas that the CQC covered. Could it be that, as well as providing a measure of partners' earnings and tax bills, that a properly analysed set of accounts could provide a useful steer on certain CQC performance issues? Here are some examples I spotted using some of the key questions that the CQC ask.

CQC question: Are services safe?

Accountant's input: One of the areas the CQC looks at under this heading is medicines management and, in particular, the control and storage of drugs. Accountants report on stock write-downs in the practice accounts, where medicines have gone past use-by dates or have been stored incorrectly. This tends to come up when a practice has suffered a sudden fall in its drugs gross profit percentage when we compare the cost of the drug to the overall reimbursement. I have made a mental note to point out the CQC implications of this if I am advising on this in the future.

CQC question: Are services effective and caring?

Accountant's input: The CQC concentrates on certain 'groups' of patients, such as the elderly and the young to assess the effectiveness of the service offered by the practice. A number of the reports that I read included reference to the provision of flu vaccinations for the elderly and also immunisation programmes for children. As a matter of course in our practice accounts we always compare our client's year-on-year financial performance on enhanced services and look into significant differences, particularly if there has been an unexpected reduction in income. In addition we assess performance on a 'pence per patient' basis and compare this against overall averages for our client base. Of the practices being reported on by the CQC in these areas, it is likely they would have underperformed against our overall average figures.

CQC question: Are services responsive to people's needs?

Accountant's input: When reporting on average profits per partner in a year we often find practices interpreting the 'whole time equivalent' definition in different ways. Is it nine sessions or is it eight sessions – or something totally different? A number of CQC reports commented on availability of patient appointments and commended one practice for working to a '1,000 session per annum' standard. Many of our clients are starting to look at analysing their accounts and using their financial key performance indicators (KPIs) in a slightly different way. As a result, we find that the 'per session' indicators are much more useful, particularly in larger partnerships where partners work with a variety of differing session numbers.

CQC question: Are services well led?

Accountant's input: Undoubtedly, the key expense for every GP practice is its staff costs and so this is the area that must be subject to the strictest financial controls. It is interesting to note that the CQC comments on staffing issues, which are often the cause of increasing costs in the accounts. For example the reasons for increases in staff costs can include high staff turnover, sickness and absence cover, and high deputising costs. In an era where each GP is fighting to maintain profits, we question excessive year-on-year increases in staff costs when we report these in the accounts.

I will now be taking a keener interest in the CQC reports of my GP clients and, as the CQC has reiterated, its target to ensure that every practice will have been inspected and rated by April 2016. It could be that specialist medical accountants will have a useful role to play in warning their clients about certain issues before the inspectors arrive.