

Response to consultation 3

Our next phase of regulation

Independent healthcare services

June 2018

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INTRODUCTION

CQC's strategy for 2016 to 2021 set out an ambitious vision for a more targeted, responsive and collaborative approach to regulation, so that more people receive high-quality care. Using the principles set out in our strategy, we have been consulting about how we should develop our approach further and move into the next phase of our regulatory model.

We published our first consultation about proposed changes to our regulatory model in December 2016 and a second consultation in June 2017.

Our [response to those consultations](#) is available on our website.

We now present the response to the third consultation, which set out our proposals for developing how we regulate independent healthcare services. It summarises the feedback we received about all the consultation questions and briefly sets out what we will do in response.

The proposals in the consultation were developed using the principle that we should take a consistent approach and regulate all services as far as possible in the same way, irrespective of the type of organisation or how they are funded. We received strong support for this approach in the feedback to the consultation.

The main change proposed in the consultation concerned the extension to our powers to award a rating to certain types of independent healthcare services from 2018/19, and how we propose to introduce these. The other proposals represented an evolution of our approach – rather than introducing new methods. They build on our knowledge of independent healthcare services and our specialist expertise, and were proposed to enable a more targeted, responsive and collaborative approach, in line with our strategy and our approach to regulating NHS services. Some aspects of the proposed approach will take some time to introduce; the most significant initial change will be that we will begin to rate the additional types of independent healthcare services following an inspection.

The consultation ran from 26 January to 23 March 2018. We were pleased to receive 263 responses from a range of respondents, including providers of care services, commissioners, trade bodies, members of the public, voluntary sector organisations and members of CQC's staff. These responses have been analysed by OPM Group, an independent research and consultancy organisation, and summarised in an [analysis report](#) available on our website.

We have now updated the guidance for independent healthcare providers on how we regulate them. This is available on our website: www.cqc.org.uk/providerguidance.

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

OUR CONSULTATION

Who we engaged with and who we heard from

We received a total of 263 responses during the consultation period. These comprised:

- 69 from health and social care providers or professionals
- 37 from the public, carers and people who use services
- 84 from our online community
- 9 from members of CQC's staff
- 11 from trade bodies or organisations representing health and care providers
- 15 from the voluntary and community sector
- 8 from health and social care commissioners and Parliamentarians
- 9 from other regulators or arms-length bodies
- 8 from a range of other backgrounds.

We received 224 of these responses through our online webform. The other responses were sent to our dedicated consultation email address (this includes the notes from the consultation events).

We held 13 consultation events in Spring 2018 with providers, stakeholder organisations and members of the public. Events for the public were organised to reach a broad spectrum of the population, including communities whose voices are seldom heard, to ensure they could inform our approach to inspection and rating. Events for providers formed part of a continuing programme of engagement and co-production over the year to shape the proposals within the consultation.

Overall, we received strong support for most the proposals. In particular, comments were supportive of:

- proposals to regulate independent healthcare providers in a way that is consistent to how we regulate other sectors
- our plans to strengthen our monitoring of independent healthcare services to improve transparency and accountability in the sector, and improve CQC's understanding and awareness of independent health care
- becoming more focused and targeted in our inspections over time
- introducing ratings in a way that is consistent with our approach to ratings in other sectors.

Although there was support for all aspects of the consultation, some concerns were raised about particular proposals. Some common themes in these concerns related to the potential increased workload on providers as a result of some of our plans, particularly in relation to monitoring. There were also some reservations about the consistency of our judgements when we begin rating the additional types of independent healthcare. Some concerns were raised about the impact of ratings and the length of time before a rating could be updated following an inspection, and the impact of this in a competitive commercial market.

Alongside this consultation we have carried out a Business Impact Target Assessment, which we will publish on our website soon. This will assess the impact on business of any eligible changes we have made to the way we regulate. Some of the proposals in the consultation will take some time to implement, therefore we will carry out further Business Impact Target Assessments as further changes to our approach to regulating independent healthcare are planned and introduced.

How we analysed the feedback

Responses to the consultation were analysed by OPM Group, an independent research and consultancy organisation. 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 are available in the consultation [analysis report](#) on our website.

SUMMARY OF FEEDBACK

1. Monitoring

This relates to how we will monitor independent healthcare services through:

- strengthening how we manage our relationships with providers, and local and national organisations
- developing our CQC Insight tool to monitor data about the quality of independent healthcare services
- introducing a routine information collection from providers of independent healthcare.

1.1 Relationship management

Consultation questions:

In our consultation we proposed to strengthen how we manage our relationships with providers of independent health care and to routinely work with local and national organisations to exchange information about services.

Q1a. Do you agree that this is the right approach?

Q1b. What impact do you think this proposal will have?

Q1c. Which organisations do you think we should exchange information with?

“Both parties will have a knowledge of each other that at present does not exist. Should lead to a greater understanding by CQC of the diversity of the organisations which fall under the Independent Healthcare Provider and which they are inspecting.”

Independent healthcare provider/professional

“We need to have some contact with providers and stakeholders, but we also need to maintain a professional distance to help us remain independent and objective.”

CQC employee

What you said

The majority of respondents (91%) agreed with CQC's proposal to strengthen how we manage our relationship with providers and with local and national organisations, and 4% of respondents disagreed.

Many respondents and participants in our consultation events felt that the proposed approach would improve patient safety and the standard of services, either by encouraging providers to take steps to improve the quality of their service or because increased dialogue can help organisations to address issues highlighted in inspections. Some felt that it would improve communication and relationships between CQC and providers, which would improve the transparency of regulation and accountability for providers and build trust and confidence in CQC.

However, some concerns were raised about the proposals relating to relationship management. These were primarily about the additional resources that providers may be required to have. A small number of respondents also believed that this approach could threaten the independence and impartiality of CQC. Some participants at our events for providers expressed concerns about the consistency of approach to relationship management, saying that some providers do not know or have not met their relationship manager.

On the question about who CQC should exchange information with, the most commonly suggested organisations were:

- commissioning groups, including local authorities and clinical commissioning groups (CCGs)
- other providers of healthcare services (GPs, hospitals)
- patient representative groups, such as Healthwatch
- other regulatory bodies
- Private Healthcare Information Network (PHIN).

What we will do

Strengthening our relationships with partners and stakeholders will be increasingly important as we move towards an intelligence-driven model of regulation. We will continue to improve the consistency of engagement with providers and we are committed to working collaboratively with a wide range of stakeholders to inform our regulation.

Every provider will be allocated a relationship owner who will develop an understanding of the organisation. We will try to keep the same person for a provider as far as possible. We will hold Relationship Management meetings with providers at least annually, with a clear structure and format, although these may not be face-to-face. We will be mindful of the impact on a provider's resources and ensure that this is proportionate to their size and the identified risk within services. For larger organisations we are likely to meet more frequently than annually and where individual services are part of a corporate provider, there may be a different relationship owner for the location and the provider. In this case, we will share information internally to better an understanding of quality across a provider, and reduce duplication.

We agree that it is important to be transparent when sharing information and that an effective relationship is built on open dialogue. We will share information with providers proportionately where it will not breach confidentiality or prejudice the functions of CQC. While relationship management meetings do not constitute an inspection and will not directly inform a provider's ratings, they will inform our regulatory planning.

We will continue to work in partnership with many national organisations to share information about services and people's experiences of them. These closer working relationships will increase efficiency by reducing duplication and making the best use of shared information and resources. Our inspectors and inspection managers have an ongoing relationship with organisations such as the Healthwatch network and with voluntary and community sector organisations that represent the public. We will seek to develop our relationships with a range of system partners, including what information we share.

1.2 Developing CQC Insight

Consultation questions:

We proposed to develop our CQC Insight tool to monitor data about the quality of independent healthcare services, starting with CQC Insight for acute hospitals and mental health services.

Q2a. Do you agree that this is the right approach?

Q2b. What impact do you think this proposal will have?

"It will also potentially allow CQC to carry out a more targeted and responsive inspection programme by identifying outliers or providers whose historical data suggests that current service levels are deteriorating."

Health or social care commissioner

"This approach will provide CQC with continuing insight into the quality of care delivery rather than a snap shot view of a one day inspection."

Independent healthcare provider/professional

What you said

The majority of respondents (77%) agreed with the proposals to develop our CQC Insight tool to monitor data about the quality of independent healthcare services, and 5% of respondents disagreed.

The respondents who supported this proposal felt this approach would improve quality and may help to identify trends or areas of weakness to give providers opportunities to address concerns. Some respondents said it would help to create clear benchmarks and increase the ease of comparison across areas and sectors. Some felt that it would improve CQC's overview of services, enabling a continuing view of quality rather than focusing on a 'moment in time' on the inspection. Some respondents felt that increased monitoring could improve the accountability and transparency of providers or increase trust among people who use the service.

However, some respondents also raised concerns about the use of data from other sources and felt that providers should know what data CQC holds about them. Some felt that CQC should determine what data is available and what data is necessary while avoiding duplication for providers.

Some respondents felt they needed more detail about how CQC Insight would work, when it would be introduced and the data that would be required to support it.

What we will do

We will introduce CQC Insight in stages for each different type of independent healthcare service. This will start in quarter 3 of 2018/19, with CQC Insight relating to acute hospitals, inpatient mental health services, substance misuse services, and services for people with a learning disability. We will then roll out CQC Insight to other types of service where the available data is of sufficient quality, depth, and coverage to allow us to monitor them effectively.

CQC Insight will analyse information from a range of sources and will be tailored to each sector or type of service. For example, CQC Insight for independent acute hospitals will present findings from relevant national clinical audits. CQC Insight for independent providers of specialist mental health services will include analysis of the findings of our visits to people detained under the Mental Health Act 1983 and relevant notifications under the Act.

We will use CQC Insight to monitor potential improvement or deterioration in the quality of care. This will help us to decide what, where and when to inspect and provide analysis to support the evidence in our inspection reports.

We will work with providers as we develop CQC Insight, and will be transparent about the data sources we are using.

1.3 Routine provider information return

Consultation questions:

In the consultation we proposed to collect information regularly from independent healthcare providers to help us to monitor the quality of services in between inspections

3a Do you agree that this is the right approach?

3b What impact do you think this proposal will have?

"A better insight into the provider's activity for CQC should result in more accurate awareness of performance."

Voluntary or community sector responsive

"The resource and time required to gather information cannot be underestimated and CQC will need to work closely with independent providers to agree exactly what evidence is required and in what (uniform) format."

Arms length body or other regulator

What you said

The majority of respondents (83%) agreed with our proposals to collect information regularly from independent healthcare providers, and 9% of respondents disagreed.

Many respondents stated that this proposal would improve quality, as it raises standards through collaboration and sharing information. Respondents felt that collecting information will help to identify areas of concern more quickly or identify areas of good practice and allow these to be recognised and shared. Some respondents believe that information collection and monitoring will increase the accountability and transparency of providers.

Some respondents said that this approach would improve the inspection process by reducing the amount of data that must be submitted beforehand.

However, several respondents and participants at our consultation events raised concerns about the potential impact on the workload for providers, particularly smaller providers, which could have a negative impact on patient care. There were also some concerns about duplication of data requests and the particular impact on smaller organisations.

Some respondents felt that the data collected could be misleading or inaccurate, therefore inspections are still necessary to make sure that no areas of concern are being missed as a result.

What we will do

In line with our regulation of other sectors, we will move to a process that involves collecting information directly from providers on a routine basis. We will explore how we can develop this information collection as a digital service. However, this will take some time to introduce and in the interim period there will be little change to the information we request from providers. When we begin collecting information routinely, this will contribute to CQC Insight as one important source of data to enable us to better monitor services between inspections and provide analysis to support the evidence in our inspection reports.

We will work with all types of independent healthcare providers to develop how we collect this information.

To minimise the impact on providers we will only request information through the routine provider information return that we cannot reliably obtain from another source, and we will only collect information that will inform our understanding of the quality of care. We will only collect information directly from providers that we can use to monitor services effectively. This is to ensure that the impact on providers of any data collection is proportionate.

We will not rely solely on the information supplied through the routine provider information collection. Rather, we will use it alongside a range of other sources as we carry out our monitoring and inspection activities. We will also look to develop how we collect and use what patients tell us about a service.

2. Inspecting

The proposals in the consultation described some changes to the way we inspect. However, most of the inspection process will be the same for providers of independent healthcare. The proposed changes were in the following areas:

- moving towards more unannounced inspections
- changes to core services for acute and community services
- using accreditation schemes.

2.1 Unannounced inspections

Consultation questions

We proposed to move towards more unannounced and short notice inspections.

4a. Do you agree that this is the right approach?

4b. What impact do you think this proposal will have?

“I think the key to any true form of measurement is to view matters in their true light and certainly by turning up unannounced, this should happen.”

Member of CQC’s online community

“Service delivery can be disrupted in a very small organisation and my concern here relates to disruption in patient care. We should always be mindful of the impact the inspections have on delivery of care with core staff”

Independent healthcare provider/professional

“Providers should have management and operational measures in place to deliver high quality, value for money services on any given day that an individual or formal inspector wishes to view its operations. Therefore more unannounced / short notice inspections should be seen as routine to the best providers.”

Health and social care commissioner

What you said

The majority of respondents (77%) agreed with CQC’s proposals to move towards more unannounced and short notice inspections, and 14% of respondents disagreed.

Many respondents felt that more unannounced and short notice inspections would help CQC to give a more accurate assessment of quality by removing or reducing the opportunity for services to prepare for inspections and ‘mask’ areas of weakness. Many also believed it would improve the quality of services or ensure that providers maintain their levels of performance at all times. Members of the public in the focus groups typically supported a move towards more unannounced inspections as they felt this would prevent services from covering up issues and would make them feel safer.

However, some respondents felt that this proposal could place an unnecessary burden on providers and have a negative impact on the people who use the service as a result. They thought providers may have to cancel appointments or that staff would have less time to be able to provide care. Others commented that an unannounced inspection would not work for all providers, particularly smaller services, because of the availability of key personnel, data or the impact on patients. A few felt that an unannounced inspection was most appropriate if there were concerns about a service.

What we will do

To enable us to observe normal practice on inspections, we will introduce more unannounced inspections as part of our routine inspection methodology for independent health care services. Because we request information from providers before an inspection, the inspections will take place within three months of the provider submitting its provider information request. We will not announce the day on which we intend to inspect. However, in response to feedback, we recognise that for practical reasons we will need to give short notice of an inspection to some providers to avoid affecting patient care. This will usually be 48 hours' notice.

CQC's lead inspector may decide to carry out a short notice inspection for any of the following reasons:

- Where an unannounced inspection is likely to have a detrimental impact on the people who use the service and the quality of care of care they could receive.
- Where the availability of the service is variable and it opens on different days or times of the week.
- Where the service is dispersed and delivered across a large geographical area.

Our inspection teams will continue to ensure that in all instances the impact of an inspection on the staff delivering the service, as well as the people using them, is kept to a minimum.

2.2 Changes to core services in inspections of acute services

Creating two distinct core services of outpatients and diagnostic imaging

Consultation questions:

In independent acute hospitals, we currently assess the existing core service of 'outpatients and diagnostic imaging'. We proposed to separate this core service to create two distinct core services of 'outpatients' and 'diagnostic imaging'

5a. Do you agree that this is the right approach?

5b. What impact do you think this proposal will have?

“Separating the assessment of outpatients and diagnostic imaging services would allow for these services to be rated separately, giving patients a clearer picture of the quality of each service.”

Arms length body or other regulator

What you said

The majority of respondents (61%) agreed with the proposal to create two distinct core services of ‘outpatients’ and of ‘diagnostic imaging’. However, 34% of respondents neither agreed nor disagreed with the approach and 5% of respondents disagreed.

Several respondents commented that this proposal would give a more accurate reflection of how services are provided and would therefore have a positive impact on the accuracy of providers’ ratings. In addition, assessing them separately would give the public, patients and providers a more transparent view of quality. Some respondents said that the differences between outpatients and diagnostic imaging require separate assessments.

Only a small number of respondents raised concerns about this proposal, focusing on the perceived low levels of patient satisfaction with outpatients and diagnostic imaging services.

What we will do

Our experience to date, and feedback from the consultation, supports the view that ‘outpatients’ and ‘diagnostic imaging’ are distinct specialities. We believe that by assessing them separately, all parties – including the public, patients and providers – will have a more transparent view of the quality of the services.

We will therefore separate the existing core service of ‘outpatients and diagnostic imaging’ into two distinct services and inspect each routinely in independent acute hospitals. To ensure that we take a consistent and proportionate approach to inspecting each of the services, inspections will be supported by distinct service specific inspection frameworks. We are confident that doing this will not only better reflect the way in which these services are delivered, but will also ensure that we inspect both services fully and provide a rating and a clear report on the quality of care for each service.

Having two separate inspection frameworks for these services is consistent with our approach to regulating NHS acute trusts where we have already separated outpatients and diagnostic imaging. In the NHS, diagnostic imaging is now an additional service and we do not inspect it routinely, but where we have concerns. However, unlike in the NHS, there is less data available about diagnostic imaging in independent healthcare settings to enable us to confidently and accurately assess the level of risk to determine when to inspect this service. Therefore we have decided it will continue to form part of the routine inspection methodology for independent health services, rather than be considered an additional service.

Combining core services of medical care and surgery in some inspections

Consultation questions:

In independent acute hospitals, we currently assess 'medical care' and 'surgery' as two separate core services. Some hospitals manage these services together, with no separate governance or organisational arrangement, and they treat patients on the same wards with the same staff. For these hospitals, we propose to combine these two services into a single core service of 'inpatients'.

6a. Do you agree that this is the right approach?

6b. What impact do you think this proposal will have?

In hospitals where medical and surgical services are managed separately, we proposed to continue to inspect the two separate core services of 'medical care' and 'surgery'.

7a. Do you agree that this is the right approach?

7b. What impact do you think this proposal will have?

"The experience of patients who have had surgery and those receiving medical care may be distinctly different, even if they are managed together by the service. The public want to know what their expectations of the service should be in each discrete category."

Member of the public

"Wonder if this will skew results and not provide that bigger overview of the whole service. The dimension reviewed where surgical or medical patients are cared for as inpatients should not be different if separately located or co-located."

Arms length body or other regulator

"The process has so many overlaps in the case so, yes, the services should be assessed as one."

What you said

Feedback from respondents on these proposals was more mixed.

- **Combining medical care and surgery as one core service of ‘inpatients’ where they are delivered together:** 51% agreed with the proposals, 38% neither agreed nor disagreed, and 10% of respondents disagreed with the approach.
- **Continuing to inspect ‘medical care’ and ‘surgery’ as two separate core services where they are managed separately:** 69% agreed with the proposals and 4% of respondents disagreed

Several respondents commented that medical care and surgery are too distinct to be assessed together and some commented that while the management of these services may be delivered together, the risks associated with individual services can be different, which may make it harder to determine their quality. A few respondents also suggested that the proposed approach would cause the quality of services to deteriorate as it may allow risks to be overlooked or obscured.

There was also some support for this proposal: several respondents said the combined approach is logical and sensible given that these services are often delivered together, with common personnel and management of services. Some respondents highlighted that this proposal would have the potential benefit of a simpler inspection process that reduces duplication by spending less time on keeping records and assessing the same governance. Respondents also highlighted the potential benefits of being able to better assess patient pathways between medical care and surgery.

What we will do

Following the concerns expressed by some respondents, we have decided not to proceed with the proposal to combine ‘medical care’ and ‘surgery’ into a new core service of ‘inpatients’ for some providers.

We will continue to inspect both these services separately for **all** providers regardless of their management or governance structure.

While we recognise that there was broad support for the proposal from a practical point of view in how these services are typically organised and managed, we want to ensure that our approach is consistent, proportionate and transparent for both providers and the public. Inspecting and rating all medical care and surgery services on the same basis will help ensure that we achieve this. To address some of the concerns raised about duplication as a result of looking at medicine and surgery separately, we will develop how we inspect services that share the same governance and staff and we will improve how we inspect combined aspects of these services to minimise duplication and workload for providers.

Furthermore, we recognise that the proposed change could have a potential detrimental impact on the quality of these services by failing to take into account the distinct nature of the services, the staffing skills and the quality of care for patients under the different disciplines. By keeping them distinct, we are able to ensure that the risks associated with each service are not overlooked or obscured in our inspections.

Changes to core services for independent community health care

Consultation question:

Some independent community health care providers may only deliver a single service, or may deliver only a small part of a community service. For these providers, we proposed to introduce the 'community single specialty' service.

8a. Do you agree that this is the right approach?

8b. What impact do you think this proposal will have?

"This needs to be proportionate to the size of organisation and the resources that they have and I would say fairly light touch. It would not want to deter them from operating a community service."

Parliamentarian/councillor

"Seems an unduly bureaucratic approach. Each service will have a rating. That is what will matter to the user."

Voluntary or community sector representative

"Again avoids duplication and reduces time spent for both CQC and the provider."

Health and social care commissioner

What you said

The majority of respondents (65%) agreed with CQC's proposal to introduce the 'community single specialty' service, 32% of respondents neither agreed nor disagreed with the approach and 3% of respondents disagreed.

Several respondents supported the proposals because they felt it would improve the quality of assessment, reduce duplication and improve the accuracy of ratings. Some felt it is a logical and sensible approach given that these services are often specific in the way they deliver care.

However, some respondents raised concerns about the impact of this proposal on the quality of inspections and assessment, including the potential for an undue increase in bureaucracy, particularly for smaller providers.

What we will do

We recognise that, while many of the responses to this proposal were positive, there remain a number of concerns about the impact on the quality of inspections and assessment. These concerns particularly reflect the difficulty in being consistent and ensuring a clear set of criteria for when we would apply a community single specialty approach in place of existing community health core services.

Therefore, in response to concerns about consistency, we will not introduce a 'community single specialty' service. We will continue to inspect the core services for community health using the current inspection frameworks, which are consistent with the frameworks for NHS services. To ensure consistency when looking at locations that deliver care to both adults and children, we will always report separately on the services for children. This is in line with our approach for providers of acute independent healthcare where we always report and rate services for children and young people irrespective of the size of the service. We believe that this approach will maintain consistency and ensure that services for children and young people are considered proportionately.

To support this, we will develop guidance for our inspection teams to build on their understanding of specific services.

2.3 Using accreditation schemes to inform inspections

Consultation question:

If a service has gained accreditation by an appropriate recognised scheme, we propose to use this to both inform CQC inspections and, over time, reduce our inspection activity and duplication for providers

9a. Do you agree that this is the right approach?

9b. What impact do you think this proposal will have?

"A comprehensive and evidence based accreditation scheme will deliver a root and branch review of the quality of a particular service and demonstrate areas in need of quality improvement. Engagement with these schemes is evidence of a positive culture within a particular service, and at Board level, a commitment to quality and improvement."

Arms length body or other regulator

"We strongly believe that all services should receive regular, rigorous and comprehensive inspections regardless of gained accreditation... Accreditation should contribute to informing the inspection process and not replace it."

Voluntary or community sector representative

What you said

The majority of respondents (67%) agreed with CQC's proposal to use accreditation by an appropriate recognised scheme to inform inspections and reduce duplication, 11% of respondents neither agreed nor disagreed with the approach and 22% disagreed. The majority of respondents supported the proposal because it would help to avoid duplication of work and that recognising an appropriate accreditation scheme, where such a scheme exists, would free up time, money and resources. Respondents felt it would reduce the workload for providers from inspections. Several respondents argued that accreditation schemes are evidence of a provider's attainment of high standards or commitment to improve.

Some respondents added a caveat to their support, stating that the standards and rigour of the accreditation schemes must be consistent as standards vary across different accreditation bodies.

Some concerns were raised regarding the potential for the proposals to reduce inspection activity for accredited services, as the respondents felt that inspections are still necessary to ensure that standards are maintained.

What we will do

We recognise the difference in respondents' views to this proposal. Therefore we will only use an accreditation scheme as a source of information if it meets key quality standards so that we are assured that it is of sufficient quality and rigour. Furthermore, we will only use an accreditation scheme to reduce our inspection activity in a particular service if there is also adequate uptake among providers. This is likely to take some time to introduce and is in line with our approach to accreditation schemes in the NHS.

Any accreditation scheme that we use will also need to be able to map its standards to our assessment framework for healthcare services, with corresponding key lines of enquiry (KLOEs) and prompts, to ensure that it has adequate breadth and coverage.

Participation in accreditation schemes is an indicator of a good or outstanding service, but it is not the only indicator we will use when inspecting, therefore the absence of accreditation would not limit a rating. Equally, the fact that a service is accredited will not prevent CQC from inspecting the service if there are concerns or if there is evidence of outstanding care from which other services could learn.

2.4 Additional aspects to our proposed inspection approach

As well as our proposals for change, the consultation document also included a number of aspects to our inspections that we did not specifically consult on, but which prompted some feedback from respondents.

The consultation describes a move towards a more targeted and tailored approach to inspection. Initially we will carry out comprehensive inspections for independent healthcare services to rate them for the first time, considering all key questions and core services. We will also carry out comprehensive inspections of newly-registered services and those where we have significant concerns.

Once these services have been rated for the first time, we intend to continue with comprehensive inspections for most independent healthcare services rather than moving towards routine inspections that are more focused. This is because independent healthcare services are usually small services provided from one location, and only limited data is available to support a more focused inspection. Over time, and once we have completed our initial programme of inspection and ratings, we can use the learning and consider again how inspections might become more targeted and focused, in line with our strategy.

The two exceptions to this approach are:

- Inspecting community interest companies (see below).
- Inspecting some independent mental health services that provide a number of core services that we have already rated. In some of these instances it may be more proportionate to inspect only some, rather than all core services if we have already rated them. These services often provide NHS-contracted services therefore our approach will be consistent with the approach for NHS trusts that provide mental health services.

In line with our approach in other sectors, we want to continue to focus on leadership and governance in all our inspections, and we began using the strengthened KLOEs for the well-led key question in the [assessment framework](#) for healthcare services from April 2018.

The development of our overall approach to assessing leadership at provider level and our approach to registration is also progressing and, in time, this may support how we focus on the leadership of independent health care at all levels. By engaging with independent providers in the summer, we will be able to share our interim approach and work together to develop this into a long-term approach to regulating independent providers of both health and social care.

We are currently considering how to strengthen our focus on the well-led key question at location level for those independent acute services with multiple core services. Our current approach considers and rates this key question for each core service and aggregates ratings for the well-led key question up to a location level rating. These inspections include considering medical advisory committees, monitoring practising privileges and multi-disciplinary working across services. However, we want to explore how we can improve our inspection of leadership and governance at a location in our inspections and reporting.

In our consultation we indicated that for some services, our inspections will focus on particular core services or key questions where information suggests that risk is greatest or that quality is improving over time. Where a provider of independent community healthcare and/or mental health care meets all of the following criteria, we will follow the approach used for inspecting NHS trusts:

- It delivers care to people in a specific geographic area.
- It delivers multiple services similar to an NHS trust.
- It is run as a single organisation, where its staff identify themselves as being part of one organisation.

Following changes to our powers to rate this sector, the first inspections of community healthcare providers in this category will be comprehensive, which will enable us to establish a baseline rating. For subsequent inspections, and for inspections of mental health care providers that meet these criteria, we will carry out an annual inspection of the five key questions in at least one core service, followed by an inspection of the well-led key question for the provider.

Please see [How we monitor, regulate and inspect NHS trusts](#) for further details.

Independent doctors and clinics providing primary care services, including online and independent doctors providing non-hospital acute services

The consultation referred to how we may regulate independent doctors that provide non-hospital acute services in a similar way to how we regulate independent doctors that provide primary care services. This is because they provide services in a similar way, often providing consultations and minor treatment in clinics and consultation rooms. To date, this work has focused on aligning our inspection frameworks so that our expectations on quality and our judgements and assessments of these services are consistent, where appropriate.

The notice periods and inspection frequency in the established approach to regulating independent doctors providing primary care are different to our approach to regulating independent healthcare, following this consultation. .

We are currently still inspecting (but not rating) independent doctors providing primary care services and will reach a decision on the above points before we start to inspect and rate all independent doctors from April 2019.

We will update our guidance for providers which will confirm our approach to regulating these services; including information on notice periods and inspection intervals.

3. Reporting

Consultation questions:

We proposed to publish a more accessible and user-friendly inspection report with a separate appendix of evidence for some independent healthcare providers.

10a. Do you agree that this is the right approach?

10b. What impact do you think this proposal will have?

"It needs to be in plain and simple language for all members of the public to be able to understand. Too often reports are full of jargon and acronyms that make reading very difficult and seem a waste to publish."

Member of CQC's online community

"By providing simpler more user friendly reports service users will be able to make informed decisions about the best places of care and treatment for their condition."

Independent healthcare provider/professional

What you said

The majority of respondents (83%) agreed with our proposal to publish a more accessible and user-friendly inspection report with a separate appendix of evidence for some independent healthcare providers, and 8% of respondents disagreed.

Feedback from many respondents supported the use of clearer and simpler reports with no jargon and complicated language. Several respondents supported a shorter more concise report as they felt this would be easier to digest and quicker to read. Some respondents felt that clearer reports would help the public to compare services. Several felt that this proposal may help to improve standards or identify areas of improvement, as more accessible reports would enable providers to recognise and address areas of concern more quickly. Several respondents raised concerns about this proposal. The most common concern was that it would result in insufficient information being included in reports. Some supported the current approach to reporting, and not all supported the introduction of an evidence appendix.

At our consultation events, providers said that CQC's quality assurance processes could be clearer and felt that sometimes the quality of our reports could be improved.

What we will do

We will continue to publish inspection reports for independent healthcare providers using the same format as at present. This includes ensuring that reports and ratings are available on our website. Providers will continue to be required to display their ratings (under Regulation 20a of the Health and Social Care Act).

For some types of independent healthcare provider, we will look to introduce an evidence appendix that presents the facts and figures in a separate report, which anyone can access when required. Our approach will depend on an evaluation of our approach in the NHS, as well as the availability of data from CQC Insight for the types of independent healthcare.

As part of our public engagement strategy, one of our priorities is to produce and promote simple, clear and concise information for the public that explains what good care looks like and supports people to make decisions about services. In doing this, we continue to improve the use of simple, clear and concise language in all our information for the public, including our inspection reports.

4. Rating

Consultation questions:

We proposed to rate the independent healthcare services that we now have the powers to rate in the same way that we rate all other services. Do you agree with the following specific proposals?

- 11a. Award a rating for CQC's five key questions (are services safe, effective, caring, responsive and well-led?) and aggregate these up to an overall rating at service and/or location level.
- 11b. What impact do you think this proposal will have?
- 12a. Rate at the service and/or location level on our four-point scale of: outstanding, good, requires improvement and inadequate.
- 12b. What impact do you think this proposal will have?
- 13a. Aggregate ratings using our published ratings principles.
- 13b. What impact do you think this proposal will have?

"It will help an organisation to focus on specific areas that require optimisation"

Independent healthcare provider/professional

"Weaknesses in some areas will rightly decrease the end rankings and encourage all areas to excel."

Member of the public

"Public funding (i.e. NHS commissioned) is now the second highest income stream for private healthcare and independent providers should be under the same level of scrutiny, assessed using the same rating system for regulation as NHS providers."

Arms length body or other regulator

What you said

The majority of respondents supported our proposals for how we would introduce ratings for the independent healthcare services that we now have powers to rate.

- 88% of respondents agreed with the proposal to award a rating to independent healthcare providers for the five key questions and to aggregate these up to an overall rating, and 5% of respondents disagreed.
- 87% of respondents agreed with the proposal to rate independent healthcare providers at the service and/or location level on our four-point scale, and 7% of respondents disagreed.
- 73% of respondents agreed with the proposal to aggregate ratings for independent healthcare services using our published ratings principles, and 8% of respondents disagreed.

Many respondents supported these proposals as they would ensure consistency across the whole of the health care sector and parity between statutory and independent healthcare services. They felt that this can help to inform patient choice as people can make comparisons more easily. Several respondents felt that these proposals could drive improvement in standards of care as providers are incentivised to achieve the best possible overall rating. They felt that the five key questions and the aggregated overall rating provide a good overview of a service and there was support that ratings will be displayed.

There were some concerns about these proposals relating to the aggregation into an overall rating. This was because independent providers may not provide care across all services that we rate, so it is important that ratings reflect this. A few respondents raised concerns that some types of independent healthcare services had not yet been rated and wouldn't be rated for a long time. They felt that it is unfair that a provider could be rated very early in the inspection cycle while another may have to wait much longer, giving some providers an unfair competitive advantage. Concerns were also raised about the impact of a poor rating on business and that a rating cannot then be changed until the next inspection.

Some respondents raised concerns about consistency of ratings across locations or inspection teams. A few respondents expressed concern about the length of time between identifying areas that require improvement and the re-assessment of these areas.

What we will do

Introducing ratings

Now that we have the powers to rate most independent healthcare services, and taking into account the feedback from this consultation, we will rate them in the same way that we rate all other services. We will award a rating for CQC's five key questions (are services safe, effective, caring, responsive and well-led?) and aggregate these up to an overall rating at service and/or location level. Our guidance for providers describes in more detail how we will rate different types of independent healthcare providers.

From July 2018, we will start to rate independent healthcare providers following an inspection where we have sent a provider information request.

However, for some types of independent health care we will not start rating from July 2018. These services continue to be excluded from ratings because either:

- the number of providers is so small that ratings would not contribute to consumer choice
- the service providers are already regulated by other agencies so a CQC rating could confuse the public
- the sector is relatively low risk and CQC inspects too infrequently to make a rating meaningful.

These services are:

- primary dental care
- some minor cosmetic surgery services
- national screening programmes
- health and justice services
- hyperbaric chambers
- blood and transplant services
- services licenced by the Human Fertilisation and Embryology Authority (HFEA)
- independent pathology laboratories
- independent podiatry services
- children's homes undertaking regulated activities

The Department of Health consulted on amending the performance assessment regulations to enable CQC to rate most independent healthcare services. The response to that consultation sets out more detail about those services that continue to be excluded from ratings.

Updating ratings following improvements

In the consultation we set out our proposed maximum inspection intervals for independent healthcare services. Once we have rated an independent healthcare service, we will use the most recent location-level ratings as a guide to planning the next inspection and determine what we will look at. Based on the level of risk, we will set maximum intervals for re-inspecting locations as follows:

- one year for ratings of inadequate
- two years for ratings of requires improvement
- three and a half years for ratings of good
- five years for ratings of outstanding.

These maximum inspection intervals have been confirmed in our guidance for providers. These are from the publication of the previous inspection report.

In the responses to our consultation, and at some of our events with providers, we heard concerns about the length of time between identifying areas that require improvement and the re-assessment of these areas. In our updated guidance for providers, we have clarified our approach to focused inspections. These are more targeted than comprehensive inspections and do not look at all five key questions. They can be used to follow up findings from a previous inspection. Focused inspections can change a rating for an overall location at any time, using key question ratings from the focused inspection as well as the remaining key question ratings from the last comprehensive inspection. This will address some of the concerns raised about the length of time between identifying areas that require improvement and the re-assessment of these areas.

Consistency and quality of judgements and ratings

Our approach to reaching judgements and awarding ratings is supported by a number of tools and processes to support consistency. Each rating is based on our assessment of the evidence we gather against the key lines of enquiry in the assessment framework for healthcare services. Inspectors refer to the corresponding ratings characteristics for the key lines of enquiry and use their professional judgement to decide on the rating. To ensure that we make consistent decisions, we follow a set of 16 ratings principles and apply professional judgement when rating core services and locations.

Before publishing, we check the quality and consistency of each report to quality assure our findings and check that our judgements are consistent. Providers have an opportunity to check the factual accuracy of the draft report before we publish it.

IMPLEMENTATION

We have published our guidance for providers alongside this consultation response and will start to implement this next phase of our regulation from 2 July 2018. For services that we have already rated, we will continue to inspect them using the inspection frequencies described in our guidance for providers. These apply from April 2018.

| Our approach to rating independent healthcare services | | | | | |
|---|--|---|--|-----------------|-----|
| Type of service | Rating | Maximum inspection intervals | Frequency applies from | | |
| Independent acute hospitals, <i>excluding standalone cosmetic surgery and hair transplant locations</i> | Already rated | Inadequate: one year | April 2018 | | |
| Single specialty: Acute long-term conditions | | | | | |
| Independent mental health hospitals | | | | | |
| Hospices | | | | | |
| Cosmetic surgery including hair transplant (involving a surgical procedure) | Will be rated at next comprehensive inspection | Requires improvement: two years | Date of publication of report for first rated inspection | | |
| Single specialty: Termination of pregnancy | | | | | |
| Single specialty: Dialysis | | Good: three and a half years | | | |
| Single specialty: Refractive eye surgery | | | | | |
| Single specialty: Diagnostic imaging | | Outstanding: five years | | | |
| Single specialty: Endoscopy | | | | | |
| Independent ambulance services | | | | | |
| Community health services | | | | | |
| Independent standalone substance misuse services | | Not rated | | Inspect by 2021 | n/a |
| Single specialty: Hyperbaric services | | | | | |
| Single specialty: Fertility | | | | | |
| Single specialty: Laboratory | | | | | |
| Blood and Transplant services | | | | | |

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