

Response to Consultation 2: Our next phase of regulation

- **Structure of registration**
- **New and complex providers**
- **Provider-level assessment and rating**
- **Quality of care in a place**
- **Regulation of primary medical services**
- **Regulation of adult social care services**
- **Fit and proper persons requirement**

October 2017

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 register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can.

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Introduction

Our strategy for 2016 to 2021, *Shaping the future*, set out an ambitious vision for a more targeted, responsive and collaborative approach to regulation, so that more people get high-quality care. Using the principles set out in our strategy, we have continued to discuss how we should develop our approach further and move into the next phase of our regulatory model.

We started the detailed discussions about our regulatory model in December 2016, when we published our first consultation, *Our next phase of regulation*. This proposed principles for how we will regulate new models of care and complex providers, and changes to our assessment frameworks for health and social care and to how we register services for people with a learning disability. It also set out changes to our approach to regulating NHS trusts. The outcome of that consultation can be seen at www.cqc.org.uk/nextphase1.

We published a second consultation in June 2017, which contained proposals on how we register, monitor, inspect and rate new models of care and large or complex providers; how we use our unique knowledge and capability to encourage improvements in the quality of care in local areas; how we carry out our role in relation to the fit and proper persons requirement; and how we regulate primary medical care services and adult social care services.

This document is the response to the second consultation. It summarises the feedback we received about all the questions we asked and briefly sets out what we will do.

The consultation ran from 12 June to 8 August 2017. We were pleased to receive 380 responses from a range of respondents, including providers, commissioners, trade bodies, members of the public, voluntary sector organisations and members of CQC staff. These have been analysed by OPM Group, an independent research and consultancy organisation, and summarised in their consultation analysis report on our website: www.cqc.org.uk/nextphase2.

You can also find our updated guidance for providers on how we regulate primary medical care services and adult social care services on our website: www.cqc.org.uk/providerguidance. We have also integrated this content into our provider web pages.

We are grateful to everyone who took part in the consultation.

Developing our next phase of regulation – consultation 3

Later in 2017/18, we will publish our final next phase consultation. This will include specific proposals for how we will regulate and rate independent healthcare services, which will come into effect during 2018/19. In developing our proposals, we will take account of the decisions we have made about the next phase approach for NHS trusts as well as the feedback we received from independent healthcare providers and stakeholders to our first and second consultations.

Our consultation

Who we engaged with and who we heard from

We received a total of 380 responses during the consultation period. These comprised:

- 176 from health and social care providers or professionals
- 46 from the public, carers and people who use services
- 15 from members of CQC staff
- 35 from trade bodies or organisations representing health and care providers
- 39 from the voluntary and community sector
- 27 from health and social care commissioners and Parliamentarians
- 13 from other regulators or arms-length bodies
- 29 from a range of other backgrounds.

Of the total responses, we received 308 through our online webform. The additional responses were received through our dedicated email address.

We also held 10 consultation events in June and July 2017 with providers, stakeholder organisations and members of the public. For the public, events were organised to reach a broad spectrum of the population, including seldom heard communities, to ensure they could inform our approach to inspection and rating. For providers, the events formed part of a continuing programme of engagement and co-production over the year to shape the proposals within the consultation.

How we analysed the feedback

OPM Group, an independent research and consultancy organisation, analysed the consultation responses. The full set of consultation responses, a summary report of the analysis, detailed information about who responded to the consultation, and the methods used for the analysis can be found in the OPM Group consultation analysis report on our website: www.cqc.org.uk/nextphase2.

PART 1: REGULATING IN A COMPLEX CHANGING LANDSCAPE

1.1 Clarifying how we define providers and improving the structure of registration

This section covers our response to feedback on how we will make changes to:

- the scope of registration
- the structure of registration.

The scope of registration

Consultation questions

1a. What are your views on our proposal that the register should include all those with accountability for care as well as those that directly deliver services?

1b. What are your views on our proposed criteria for identifying organisations that have accountability for care?

“Organisations and individuals that own a service or services that deliver care are likely to have an important influence on the way those services operate and can set the tone and ethos.”

Voluntary or community sector representative

“The sheer diversity and complexity of ownership models do not fit into the structure proposed. The structure might work for a textbook organisation but most large care and support providers have grown through acquisition, so their structures and governance arrangements are far more complex than we believe has been anticipated.”

Provider trade body or membership organisation

What you said

Registering all accountable organisations

The majority of respondents, including members of the public, providers and community sector representatives, supported our proposals to register all organisations with accountability for care. They believed that organisations that currently sit above CQC-registered providers have an impact on the quality of care delivered and expressed concern that they are not held to account under the current regulatory system. Several respondents believed the proposal to register all accountable organisations will provide a greater level of transparency among the entities that are responsible for care. Some respondents felt the proposals will help ensure consistency in regulation across a group, by making structures responsible for regulated activities more visible and by keeping a record of when providers make changes.

Some respondents were unsure how much benefit there will be from including more organisations on the register and did not feel we have explained how this will benefit people who use services clearly enough. Several were concerned about the burden this may place on organisations, describing the plans as “overly bureaucratic” and the creation of more “red tape”. A few respondents mentioned the resources that will be required for CQC to deliver the proposals and question our capability to monitor all those accountable for care as well as delivering the core function of inspecting services. Others were worried that more stringent rules on accountability may stifle innovation, or that maintaining services’ regulatory history from a previous provider could discourage organisations from taking over struggling services to improve them.

Criteria for identifying organisations

Most respondents expressed broad support for all the proposed criteria, based on the reasons discussed above, such as greater transparency and accountability. However, a few disagreed with the criteria, for example suggesting that including so many large groups would result in a reduced level of individual accountability for care.

Some respondents were concerned that the criteria did not go far enough, particularly in not being able to capture organisations based outside England. A few respondents feared this may cause some organisations to move overseas to avoid scrutiny.

Several respondents thought that the criteria would have the unintended consequence of bringing investors and commissioners into regulation. Some respondents thought that the criteria needed to be more specific about the meaning of accountability for care.

Some respondents suggested that we would struggle to deal with the complexity of organisations, and the criteria would be applied differently and result in inconsistent registration.

What we will do

We will further develop and begin to implement these proposals. We will require all entities meeting our revised criteria for defining a provider of regulated activities to be registered with CQC. This requirement will be implemented in a phased way across different types of provider, with the first registrations of this nature in 2018/19. We will publish the schedule for these changes, once detailed impact assessments have been completed. By implementing these changes we will make ownership relationships and links between providers clear to the public on our register. We are

committed to ensuring that people receiving care are protected, and that ratings and reports are meaningful to the public. For this reason, we will continue to inspect at location level.

We will carry out an impact assessment to assess the potential resource implications of the proposal. However the expectation is that extra resources will not be needed.

We will not register overseas providers as we do not have jurisdiction outside England. We will provide the public with more information about the involvement of overseas entities in their care. We will improve transparency, for example by displaying information on our website about providers with overseas owners that we are unable to register.

Criteria defining a provider of regulated activities

In implementing our proposals, we will focus on criteria that describe the direction and control of care rather than on financial interests alone. This means that we will clarify our definition of a provider of regulated activities so that entities meeting these 'direction and control of care' criteria will need to register with CQC. We will also require providers to inform us of their ultimate economic owner so that this information can be made available to the public.

Among the criteria for defining a provider, we proposed to include the right to make employment decisions. We recognise that the description of an entity that can make employment decisions in relation to board membership may not always be an appropriate means of describing the direction and control of regulated activity. This is because:

- a) Appointing board members is not necessarily an employment decision.
- b) Entities that meet this criterion and no others will not necessarily consider the quality of care in delivering their function. This means that there is a risk that entities with financial influence, but which can't be said to direct and control care, would be brought into the scope of registration.

For the reasons above, we will not be requiring entities that only meet the criteria of appointing board members to register with us.

We will continue to work with providers to develop more detailed criteria and indicators that describe what it means to 'direct and control care' and how this supplements how we currently define the management of day-to-day care delivery in setting out who needs to register. We will publish this in Spring 2018, ahead of our phased implementation of these proposals. The criteria will cover:

- Entities that manage and deliver assurance and auditing systems or processes that assess, monitor and drive improvement in the quality and safety of the delivery of regulated activity, and to which entities delivering that activity are accountable.
- Entities that directly develop and enforce common policies on matters such as staffing levels, clinical policy, governance, health and safety, pay levels and procuring supplies that must be followed by entities providing regulated activity.
- Entities with the right to make employment decisions concerning:
 - people who work, or who are seeking to work, in support of the delivery of regulated activity
 - people who run, or who seek to run, individual care settings that deliver regulated activity.

We will complete full impact assessments and work with providers to develop our registration and assessment process for providers that have not needed to register before, to ensure that this is proportionate, transparent and minimises duplication.

We will develop an approach that ensures that the regulatory history of a service (ratings, enforcement action and inspection reports) are still visible when its ownership changes. This will ensure that providers continue to make improvements where they are needed, and that the history is maintained when providers are performing well. We will ensure that this approach is transparent and proportionate, so that providers are not discouraged from taking over poorly performing services in order to improve them.

Registration changes will be aligned with our work on provider-level assessment (section 1.3), which will describe our approach to assessing providers newly required to register as a result of these changes.

The structure of registration

Consultation question

2. We have suggested that our register show more detailed descriptions of services and the information we collect. What specific information about providers should be displayed on our register?

"We agree that CQC's register of services should include more detailed descriptions of services and we believe the provider Statement of Purpose is a good existing resource to support this."
Voluntary or community sector representative

"We would wish to register a concern over any likelihood of the changes having an impact on fees payable to CQC. We would not be supportive of any unintended increase in our fees."
Provider trade body or membership organisation

What you said

There was a broad level of support for providing more detailed and clear information on the register to make it easier for people to be informed about services. Many respondents agreed with the suggestions for information outlined in the consultation document. There were also many suggestions on what the register should include, such as:

- the name of the provider or the ownership details of the company on the register.
- who the service is for, and where it is
- the level of training and specific skills that staff have to care for people, for example if they have specialist skills in supporting people with dementia.
- feedback from people using services.

Several respondents were concerned about the increased burden this could place on providers who will be required to provide this information to CQC. They also highlighted the potential resource required for CQC to keep this information up-to-date and how this may impact on fees, and suggested that a streamlined approach should be adopted.

What we will do

We will implement these proposals in a phased way through provider information collections and as providers make changes to their registration. The information will describe the provider and the services it provides. Providers will need to inform us when these details change. In some instances, depending on the individual registration with CQC, they will need to apply to us and have the change agreed before changing their service provision. The scenarios in which applications are required will be tailored to the type of service being provided, and will be proportionate to the impact of the change on people receiving care. For example, a care home will always need to apply to us before moving to a new address, whereas a service providing care in people's own homes will only need to inform us of an address change.

We are investing in improved systems to make this process simple and streamlined. We currently require providers to share information with us in advance of each inspection. Some of this is information that rarely changes, and can result in duplication for providers. In implementing this new approach, we will use a digital system that presents information we hold back to providers and requires them to take action only if the information changes. We are testing this digital system and will begin collecting this information from some providers in late 2017.

We agree that information about staffing, skills and feedback is important but do not believe that this should be included on the register. If this information was included, then providers would have to notify or apply to us to make changes. This would increase workload for providers and could result in increased fees. To provide the public with transparent and detailed information, we will work with providers to develop the existing Statement of Purpose. This is a document that providers are required to keep up-to-date with CQC, setting out information about the provider, such that it is accessible and meaningful to the public. We will publish this information routinely on our website. More information about the existing Statement of Purpose arrangements, and the relevant regulation is [available on our website](#). We will continue to ensure that inspection reports and ratings are available on our website, and providers will continue to be required to display their ratings. We are also exploring how we might publish other existing information on our website alongside our inspection reports.

1.2 Monitoring and inspecting new and complex providers

Consultation questions

3a. Do you agree with our proposals to monitor and inspect complex providers that deliver services across traditional hospital, primary care and adult social care sectors?

3b. Please explain the reasons for your response.

“As we move to localities and hubs, we need to work together to develop fair and appropriate inspection methods tracking a patient journey. For example, long-term conditions, or out-of-hours access to primary care.”
Arm’s length body or other regulator

“Some of the emerging care models are complex with varying levels of integration and governance, therefore the approach must be flexible enough to be readily applied to the variety of models whilst retaining common standards and without being overly complicated.”
Provider trade body or membership organisation

What you said

Eighty-three per cent of respondents agreed with our proposals to monitor and inspect complex providers; 6% disagreed.

The most common reason that respondents gave for supporting the proposals was the importance of holding all the appropriate levels of an organisation to account, particularly for independent sector providers. Some also supported the greater transparency this will bring, enabling the public to be better informed about the quality of care and leadership within a complex provider and who to contact when things go wrong.

Many respondents said that the coordination of inspections will help to reduce the regulatory burden for providers and make it easier for comparisons to be made across services and providers. They also pointed out that, since the landscape of health and care provision is changing, it is right that CQC adapts its approach to ensure these changes are implemented appropriately. Several agreed with our proposals to test the new approach to regulating complex providers, recognising the complexity of new models of care that are still evolving.

Several respondents countered this by saying that we should avoid making our regulatory systems more complex, despite the growing complexity of the provider market, and that monitoring and

inspection should be simple, clear and equitable. Other respondents expressed concerns that a focus on generalist inspections may not provide the information that the public would find most valuable when selecting a service.

What we will do

We have taken on board feedback about where we could further develop some of our proposals and we will make sure that the process for monitoring and inspecting complex providers is clear. For example, we will ensure that the unit of inspection remains easily identifiable to members of the public. Coordinated monitoring of complex providers will help us to identify any changes in quality and to respond appropriately through a proportionate and targeted inspection approach.

As the landscape of care changes and becomes more integrated, it will also be important that inspection processes and procedures are proactive in reflecting this.

We will begin to implement the consultation proposals. This means that we will:

- Identify a single CQC relationship-holder for each complex provider, who will work alongside named leads for each type of service to coordinate our regulatory activity.
- Align the way we collect information from providers and combine our monitoring information to inform a single regulatory plan.
- Coordinate our inspection activity within a defined period, except for any focused inspections in response to concerns about quality in individual services.
- Assess leadership and governance across all services when we assess the well-led key question in NHS trusts, and in any future provider-level assessments in other sectors.
- Test this approach, including with a small number of accountable care organisations and systems.

We will continue to engage with providers developing new models to learn about their work and consider implications for each part of our operating model, in line with our principles for [regulating new models of care](#) published in August 2017. We will also work with NHS Improvement and NHS England to develop an aligned approach to oversight of accountable care organisations and accountable care systems.

1.3 Provider-level assessment and rating

Consultation questions

4a. Do you agree that a provider-level assessment in all sectors will encourage improvement and accountability in the quality and safety of care?

4b. What factors should we consider when developing and testing an assessment at this level?

"Whilst we see this as being a positive move forward in terms of governance and the 'well-led' category we don't believe a provider level assessment would be capable of incorporating the other principles of 'caring, responsive, effective and safe.'"

Provider trade body or membership organisation

"Whilst we agree with the overall aims and objectives, for example more accountability for parent companies, CQC must continue to place a premium on easy-to-compare, easy-to-understand ratings for individual services."

Voluntary or community sector representative

What you said

Seventy-two per cent of respondents agreed that a provider-level assessment in all sectors will encourage improvement and accountability in the quality of safety and care; 10% disagreed.

Those who supported it called for a consistent and proportionate approach to assessment across different sectors and stated that increased accountability and transparency will encourage systemic issues to be addressed and the quality of care to be improved.

Of the options proposed, a single well-led assessment framework, based on the existing healthcare framework, received the most supportive comments because it is considered to be clear, simple and practical. However, a few respondents were concerned about the well-led key question having primacy over the other four (safe, effective, caring and responsive).

Many respondents expressed concerns about the accuracy of aggregated ratings, fearing that inadequate services could be masked by overall better care across a group or, conversely, that high performing services would be unfairly penalised if other parts of the group are rated as requiring improvement.

Respondents also felt that the proposals are at an early stage, and that further consultation and testing will be required with providers, members of the public and other stakeholders before a final approach is established.

What we will do

We will proceed by developing a methodology and testing this with a small number of providers across all sectors from January 2018. This will include where we find issues at location-level and believe that we can more effectively encourage improvement by intervening at a higher level. This level of assessment may become a standard part of our approach if it is shown to be effective in encouraging improvement, reducing duplication, and supporting greater consistency.

We will now develop and test our approach to provider-level assessment, taking into account the feedback received. Our work will take into account the following principles:

- There should be a consistent approach taken to these assessments.
- Any assessment will include a focus on accountability and leadership demonstrated at provider level.
- Organisations that take over services that are failing should not be penalised.
- It should not result in duplicating inspection at provider level and the existing location level.

The feedback received about ratings, and in particular whether or not to aggregate service level ratings, will be a key consideration as we develop this work.

We will develop and test CQC's approach through co-production, working with providers, people who use services, patients and commissioners in adult social care, primary care and community health services, and independent health care over the coming year.

1.4 Encouraging improvements in the quality of care in a place

Consultation questions

5a. Do you think our proposals will help to encourage improvement in the quality of care across a local area?

5b. How could we regulate the quality of care services in a place more effectively?

"We would welcome the proposal to develop a framework focusing on leadership, governance and collaboration between providers and commissioners in addition to the current focus on providers."
Parliamentarian / councillor

"Whilst agreeing in principle, this will introduce more cost into the system as a whole which will inevitably need to be balanced by cost savings elsewhere."
Provider / professional, independent healthcare

What you said

Sixty-eight per cent of respondents agreed that CQC's proposals will help to encourage improvement in the quality of care across a local area, and 9% disagreed. Among those who agreed, several felt this would ensure a greater focus on the overall experience of people using care and help to identify and address system-wide issues, including those between primary care and other sectors. They thought it would also encourage greater cooperation between providers and drive local improvements in the quality of care.

However, some respondents were concerned about the proposed approach increasing cost and bureaucracy. Others commented that the proposal to encourage improvements in the quality of care in a place would represent a move away from regulation towards 'care co-ordination' or acting as 'a conduit for information'.

Several respondents made suggestions including:

- increasing information sharing across local and national bodies
- seeking feedback on the quality of care across a local area, including focusing on people's care pathways and experiences across systems
- examining the particular demographics of an area to work out people's needs
- recognising and reflecting providers' experience of commissioning.

What we will do

The feedback from our consultation told us that respondents generally agreed that our proposals will help to encourage improvement in the quality of care across a local area.

Our approach will recognise the importance and value of the wider health and social care setting. We will review the language we have used to ensure it is clear and easy to understand. We will inform our approach with learning from the 20 system reviews we are undertaking this year to understand how people's experiences and outcomes are affected by the way that care services work together.

We will proceed with our approach to strengthen our assessment of how well providers work with others to share information and coordinate care during individual provider inspections, and when undertaking wider system reviews. This includes exploring how the system works as a whole to assure and improve the quality of care and improving our understanding of how people's experiences are affected by the way services work together.

We will also use our insight about the quality of care in a place to help us understand the context in which providers are working. This includes the extent to which the quality of care within a provider is influenced by factors that are outside their direct control. This will allow us to make use of insight to highlight wider issues affecting health and social care.

To achieve this we will:

- Build our capability to understand people's experiences of care where services are organised by pathways or across organisational boundaries.
- Use our monitoring and inspections of individual providers to assess how well services are working together and to understand the impact on people's experiences.
- Use our independent voice and relationships with national, regional and local partners to share our view of quality across health and social care and to highlight cross-system issues.
- Consider reporting on a system as a whole (when an area works in such an integrated way), for example when accountable care organisations are registered with CQC in the future.
- Continue to work with local providers and commissioners, and national oversight bodies such as NHS England and NHS Improvement, to coordinate how we make best use of our respective powers to overcome barriers to improvement.

PART 2: NEXT PHASE OF REGULATION

2.1 Primary medical services

This section covers our response to feedback on how we will:

- monitor general practices
- inspect, report and rate general practices
- regulate independent sector primary care services, NHS 111, GP out-of-hours and urgent care services, primary medical care delivered online, and large scale models of primary care.

We set out the detail of our approach in the updated guidance for primary medical services on our website: www.cqc.org.uk/providerguidance.

Monitor general practices

Consultation questions

6a. Do you agree with our proposed approach to monitoring quality in GP practices?

6b. Please give reasons for your response.

“For many, a GP is someone’s key point of contact and we would therefore support CQC’s proposal to promote ongoing rather than periodical monitoring, as this has the potential to empower providers to more regularly review the care they provide and make ongoing improvements.”

Voluntary or community sector representative

“It is unclear how many questions will be asked of practices and the amount of information needed to support a response. As such it is difficult to assess the extent of the burden that practices will undoubtedly have to confront when making such declarations.”

Provider trade body or membership organisation

What you said

The majority of respondents (60%) agreed with CQC’s proposed approach to monitoring quality in GP practices. Twenty-four per cent disagreed with the proposed approach. The majority of responses came from healthcare providers or professionals, where 44% agreed or strongly agreed with the proposals. The remainder of respondents, which included members of the public, commissioners, and

respondents from voluntary organisations and carers, were more supportive, with 73% agreeing to the proposed approach.

Several respondents suggested that the introduction of an annual online information collection could encourage practices to analyse their own performance and help them to highlight areas that require improvement. Others felt it may “minimise administration” or ensure “reduced duplication”.

By contrast, those respondents who expressed concerns said that the proposals would increase the regulatory burden on practices. This is because they felt that the requirements for data submission will increase rather than reduce bureaucracy, and duplicate information that is already collected elsewhere.

What we will do

We have already introduced our new CQC Insight model. This uses nationally available data to help our inspectors monitor providers and plan what to inspect. We will use the information as part of the evidence in our inspection reports.

We intend to introduce an online provider information collection in 2018. This will enable providers to share with us any changes to their services. We will continue to use a provider information request as part of pre-inspection planning until the provider information collection is introduced.

In response to the concerns raised we will:

- work with providers and their representatives to develop and test the provider information collection
- work with the General Medical Council and Nursing and Midwifery Council to highlight where the information we request can also be used to support revalidation and appraisal
- work with NHS England to streamline and align our requests (including the Annual Electronic Declaration – eDEC).
- ensure we only request information that is not available from any other source
- carry out an impact assessment before we introduce it.

We will use all of the information we have about a provider to ensure that our monitoring and planning decisions are made clearly, consistently and transparently.

The relationships we have with partners and stakeholders will be increasingly important as we move towards an intelligence-driven model of regulation. We will continue to improve how we share information, reduce duplication and coordinate action where support is needed to improve. We will continue to work with other stakeholders, as members of the Regulation of General Practice Programme Board, to minimise the impact of regulation on general practice workload by streamlining our data collections and identifying opportunities for closer working. Through the Programme Board, we have developed a framework with NHS England and NHS Clinical Commissioners to improve the effectiveness of our joint working with NHS England and clinical commissioning groups. This will be introduced in November 2017. We will continue to work with stakeholders to ensure we are being consistent in the evidence we gather to support judgements about quality.

Inspect, report and rate general practices

Consultation questions

7a. Do you agree with our proposed approach to inspection and reporting in GP practices?

7b. Please give reasons for your response.

8a. Do you agree with our proposal to rate population groups using only the effective and responsive key questions? (Safe, caring, and well-led would only be rated at practice level.)

8b. Please give reasons for your response.

9a. Do you agree with our proposal that the majority of our inspections will be focused rather than comprehensive?

9b. Please give reasons for your response.

"We recognise and accept that the move towards a risk-based approach to inspection will mean that services rated good or outstanding will be inspected less frequently. This seems appropriate given CQC is also looking to introduce a new insight model to alert inspectors to changes in the quality of care."

Voluntary or community sector representative

"There are positives in the approach but also concerns that the majority of GP practices locally are rated as good and therefore will have less frequent inspection meaning standards could slip and there is less incentive to aspire to be better. We pick up issues with many practices including those rated as good."

Voluntary or community sector representative

What you said

Our proposed approach to inspection and reporting in GP practices

Sixty per cent of respondents agreed with our proposed approach to inspection and reporting in GP practices. Twenty per cent disagreed and a similar proportion neither agreed nor disagreed. Members of the public, commissioners and voluntary sector representatives generally expressed more support for the proposed approach than service providers.

Several respondents gave specific comments supporting the introduction of longer periods between inspections for practices rated as good or outstanding. Some respondents suggested that having longer periods between inspections will reduce the burden of regulation on doctors and practices and improve efficiency. However, others were concerned that problems may develop over the course of the extended inspection interval, which would be picked up by an inspection but monitoring may not capture.

Some respondents, all of which were organisational groups including commissioners and voluntary sector groups, supported the use of unannounced inspections. Several respondents specifically agreed with the use of more accessible and concise language in inspection reports, as well as their faster publication.

Some responses, the vast majority from general practice providers, argued that inspections (especially if unannounced) and the associated bureaucracy put pressure on practices.

Focused inspections

Sixty-three per cent of respondents (including the majority of provider respondents) agreed that the majority of inspections should be focused rather than comprehensive because it would allow inspectors to carry out “a more in-depth review” of new services or areas that require improvement. Some argued that focused inspections would also be less demanding for practices and reduce “unnecessary work”.

Fifteen per cent disagreed with the proposal, concerned that issues may be overlooked or opportunities for sharing innovative practice may be lost.

Rating population groups

Half of respondents agreed with our proposed approach to rating population groups. They said that, as a practice’s approach to safe, caring and well-led has been shown to be consistent across population groups, it is appropriate that these elements are assessed at practice level. Several said that this approach is “sensible”, “simpler”, “clearer”, “makes logical sense” and is more patient-focused.

Twenty per cent disagreed and nearly 30% neither agreed nor disagreed. The majority of respondents who expressed concerns about the proposed rating for population groups are general practitioners or respondents from healthcare organisations. Many of these commented that omitting caring, well-led and safe would lead to an inaccurate overall rating, and could result in missing certain issues during inspections. A few respondents suggested alternative population groups, including people with a learning disability, carers, and those requiring end of life care.

What we will do

As indicated in the General Practice Forward View, in November 2017 we will introduce an inspection interval of up to five years for providers rated as good or outstanding. We will inspect a proportion of these providers every year in order for them all to be inspected within the period. We believe this creates a balance between reducing the impact of regulation and the public desire for regular inspection.

We will continue to inspect providers rated as inadequate within six months and those rated as requires improvement within 12 months. For these providers our inspections will be comprehensive, looking at all five key questions and all six population groups.

From April 2018, most of our inspections of providers rated good or outstanding will be focused rather than comprehensive. The focus will be determined by what we know about each service – including data, information from the provider and other stakeholders, and the findings from our previous inspections. All of these focused inspections will include looking at the well-led key question. These changes are part of our commitment to use information from the public and providers more effectively to target resources where the risk to the quality of care is greatest and to check where quality is improving. Looking at areas of potential improvement will give practices the

opportunity to improve their ratings, and ensure areas of outstanding and innovative practice continue to be shared.

As we already do, we may use short notice or unannounced inspections if we receive information of urgent concern, for example from whistleblowers.

We will continue to refine our approach to inspecting and rating population groups. This includes the evidence we gather to support our judgements and how we use outcomes data in assessing care for these groups. We proposed that we would no longer rate population groups for the safe, caring and well-led key questions, with only the effective and responsive key questions rated for population groups. We want to ensure that these changes will make our ratings more transparent and easier to understand and help better highlight the quality of the care for individual population groups. We will introduce any changes in April 2018.

Regulate independent sector primary care services, NHS 111, GP out-of-hours and urgent care services, primary medical care delivered online, and large scale models of primary care

Consultation questions

10a. Do you agree with our proposed approach for regulating the following services?

- i. Independent sector primary care**
- ii. NHS 111, GP out-of-hours and urgent care services**
- iii. Primary care delivered online**
- iv. Primary care at scale**

10b. Please give reasons for your response (naming the type of service you are commenting on).

"If the way that we consume primary medical care services changes, then it is vital that regulation changes so that carers and patients can have similar confidence in the services that they will be of the same quality as if they attended other services in person."
Voluntary or community sector representative

"Having undergone 2 separate inspections by 2 separate CQC teams... we would like to see a more joined up approach, and for inspections of these services to inform an overall provider inspection rather than a standalone inspection with a separate report."
Provider / professional, ambulance service

What you said

Sixty-four per cent of respondents agreed with our proposed approach for regulating independent sector primary care; 14% disagreed.

Sixty-seven per cent of respondents agreed with our proposed approach for regulating NHS 111, GP out-of-hours and urgent care services; 11% disagreed.

Sixty-five per cent of respondents agreed with our proposed approach for regulating primary care delivered online; 11% disagreed.

Sixty-one per cent of respondents agreed with our proposed approach for regulating primary care at scale; 12% disagreed.

Respondents felt that independent healthcare providers should be regulated in the same way as NHS providers. They felt this would help ensure that the quality of service is consistent and would increase transparency and accountability. However, some felt it could lead to overregulation. Most respondents who commented on NHS 111, GP out-of-hours and urgent care services supported the proposals for regulating them, as they believe this will improve the standard of care provided by these services. Those who commented on the proposals to regulate primary care being delivered online believe that this is an increasingly important service, which therefore requires regulation. Those who commented on the need to regulate primary care at scale believe that a flexible approach is required, to allow for new models of primary care.

What we will do

We will assess independent sector primary care services using the approach set out for general practice. We will develop sector-specific guidance for our inspection teams. In a small number of cases, we may consider how providers offering private GP services care for population groups. We will not rate these services until we have the powers to do so. Should we get the powers to rate, we will consult further on how we propose to do it.

We recognise that the way urgent care is being delivered is changing and becoming more complex as a result of greater integration. This is leading to increased local variation. Our approach to regulation and inspection for these services will be driven by what we know about them. We will work more closely with providers, local stakeholders and our partners to ensure our approach is tailored to services, and makes sense for the provider as a whole. Our proposals for regulating NHS 111, GP out-of-hours and urgent care services will be implemented to the same timescale as our next phase of general practice regulation.

We will proceed with our proposed approach to primary medical care delivered online. We will inspect and make judgements about the quality and safety of these services. We will not rate these services until we have the powers to do so. Where GP practices offer online consultations, we will apply the same methodology as we use for online providers of primary care.

We recognise that models of primary care at scale vary in complexity. Many providers work collaboratively through federations, in some places these are becoming more formal arrangements. Other examples include super-partnerships and multi-site practice organisations. We will continue to work with our stakeholders to develop and refine a regulatory approach that is flexible to be able to respond to the different models we see. We are working with a small number of providers to co-produce and test this approach.

2.2 Adult social care services

This section covers our response to feedback on how we will:

- monitor adult social care services
- inspect and rate adult social care services
- take action to improve adult social care services.

We set out the detail of our approach in the updated guidance for adult social care services on our website: www.cqc.org.uk/providerguidance.

Monitor adult social care services

Consultation questions

11a. Do you agree with our proposed approach to monitoring quality in adult social care services, including our proposal to develop and share the new provider information collection as a single shared view of quality?

11b. Please give reasons for your response.

“Any action which removes or reduces the duplication of data collection is welcomed. We offer the principle of collecting what is important, rather than making important that which can be collected.”

Provider trade body or membership organisation

“CQC Insight has the potential to be very powerful, but also has the potential to become a bureaucratic and onerous data entry system which social care providers are less likely to have the resources to manage.”

Provider / professional, adult social care

What you said

Eighty-two per cent of respondents agreed with our proposed approach to monitoring quality in adult social care, and 6% disagreed.

Respondents were generally supportive of the online provider information collection process, suggesting that it could encourage providers to assess their own performance regularly, and demonstrate continuous improvement of their services.

Most respondents also welcomed the CQC Insight tool, with some saying that sharing information between providers could facilitate joint working and integration between services, and be more

efficient and avoid duplication. Some respondents believed that an ongoing provider information collection process and CQC Insight should improve monitoring by enabling inspectors to see accurate information in context and in real time.

Many respondents were concerned about the availability of data on adult social care services and their performance. They noted the long-term plan to develop a single core dataset, but asked when it will be phased in. Other respondents had reservations about how much confidential data will be visible, particularly to the wider public.

Some respondents expressed concern about the increased administrative burden the new monitoring systems may create, especially for small providers with low numbers of administrative staff and often old technology. Others raised concerns that poorly-performing providers may not complete the forms accurately.

What we will do

Given the strength of support for this proposal, we will introduce the proposed online process for collecting information from providers, via a statement of quality about the five key questions and how providers are supporting continuous improvement. We will require providers to update this at least once annually, although more frequent updates can be made to record changes in quality, including improvements. We will communicate with the sector on when and how we implement this.

We will work with providers, commissioners and other stakeholders to consider how best this information can be developed and shared as a single core dataset, to help reduce duplication of information collection and burden on providers. This will help us to monitor quality and compare service performance over time, including of providers with more than one location as well as corporate providers. We will continue to conduct ongoing monitoring, gathering information from a range of sources, including people who use services and commissioners. This will enable us to respond appropriately to changes in quality, including improvement. Addressing the concerns expressed, we can confirm that we will only share confidential information where we have considered the likely impact of making the disclosure and where we judge the public interest justifies us doing so. We will record these decisions.

We will implement our plans to engage more with leaders of provider organisations, commissioners and others where we find poor quality services, including across a provider's portfolio and coordinate our regulatory response appropriately.

Inspect and rate adult social care services

Consultation questions

12a. Do you agree with our proposed approach to inspecting and rating adult social care services?

12b. Please give reasons for your response.

13a. Do you agree with our proposed approach for gathering more information about the quality of care delivered to people in their own homes, including in certain circumstances announcing inspections and carrying out additional fieldwork?

13b. Please give reasons for your response.

"We believe the proposed approach, especially the concept of a focused inspection for those services with identified concerns is proportionate and responsive to the needs of people we support."

Provider / professional, adult social care

"Any reduction in comprehensive inspections is a retrograde step. It also suggests focused inspections will be reliant on intelligence around concerns being shared (and acted upon) by CQC"

Voluntary or community sector representative

What you said

Inspect and rate

Seventy-three per cent of respondents agreed with CQC's proposed approach to inspection and rating in adult social care and 17% respondents disagreed.

Many respondents believed that, overall, the proposals recognise good performance and focus on providers rated as requires improvement. Respondents also welcomed the flexibility of CQC being able to direct inspection resources where they are needed.

Many respondents supported the proposed frequency of inspections. However, several thought it would be appropriate to have relatively frequent inspections if a change, such as new leadership, has taken place. Several also emphasised that monitoring should continue to take place alongside inspections, and some raised concerns that information about changes or service deterioration would not reach CQC.

Many respondents supported the proposals for rating services in adult social care, as they believe the system is effective in informing people who use services about quality. There was wide support for the removal of the 'six-month limit' on aggregating ratings, as this will enable ratings to reflect service improvement more accurately and responsively.

Care in people's own homes

Seventy-nine per cent of respondents agreed with our proposed approach to quality of care in people's own homes, and 5% disagreed.

Respondents generally felt that more information about care in this setting will be helpful, and that more focus on safeguarding people receiving care at home is crucial as it is a relatively 'hidden' form of care. Several respondents welcomed announced inspections of care at home, given the practical difficulties of interviewing staff and people who use services in this setting. However, similar numbers raised concerns about the loss of the 'surprise' element of unannounced inspections.

Many welcomed the introduction of the 'toolkit' to support inspectors to tailor their approach. However, some requested further detail on what the toolkit might look like, and offered their support in helping to develop it. Others suggested that we should continue to develop our methods even further for engaging people who use services in our inspection processes.

What we will do

We will implement our proposal to introduce more proportionate and targeted inspections. Every service will receive a comprehensive inspection that considers all five key questions. We will also conduct focused inspections, targeted on areas of concern, risk or improvement, informed by CQC Insight and information collection. These inspections, which will always consider the well-led key question, will be able to change an overall rating at any time, combining ratings from the key questions considered in the focused inspection and the remaining key question ratings from the previous comprehensive inspection.

From April 2018, the maximum inspection interval for comprehensive inspections for services rated as good and outstanding will be 30 months. Until then, we will maintain current inspection frequencies of within 24 months. This will be underpinned by ongoing monitoring using a broader range of information sources. We will continue to follow up and respond to risks and concerns through the use of focused inspections at any time. We will engage with stakeholders in advance of extending further the inspection interval for services rated as outstanding.

We welcome the support respondents gave to these proposals, along with their feedback and suggestions. Taking this into account, we will engage with the care at home sector to provide more information about our new tools and methods, and how they will be used in different settings and services. We will also consider how we can gather more robust information about care at home services. Our inspections will also be informed by better quality data generated by services and people who use them helped by new technology.

Take action to improve adult social care services

Consultation questions

14a. Do you agree with our proposed approach for services which have been repeatedly rated as requires improvement?

14b. Please give reasons for your response.

“Fully agree with the proposed approach for services who have repeatedly achieved a requires improvement rating. This will ensure the system is robust and thorough and that services/providers are given full support where needed to increase their rating in a supportive manner”.
Voluntary or community sector representative

“There is an emphasis here on giving the provider time to improve rather than looking at what the residents need. If a service requires improvement for the first time, there should be a very short timescale e.g. two weeks maximum to improve”.
Member of the public / person who uses health or social care services

What you said

Seventy-nine per cent of respondents agreed with our proposed approach to services that have been repeatedly rated as requires improvement, and 9% disagreed.

Some comments supported taking a harder line than we proposed around providers rated as requires improvement, noting the impact on people using services of poor or inadequate care. Many said that addressing failure is an important priority in the interests of safety, and that renewed action will promote confidence across the sector and with people who use services. However, several people felt that the proposals are too similar to the existing approach.

In general, there were mixed views about the early publication of results from inspections where poor quality is found, ranging from it being helpful for the public and people using services, to balancing this with treating providers in a fair and proportionate way. A number of respondents suggested we should not publish details until relevant appeals procedures had been completed as outcomes could change.

What we will do

We acknowledge the strength of support for the proposals and will implement them flexibly and proportionately to encourage improvement. We will ask providers repeatedly rated as requires improvement to complete an improvement action plan to show how and by when they will improve their overall rating to at least ‘good’. We will engage with a provider’s leadership where we find more

than half of their services are rated as requires improvement or inadequate, or if we find significant concerns in a smaller proportion.

We were pleased to see the strong level of support for our proposals in Part 1 of this consultation to encourage improvement and accountability at provider level through changes to the level of registration. We will therefore proceed to implement the proposals to be able to take enforcement action at provider level where this is appropriate.

We will continue to engage with services and other stakeholders to help develop our plans to publish information about enforcement activity in inspection reports when we have more details to share, including about timescales.

PART 3: FIT AND PROPER PERSONS REQUIREMENT

Consultation questions

15a. Do you agree with the proposal to share all information with providers?

15b. Do you think this change is likely to incur further costs for providers?

16. Do you agree with the proposed guidance for providers on interpreting what is meant by “serious mismanagement” and “serious misconduct”?

“[Information sharing] will improve accountability and promote transparency. It will enable providers to hold a comprehensive view over their challenges and will enable them to respond, which will enable CQC to identify gaps.”

Voluntary or community sector representative

“The suggested drafting in ‘mismanagement’ needs to be tighter. The drafting is very wide and very subjective which could lead to the provisions being widely interpreted.”

Provider/professional, acute or single specialty hospital

What you said

Seventy-eight per cent of respondents agreed with our proposal to share all information relating to their directors with providers. Some respondents told us this will increase transparency, improve the accountability of senior staff and help prevent mismanagement or misconduct.

Around half of respondents thought that sharing all information with providers is likely to incur further costs, a quarter thought it was not likely, and a quarter were not sure. There were mixed views from those who thought it would increase costs – several thought these would be “minimal” or “manageable”; others thought the increases were justified; and others thought it would have a negative impact on providers and people using services.

Of the 137 respondents, 102 explicitly supported the proposed guidance for providers on interpreting what is meant by “serious mismanagement” and “serious misconduct”, with several highlighting the proposals’ potential for increased clarity and accessibility. A minority of respondents opposed the proposed guidance, with some criticising the perceived ambiguity of the language, for example questioning how one can accurately measure an individual’s performance against the term “reasonable”.

What we will do

We welcome the response to our question around sharing all information we receive in relation to a fit and proper persons requirement referral with providers. We will publish refreshed guidance for all providers at the end of this year. This will detail the following:

- How we will take forward our plans for when we receive concerns from the public or health and social care staff about the fitness of directors, and how we will notify providers of all concerns relating to their directors and ask them to assess all the information we receive.
- How we will ask the person providing the information for their consent to do this, and how we will protect their anonymity. (Please note that in exceptional cases, where we are concerned about the potential risk to people using services, we may need to progress without consent. The person providing the information would be informed of this.)
- How we will communicate with the director to whom the information of concern relates.
- What we will expect from providers when we share information of concern.
- What will happen if a provider has shown that it applied the appropriate checks but we have concerns that the decision it has made about the fitness of a director is a decision that no reasonable person would have made. This will reference how we could use our enforcement policy to decide if there has been a breach of the requirement relating to good governance (regulation 17) and/or the requirement relating to fit and proper persons employed (regulation 19).

We recognise that this may incur an extra cost for a small number of providers on a case-by-case basis. However, we want the changes to improve the process around the fit and proper persons requirement and aim for these to remain minimal and manageable for providers.

The interpretation of serious mismanagement and serious misconduct should offer greater clarity about the obligations and responsibilities of those holding director roles. It is not our intention for this to be punitive, to put off potential director candidates or to open managers up to vexatious claims. We will review and clarify language to make sure there is minimal ambiguity. We recognise that there is a need to align this guidance with that of other organisations, such as the professional regulators. We will publish the new interpretation as part of the new guidance.

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