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CQC Next Phase Regulation: Consultation 2

Summary Report

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1. Executive summary

In June 2017, CQC published their second '*Our next phase of regulation'* consultation, providing further details of how their regulatory approach is developing in line with the direction set out in their five-year strategy. The consultation sought views on specific proposals for how CQC will register, monitor, inspect and rate new models of care and large or complex providers; encourage improvements in the quality of care in local areas; regulate primary medical care services and adult social care services; and carry out their role in relation to the fit and proper persons requirement.

There were 380 responses to the consultation from respondents including providers, commissioners, trade bodies, members of the public, voluntary sector organisations and members of CQC staff. A breakdown of respondent types is provided in section 2.3 and the main themes raised in their responses are summarised below.

Regulating in a complex changing landscape

Respondents are very supportive of CQC's proposals to register organisations with accountability for care as well as those that directly deliver services. Many feel that improving accountability and transparency across organisational structures will improve quality of care and ensure a more consistent approach to regulation across sectors. However, some feel the proposals would create unnecessary burden on providers and question whether they could be implemented successfully given the diversity and complexity of ownership models in the health and social care sector.

The criteria proposed by CQC for identifying organisations that have accountability for care are broadly supported but some feel the hypothetical examples in the consultation document are overly simplistic. Some respondents are particularly concerned that organisations based outside England would be exempt from registration and feel that investors should be included on the register. Respondents provide a range of suggestions for how the criteria could be improved and encourage CQC to work with other regulators such as NHS Digital, Companies House and the Financial Conduct Authority.

Most respondents agree that CQC's register should show more detailed descriptions of services and the information they collect. A few respondents express concern that information will not be kept up to date and will duplicate existing sources. Some providers also fear the impact on their CQC fees and the proposal to use wider criteria to set limits within which a provider may operate, particularly geographical limits. They provide a range of suggestions for information they would like to see included on the register. These include more information about who provides the care, information about the service and details about where and to whom the service is delivered.

The proposals to monitor and inspect complex providers that deliver services across traditional hospital, primary care and adult social care sectors receive very strong support. Respondents welcome the consistency and coordination this will bring across all sectors in a rapidly changing marketplace. Many support a more intelligence-driven approach to regulation and welcome the plans for a single relationship holder providing they have the appropriate skills and experience. Some respondents warn the proposals could duplicate existing assessment programmes and challenge CQC's definition of a complex provider. Others stress the continuing importance of focussed inspections at service level and fear these could be overlooked in the future.

Many respondents agree that a provider-level assessment in all sectors will encourage improvement and accountability in the quality and safety of care. Some respondents comment on the four proposed options for a provider-level assessment framework with most suggesting the assessment should be limited to the well-led key question. Many respondents recognise the proposals are at a formative stage and request further consultation and testing with providers, members of the public and other stakeholders before a final approach is established. Many respondents express concern about the fairness, accuracy and complexity of aggregated ratings and worry this approach will be confusing for the public. They also fear that a provider-level rating may encourage organisations to dispose of poor-performing services and discourage providers that specialise in the turnaround of such services.

Most respondents agree that CQC's proposals will help to encourage improvement in the quality of care across a local area. They believe the proposals will ensure a greater focus on people's overall experience of care and help to identify and address system-wide issues arising from the interactions between service providers. They say the proposals will also encourage greater cooperation between providers and drive local improvements in quality of care. Some respondents argue the proposals represent a move away from regulation towards 'care co-ordination' and question whether CQC has the remit and resources to deliver their proposals. Concerned about duplication, many respondents call for CQC to improve information sharing between organisations and offer a number of suggestions for improving CQC's proposed approach.

Primary medical services

The majority of respondents from voluntary organisations or members of the public support CQC's proposals for monitoring GP practices but views amongst healthcare providers and professionals are more evenly divided. Those who support the proposals agree with the introduction of an annual online information collection, combined with the gathering of external data and the use of the CQC Insight Tool. They feel this approach would highlight areas of concern while minimising the administrative work for GPs. Some feel it would also reduce the need to duplicate data and provide a more consistent, accurate and efficient approach. Those who express concerns about the proposals feel it would unnecessarily increase the regulatory burden on general practice, particularly the introduction of the annual

online information collection, which many healthcare providers feel will be too time consuming.

While most respondents support the proposals for inspecting GP practices, some healthcare professionals express concerns. Reasons for support include the plans for longer periods between inspections, the use of unannounced inspections and the use of more accessible language in reporting. Those who oppose the proposals express concern about the increased burden they feel it will place on practices. Some disagree with the increase in time between inspections suggesting that problems could develop which would go unnoticed within this time interval.

Just over half of respondents who comment on proposals to rate population groups using only the effective and responsive key questions support these proposals. Many of them comment that this approach would be simpler, clearer, more accurate and patient-focused. Many respondents state that they neither agreed nor disagreed with the proposals, with many offering alternative suggestions. Those respondents who disagree with the proposals express concerns that it could lead to inaccurate and ineffective ratings and some feel that the classification of population groups needs reviewing.

Most respondents agree that the majority of inspections should be focussed rather than comprehensive, although respondents are divided. Those who express support for this proposal comment the targeted approach will allow for a in-depth review of services, yet some express concerns that it may lead to issues being overlooked and question how the areas of focus would be identified.

The majority of respondents agree with CQC's proposals for regulating independent sector primary care, NHS 111, GP out-of-hours and urgent care services, primary care delivered online and primary care at scale. Respondents feel that independent healthcare providers should be regulated as this will allow for more transparency for the public, however some feel it will lead to overregulation. Most respondents who comment on NHS 111, GP out-of-hours and urgent care services support the proposals for regulating them, as they believe this will improve the standard of care provided by these services. Those who comment on the proposals to regulate primary care being delivered online believe that this is an increasingly important service, which therefore requires regulation. Those who comment on the need to regulate primary care at a scale believe that a flexible approach is required, to allow for new models of primary care.

Adult social care services

Most respondents agree with CQC's proposed approach to monitoring quality in adult social care services. Respondents welcome the online provider information return (PIR), suggesting that it may reduce burden on providers and streamline inspections. Many also believe that real-time monitoring will give a much more accurate picture of the quality of services, and that increased stakeholder engagement from CQC may help to improve intelligence and CQC's responsiveness. Some providers feel that CQC Insight will help them to consistently compare performance with other providers. Several respondents, however, note ongoing

problems with access to, and quality of, data on adult social care services, and comment that increased reliance on this data will cause further issues. Others express concern that the proposal will place an additional administrative burden on adult social care services. Some doubts are raised about what a 'single view of quality' will mean in practice.

Most respondents agree with CQC's proposed approach to inspecting and rating adult social care services. Those that welcome the proposals supported the risk-based approach to inspections, and believe that CQC should focus resources on providers where inspections identify problems. There is strong support for the removal of the 'six-month limit' on seeking ratings changes, as well as for moves to produce more concise reports. However, some respondents express concern about reducing inspections even for providers performing well, due to potentially fast changes in service quality.

Most respondents agree with the proposed approach to gathering information about the quality of care delivered to people in their own homes. They note that current understanding of quality in this setting is poor, and there is wide concern about variation in quality, so additional insight provided by CQC's approach will be helpful. Respondents have mixed views about the 'announced' element of inspections, some acknowledge the need to allow planning time but others worry about the loss of the 'surprise' element to inspections. Many welcome the proposed 'toolkit' to support inspectors.

Most respondents agree with CQC's proposed approach for services which have been repeatedly rated as requires improvement, welcoming the plans for a more stringent, early intervention from CQC. Some support the increased overall focus on leadership and provider-level accountability by CQC, and how this relates to adult social care providers, while some believe that CQC's proposals may ensure that the requires improvement rating is applied in a more consistent manner. However, some respondents suggest that CQC's proposed approach does not go far enough, though some providers note the risks of early publication of inspection findings.

Fit and proper persons requirement

Across all types of respondents, most support CQC's proposal to share all information with providers and welcome the potential for improved transparency. The majority of respondents believe the proposal to share all information with providers is likely to incur further costs to providers but several say that the increase will either be minimal or justified by the positive outcomes. In contrast, several respondents state that the proposal will not incur further costs as well-managed providers should be able to mitigate this with cost efficiencies.

Most respondents explicitly mark their support for the proposed guidance for providers on interpreting what is meant by "serious mismanagement" and "serious misconduct". Several respondents explain this is due to the potential for increased clarity and accessibility in the guidance. In contrast, several respondents highlight the potential ambiguity and misinterpretation of the guidance.

Consultation events and wider context

Between June and July 2017 CQC held a series of ten consultation events with stakeholder organisations and members of the public. These included focus groups targeting seldom heard communities as well as bespoke events for general practice, dentistry and adult social care. Chapter 7 summarises the main themes raised at each event which broadly reflect the key themes set out above.

Many respondents provide general feedback about CQC and the wider health and care sector that does not relate to specific consultation questions. Chapter 8 summarises these comments which include criticism of the consultation process and documentation as well as comments about CQC's effectiveness, approach and fees. Many respondents comment on the financial pressures facing the sector suggesting that underfunding and a lack of resources is one of the main contributors to sub-standard performance and poor ratings.

2. Introduction

2.1 Background

In December 2016, CQC published a consultation entitled '*Our next phase of regulation'*. It proposed principles for how CQC will regulate new models of care and complex providers, changes to consolidate its assessment frameworks for health and social care, its approach to regulating NHS trusts, and how it registers services for people with a learning disability.

In June 2017, CQC published its second '*Our next phase of regulation'* consultation which describes how its regulatory approach continues to develop in line with the direction set out in its five-year strategy. It seeks respondents' views on specific proposals for how it will:

- Register, monitor, inspect and rate new models of care and large or complex providers.
- Use its unique knowledge and capability to encourage improvements in the quality of care in local areas.
- Regulate primary medical care services and adult social care services.
- Carry out its role in relation to the fit and proper persons requirement.

The consultation ran from 12 June to 8 August 2017 comprising 16 closed questions that asked respondents for their agreement or disagreement with specific aspects of the proposal and 17 open questions that invited respondents to provide more detailed comments.

CQC will use this summary report, alongside the full response data, to get a full and detailed picture of all the consultation responses. This will inform CQC's formal consultation response and influence the development of its regulatory approach.

2.2 This report

2.2.1 Consultation process

CQC provided a webform for respondents to submit their response to the consultation as well as a dedicated email address allowing for responses in different formats. CQC also conducted focus groups to listen to communities whose voices are seldom heard as well as events for providers focussing on specific aspects of the proposals. Summary notes from these activities were submitted for analysis along with the consultation responses and the findings are summarised in Chapter 7.

The collection of responses was managed by CQC. The analysis of responses, of which this report is the output, was conducted by OPM Group, an independent specialist company formed of OPM and Dialogue by Design. Responses were transferred in weekly batches

from CQC to OPM Group via a secure data link. OPM Group carried out data entry for responses submitted by email and imported all response data into its analysis database.

The analysis of responses consisted of two strands. For the responses to the closed questions, the analysis team conducted quantitative analysis resulting in numeric data sets. For the responses to the open questions, analysts carried out qualitative analysis through manually coding the content of responses, with the help of a comprehensive coding framework which was adapted during analysis (see Appendix 2). This resulted in a large searchable qualitative data set which was made available to CQC.

2.2.2 Report structure

The structure of this summary report follows the order of sections in the consultation document, *Our next phase of regulation: a more targeted, responsive and collaborative approach*. In each chapter of this report, the comments are broken down into sub-sections covering 'supportive comments', 'issues' and 'suggestions'. The chapters are:

- Chapter 3: Regulating in a complex changing landscape
- Chapter 4: Primary medical services
- Chapter 5: Adult social care services
- Chapter 6: Fit and proper persons requirement

Further chapters are included covering responses from the consultation events (Chapter 7) and general comments about CQC and the wider context of the health and care sector that were not specific to any of the consultation questions (Chapter 8).

The report has four appendices:

- Appendix 1: Consultation questionnaire
- Appendix 2: Coding framework used to analyse the responses
- Appendix 3: Breakdown of responses to closed questions by respondent category
- Appendix 4: List of organisations responding to the consultation

2.2.3 Guide to the narrative

The purpose of this report is to provide an overview of respondents' feedback on the consultation proposals, allowing the reader to obtain an idea of their views. The report does not aim to cover all the detail contained in the consultation responses and events and should be seen as a guide to their content rather than an alternative to reading them.

As with any consultation of this kind, it is important to remember that the findings are not representative of the views held by a wider population, chiefly because respondents and participants do not constitute a representative sample. Rather, the consultation was open to anyone who chose to participate.

Where a specific theme or point was raised by a relatively large number of respondents, the report uses the phrase 'many respondents'. Where themes are analysed and divided out into sub-themes, phrases such as 'some' or 'a few respondents' – 'a few' would signify much fewer respondents than 'some' – are used instead of smaller numbers. Because of the qualitative nature of the data and variations in respondents' use of the consultation questionnaire, any numbers relating to the open questions are indicative. The focus of the analysis is on issues raised by respondents, and opinions are often shared across respondent categories. However, where appropriate the report specifies where views were expressed by a specific category of respondents or sector.

It is common in consultations that respondents provide greater detail or variety in critical comments than they do in supportive comments. Readers should therefore note that the relative length of sections (i.e. supportive comments compared to issues and suggestions) is not necessarily a reflection of the balance of opinion.

The report includes quotations to illustrate issues raised by respondents. Most quotes are on behalf of an organisation unless otherwise stated. The quotations should not be interpreted as an indication that the view has greater significance than others. Nor should quotations be interpreted as representative of the views of other respondents of the same type.

It is important to note that, throughout the document, there is no specific 'weight' given to any respondents over others, for example, based on size. This report summarises comments based on individual responses and themes are generally prioritised by the frequency with which they were discussed across individual responses.

2.3 Respondent categories

By the end of the consultation period, 380 responses had been received. A total of 308 respondents used the webform to participate in the consultation and the additional responses, including the notes from the consultation events, were received by email.

Respondents using the webform were asked to indicate in what capacity they were responding to the consultation. For responses received by email, CQC categorised organisations based on the information provided. Where quotes have been used in this report we have indicated which category of respondent the quote has come from.

Table 2-1: Count of overall respondents by "responding as"

	Count
Provider / professional	176
Voluntary or community sector representative (including Healthwatch)	39
Member of the public / person who uses health or social care services	38
Provider trade body or membership organisation	35
Health or social care commissioner	25

CQC employee	15
Arm's length body or other regulator	13
Carer	8
Parliamentarian / councillor	2
Other	29

Table 2-2: Counts for main sector and sub-sector if specified by providers/professionals (*NB. respondents could tick more than one sector and more than one sub-sector*)

Sector and sub-sector	Count
Adult social care	**71**
Domiciliary care	19
Care home without nursing	17
Care home with nursing	12
Housing with care / Extracare housing	3
Supported living services	2
Other	12
Primary medical services or urgent care	**63**
General practice	57
Dentist	2
Walk in centre / minor injuries unit	1
NHS trust	**22**
Acute or single specialty	7
Community healthcare	4
Mental health service	2
Ambulance service	1
Other	5
Independent healthcare	7
Acute or single specialty hospital	3
Community healthcare	1
Mental health service	1
Other	1
Hospice services	**6**
Other	**2**

Table 2-3: Counts for CQC staff member respondents, by CQC directorate, if specified

	Count
Adult social care (including registration, safeguarding and market oversight)	12
Primary medical services and integrated care (including safeguarding)	2
Inspection support (specialist advisors and experts by experience)	1

As is common in public consultations, the number of responses per question[1] varied as most respondents did not respond to all questions. Table 2-4 on the following pages provides an overview of the number of responses received to each question.

[1] See Appendix 1: Consultation questions

Table 2-4: Count of respondents by question by “responding as"

	1a	1b	2	3a	3b	4a	4b	5a	5b	6a	6b	7a	7b	8a	8b	9a	9b
Arm’s length body or other regulator	3	2	3	6	3	5	2	5	3	5	3	4	3	4	3	4	3
Carer	7	7	7	7	7	7	6	7	7	6	6	6	4	6	4	6	5
CQC employee	10	9	10	11	11	11	11	11	9	4	4	4	3	4	4	5	4
Health or social care commissioner	15	14	13	16	13	16	12	17	15	12	5	12	4	11	3	12	5
Member of the public / person who uses health or social care services	20	20	21	27	23	27	21	27	23	22	19	23	16	21	15	21	13
Other	13	12	12	16	12	19	12	20	16	7	5	8	5	8	3	7	4
Parliamentarian / councillor	1	1	1	1	1	1	1	1	1	1	1	2	2	1	1	1	1
Provider / professional	94	85	83	98	76	100	77	99	76	84	68	79	58	78	43	82	49
Provider trade body or membership organisation	13	13	13	26	12	26	13	28	12	15	7	16	7	15	6	15	6
Voluntary or community sector representative (including Healthwatch)	26	20	23	28	22	27	18	28	19	23	19	22	17	23	16	23	15
Grand Total	**202**	**183**	**186**	**236**	**180**	**240**	**173**	**243**	**181**	**179**	**137**	**176**	**119**	**171**	**98**	**176**	**105**

	10ai	10aii	10aiii	10aiv	10b	11a	11b	12a	12b	13a	13b	14a	14b	15a	15b	16
Arm's length body or other regulator	5	5	5	5	1	5	1	5	1	4	1	5	1	5	2	1
Carer	6	6	6	6	5	7	6	7	6	7	6	7	5	7	6	6
CQC employee	4	4	4	4	2	12	11	11	11	12	10	12	11	10	3	3
Health or social care commissioner	11	11	10	10	4	12	10	12	6	12	8	12	9	18	8	9
Member of the public / person who uses health or social care services	21	20	20	20	10	25	13	23	14	24	15	24	15	29	19	20
Other	6	6	6	6	3	15	13	15	12	15	11	14	11	14	9	8
Parliamentarian / councillor	0	0	0	0	0	1	1	1	1	1	1	1	1	1	1	1
Provider / professional	72	72	72	72	40	87	56	89	57	85	56	87	55	136	67	67
Provider trade body or membership organisation	14	14	14	14	6	19	7	19	6	17	8	18	6	26	8	9
Voluntary or community sector representative (including Healthwatch)	20	19	20	19	15	26	21	26	19	27	21	26	17	23	15	13
Grand Total	**159**	**157**	**157**	**156**	**86**	**209**	**139**	**208**	**133**	**204**	**137**	**206**	**131**	**269**	**138**	**137**

3. Regulating in a complex changing landscape

3.1 Responses to question 1a

There were 202[2] responses to question 1a submitted via the webform, which asks: ***'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?'***

Some of the 202 respondents made comments that were more relevant to other questions within the consultation so these comments have been summarised elsewhere in the report. The analysis below summarises comments from 243 respondents in total which includes responses to question 1a via the online consultation as well as responses received by email.

3.1.1 Supportive comments

The majority of respondents, including members of the public as well as providers and community sector representatives, express support for CQC's proposal to register all organisations with accountability for care. Some respondents do not provide any further detail beyond stating their agreement with the principle but most do expand on their reasons for supporting the proposal which are summarised below.

Accountability and transparency

Many respondents highlight the clear lines of accountability that can be drawn by registering all levels of an organisation with responsibility for care. They believe that organisations that currently sit above CQC-registered providers do have an impact on the quality of care delivered and express concern they are not held to account under the current regulatory system. Some worry the current approach can allow underlying issues with parent organisations to be missed.

> *"The ability to hold an organisation to account, particularly if they are a large provider is a positive step. It moves the level of responsibility beyond the registered manager, who may have a limited influence.*
>
> *User 100039 (Other)*

Several respondents believe the proposal to register all accountable organisations will provide a greater level of transparency amongst the entities that are responsible for care. Respondents feel this goes hand in hand with accountability believing that by being

[2] See breakdown: Table 2-4: Count of respondents by question by "responding as"

transparent it will be easier to pinpoint accountability. They suggest it is important for both people accessing services as well as those commissioning the services to be able to clearly see the organisations that are in charge of care. A couple of respondents also suggest that improved transparency will allow greater scrutiny from other sources, such as the media, to highlight failings in care.

"Omitting these entities was a significant oversight allowing those with poor governance to escape regulatory scrutiny."

User 100002 (Provider trade body or membership organisation)

A few respondents feel the proposals would increase transparency by making group structures visible and keeping ratings when providers move locations between an existing corporate body.

Monitoring and enforcement

Some respondents feel the proposals will help to ensure there is consistency in monitoring and enforcement of performance across a group. This view is commonly shared by health and social care commissioners who suggest spotting positive and negative patterns will become easier, allowing CQC to pinpoint whether issues have been caused by local factors or are part of wider systemic issues. A couple of respondents say that having this information on the register will allow CQC to target enforcement actions more effectively on those who are accountable.

Some respondents believe that the quality of care is impacted by decisions made at a higher level and that including this level in the register will encourage companies to change their policies. They say this will allow improvements to flow down the organisation structure and ultimately result in a better level of care being delivered. This may also encourage a quicker response when problems are identified.

"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."

User 678 (Voluntary or community sector representative)

A few respondents specifically support the clarity about ownership changes. They feel the information about a history of a service is important for commissioners and service users in understanding the track record of service providers.

3.1.2 Issues

Although many respondents express support for the proposals there are some that oppose the proposals, express concerns or give caveats for their support. The main themes expressed by these respondents are summarised below.

Need case

Some respondents are unsure how much benefit will be derived from including more organisations on the register and do not feel that CQC has adequately explained how this will benefit people who use services.

"We are not as convinced that this change will significantly improve things for people who use services"

User 735 (Provider / professional, adult social care)

A few respondents suggest the current regulatory framework is adequate to provide a suitable level of accountability. This view is most commonly held by providers of care who feel current powers are sufficient and the current arrangements allow CQC to understand the relationships and structures of businesses already. A couple of GP practices suggest providers of care and front line services are where accountability should rest and question the need to register larger organisations.

Burden and bureaucracy

Several respondents express concern about the burden this may place on organisations, describing the plans as "overly bureaucratic" and the creation of more "red tape". This is a common concern raised by GP practices and care home providers in particular. A specific concern cited by a couple of respondents is the potential cost to organisations that form a new organisation or partnership to tender for a contract. If they are required to register with CQC before the tendering process begins then fail to win the contract they will lose the money they spent to register an organisation that will no longer exist.

A few respondents mention the resources that will be required for CQC to deliver the proposals and question CQC's capability to monitor and inspect all those accountable for care as well as delivering its core function of inspecting services.

"However, in expanding their remit, CQC should not spread their resource too thinly, as it is still vital that those delivering the services continue to have the predominant impact on people's experiences."

User 777 (Voluntary or community sector representative)

A few respondents worry about the potential for increased fees and suggest that fees should be considered carefully to ensure that resources are not taken away from the actual delivery of care. One respondent asks whether the additional organisations requiring registration will contribute to the running costs of CQC as other NHS provider organisations do.

Complexity of accountability

Some respondents express concern about the status of companies registered overseas suggesting this is a gap that could be exploited and create inconsistency in the way organisations are treated. Some respondents request more information about how CQC plans to work with other organisations to tackle this.

Several respondents feel the complexity of different organisations involved in the delivery of care will cause problems for the implementation of the proposals. Some argue that registering an organisation at multiple levels will make it more difficult to define which level should be held accountable for failures. There is also concern that the examples provided in the consultation documents are overly simplistic and do not accurately reflect the complexity of providers of care in reality.

"The sheer diversity and complexity of ownership models do not fit into the structure proposed. The structure presented might work for a text book type 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."

User 100012 (Provider trade body or membership organisation)

A couple of respondents suggest the criteria used to decide who is accountable for care will need to be very carefully considered. This is discussed in more detail in Section 3.1.3 however some respondents argue there are different sub-committees within group structures that hold varying degrees of responsibility and the criteria may not allow the correct group to be held accountable. There is particular concern about how this would work with joint ventures and new models of care adopted across organisations.

There is some concern that investors will be deterred from investing in health or care services or taking proactive steps to improve the quality of care if they are required to register with CQC. Some respondents feel this could discourage innovative partnerships across sectors that could drive positive developments in care. They worry that stifling innovation may be an unintended consequence of the more stringent rules on accountability.

A few respondents highlight specific concerns about the potential reputational risks this might have for organisations that specialise in the turnaround of services that require improvement. They suggest that maintaining a service's rating history from a previous provider could deter such providers from taking on poor quality services to improve them.

"As an organisation we broadly support the plans but given the nature of our business (we turnaround poor performing homes and have an excellent track record), we are worried that painting a picture of us as a provider will at time paint a poor picture as we very often inherit homes that rated Inadequate or Requires Improvement. What are CQC proposing to do to acknowledge this in their reporting to the public?"

User 648 (Provider / professional, adult social care)

A small number of respondents argue that the proposals will bring less clarity about who is actually accountable for the quality of care due to an increased number of registered entities being linked to an individual service.

A couple of respondents feel the proposals could dilute the individual responsibility for care and the role this has on the outcomes for service users.

3.1.3 Suggestions

Some respondents make specific suggestions about how CQC could include all those accountable for care or what other steps CQC could take to improve the way organisations and providers are held to account. A few respondents discuss CQC registration practices broadly and suggest fast tracking registration for new branches of existing providers that have been rated good or outstanding. One respondent also highlights the importance of inspection ratings to aid decision making in tendering processes.

"We suggest this would be useful to explore in the health and care sector, where CQC could work with commissioners to ensure that latest inspection ratings become a requirement in the tendering documentation."

User 100059 (Voluntary or community sector representative)

One respondent provides a detailed proposal for an entirely new regulatory framework that separates the registration of legal entities that provide care and legal entities that provide management services.

Other suggestions include:

- Ensuring the same inspectors examine groups with a common owner.
- Having a nominated individual at CQC for groups to contact regarding organisational issues.
- Ensuring better management by encouraging providers to adopt ISO 9001.
- Posting links between organisations on notice boards in GP practices or elsewhere for people who do not use the internet.

- Including regulation of day services.
- Working with community sector representative groups to track individual's cases to see how interactions between services are impacting care provision.
- Looking at the way shared decision making with family members who continue to hold a legal responsibility for care is undertaken.

A small number of respondents request more information on topics not already mentioned, including how the development of CQC Insight model is to be funded, how CQC proposes to work with other regulators such as the Homes and Communities Agency and the General Pharmaceutical Council, and if senior support workers in supportive living teams will need to register. A couple of respondents feel there should be further discussions on how this approach would work and would be happy to engage further with CQC on this.

3.2 Responses to question 1b

There were 183[3] responses submitted via the webform to question 1b, which asks*: '**What are your views on our proposed criteria for identifying organisation that have accountability for care?'***

Some of the 183 respondents made comments that were more relevant to other questions within the consultation so these comments have been summarised elsewhere in the report. The analysis below summarises comments from 208 respondents in total which includes responses to question 1b via the online consultation as well as responses received by email.

3.2.1 Supportive comments

In responding to this question respondents often comment in a similar manner to question 1a and raise similar points. Most respondents express broad support for all the proposed criteria saying they seem "appropriate" and "reasonable". Many respondents go into more detail about what benefits they consider this will bring which are summarised below.

Accountability and transparency

Similarly to question 1a, many respondents feel the proposed criteria will allow a clear line of accountability to be seen from the quality of care provided by a service to the organisation that has overall responsibility for the service. Adult social care providers often express support for the criteria based on the benefits of holding the correct organisations to account.

[3] See breakdown: Table 2-4: Count of respondents by question by "responding as"

"Again, we feel this has the potential to improve transparency and accountability"

User 796 (Provider / professional, adult social care)

Respondents commonly mention the importance of transparency and the ability to see clearly the organisations that are involved in providing care, both for service users to see who is responsible for their care as well as commissioners. A few respondents specifically support displaying the history of a service so that there is a greater sense of transparency about providers and making it easier to hold them to account.

Organisational scrutiny

A few respondents express support for criteria that include organisations responsible for developing and enforcing common policies on issues such as staffing levels, pay levels and procurement. A couple of respondents suggest that increased accountability will speed up the process of change within organisations ensuring the standard of care is improved swiftly.

"Holding organisations to account will allow for quicker organisational change, and thus improvements for more people will be felt more quickly."

User 782 (Health or social care commissioner)

3.2.2 Issues

A few respondents, mostly GP practices and individual responses, disagree with the proposed criteria. Some feel the proposed criteria are ambiguous and poorly thought through while others have a perception that CQC is trying to control organisational structures above those delivering care. The key areas of concern are summarised below along with comments from respondents who are broadly supportive of the criteria but raise some specific concerns about some of them.

Need case

A few respondents feel the proposed criteria are not required with two main reasons given to support this view. Some of these respondents suggest that accountable organisations are already easy to identify and as a result do not need to be registered with CQC. Other respondents feel there is no need for CQC to get involved in this area of regulation at all. They suggest CQC should remain as a regulator that judges when services do not meet a required standard rather than trying to get involved in decisions about large and complex structures.

Defining accountability

There are some concerns among respondents about the criteria being able to accurately include all those organisations that are accountable for care with some respondents querying how phrases such as 'significant influence' will be interpreted. Some suggest that the definitions outlined will include a lot of organisations that should not need to register as they do not have a role in providing care.

"For example, ordinary shareholders in public companies do typically have the right, albeit rarely exercised, to appoint and dismiss senior personnel, and to veto financial plans. Hence pension companies and even individual investors potentially fall within the criteria even though that is not CQC's intention."

User 100036 (Provider trade body or membership organisation)

Respondents often comment on the illustrations of hypothetical group structures provided in the consultation document and suggest that these are very simple in comparison into how actual groups are structured and organised. There are a few comments about providers that run franchise models where the units provide the care and control this aspect, but certain services such as finance or health and safety policies are run centrally. Some question how such models will fit within the proposed criteria and request further clarification from CQC about how this issue will be approached and how much time such providers will be allowed to put new procedures in place.

Some respondents express doubt that CQC will be able to accurately inspect those organisations, either because the structures are too complex or because CQC will be unable to adjust its inspection methods to suit the different organisations it needs to observe.

"Members were concerned that inspectors will not understand the difference between inspecting 'owners' and inspecting 'providers'. Members also felt that there needs to be a lead auditor system for inspecting providers owned and managed by parent companies."

User 100060 (Provider trade body or membership organisation)

A few respondents suggest that including so many large groups within the criteria will result in a reduced level of individual accountability for care. There is some concern whether CQC will hold individual managers or providers to account if they fail to apply company policies correctly or attribute blame to the parent company even if the policies are adequate.

Organisations not accountable

Some respondents are concerned about the limiting factors in the criteria and the status of organisations based outside England in particular. A few respondents fear this will create inconsistency and feel there should be some changes in legislation to allow CQC to hold more groups accountable for care.

A few respondents feel the exclusion of investors from the criteria is not justified as they believe any organisation that has a financial interest will have an influence over the level of care provided. They argue that, as investors seek profit and there is a relationship between the pursuit of profit and quality of care, investors should be included on the register.

"However, we contest the assertion that organisations such as 'Hedge Funds and other types of investors' do not as a matter of course exert influence over operational matters. We believe that as investors they may well seek to influence key decisions around expenditure, and on that basis want to see them included on the register."

User 100011 (Provider trade body or membership organisation)

A couple of respondents feel that none of the criteria reflect the role of commissioners in the quality of care. They argue that a provider may wish to provide a responsive, person-centred service but the commissioner may offer a contract and funding that does not support those expectations and that the failure to provide a high-quality service in that case cannot be seen as the sole responsibility of the care provider.

Complexity and burden

A few respondents suggest CQC will struggle to deal with the complexity of organisations and the work required to implement the proposed criteria. Some suggest that detailed interviews and consultation will be required to determine if an organisation meets the criteria which they fear will be a considerable burden. A couple of respondents argue the criteria proposed may deter investors from taking an interest in care where it "tips over into being accountable and registrable" and the corresponding legal responsibilities that would come with it.

"The new approach needs to be sufficiently sophisticated to identify appropriate level of regulation for different aspects of the healthcare activity being provided and thus to avoid duplicatory regulation which adds to the costs not only of providers but also of CQC at a time when funding has never been tighter. The consultation recognises this in principle but seems to us to underestimate the complexity and level of expertise needed to exercise such judgements in practice."

User 746 (Provider trade body or membership organisation)

3.2.3 Suggestions

Several respondents suggest specific criteria that could be used to define whether an organisation or entity should appear on the register. These mostly come from organisations although there are also some suggestions from members of the public.

The most common suggestion is for any entity that has a financial influence or takes finances out of the business to be included on the register, including overseas owners.

"However, we think that financial control could be considered as a potential criterion in defining accountability."

User 100048 (Arm's length body or other regulator)

A few respondents suggest CQC should focus on accountability at a divisional level rather than across a whole group. They feel that one organisation may work in a variety of care sectors, such as health care as well as adult social care, and registering at group level would not reflect the different conditions and factors affecting care in these sectors.

Other suggestions made by respondents are:

- To use definitions used by NHS Digital's Organisation Data Service.
- Linking to the Companies House website where corporate organisations are already listed.
- Ensuring directors are fit and proper to deal with issues that affect patients.
- Applying a higher level of individual accountability.
- Defining an accountable organisation as one that takes responsibility for the standards of care and quality within an organisation they exert significant influence over.
- Asking the registered provider who the parent undertaking is and recording that.
- Excluding all investors from having to register and leave the Financial Conduct Authority to oversee the financial issues.
- Working with regulators in Scotland, Wales and Northern Ireland to ensure they follow similar approaches.
- Ensuring information highlighting changes in ownership is kept up to date.

Queries

A few respondents request more information on certain elements of the proposals as follows:

- Does a group need to meet just one of the proposed criteria to be included or all of them?
- When will these entities be inspected?
- How will ratings be used if an organisation is rated as requires improvement overall but some services it provides are rated outstanding?
- How will the information held about services on CQC's database be kept up to date?

3.3 Responses to question 2

There were 186[4] online consultation responses to question 2 via the webform, which asks*:* ***'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?'***

Some of the 186 respondents made comments that were more relevant to other questions within the consultation so these comments have been summarised elsewhere in the report. The analysis below summarises comments from 226 respondents in total which includes responses to question 2 via the online consultation as well as responses received by email.

3.3.1 Supportive comments

Although the question asks for suggestions, many respondents express broad support for the proposal to provide more detailed and clear information on the register and make it easier for people to be informed about services. However, they do not provide further explanation for their support.

3.3.2 Issues

There are many suggestions on what the register should include although some respondents do raise some questions and concerns about the proposals. A few respondents, particularly GP practices, express opposition to displaying more information on the register because they feel this is unnecessary or at odds with person-centred care.

Several respondents fear the increased burden this could place on providers who they presume will be required to provide this information to CQC. They also highlight the potential burden for CQC in keeping this information up to date and suggest that a streamlined approach should be adopted to ease the potential burdens. A few respondents express doubt in CQC's suggestion that "the overall cost of regulation will not increase as a result of this work".

A small number of respondents worry about the perceived impact this will have on fees they pay CQC.

"We would wish to register a concern over any likelihood of the changes having an impact on fees payable to CQC. Of all the providers registered with CQC, [adult social care] already provides the greatest percentage of the costs borne by CQC in their inspection duties. We would not be supportive of any unintended increase in our fees."

[4] See breakdown: Table 2-4: Count of respondents by question by "responding as"

User 100054 (Provider trade body or membership organisation)

Some respondents have concerns about CQC's proposal to use wider criteria to set limits within which a provider may operate, particularly geographical limits. A few providers argue this proposal may inhibit the ability "to grow and widen" the services they provide and suggest CQC adopts a flexible approach in managing this. A few respondents fear this could harm particular types of care such as specialist live-in carer agencies which may serve a wider geographical area than a more typical home care service. Some respondents feel more clarity would be helpful about CQC's approach.

A few respondents worry that including more information on the CQC register will duplicate information that is held elsewhere such as the NHS Choices website. They suggest this could be confusing for users and providers as well as being a waste of resources.

"Consideration should be given as to how this will fit with the NHS choices website – some of the measures/indicators on this site may be usefully added to the register, however it is likely to be confusing for users and providers if both sites are fulfilling similar purposes."

User 787 (Other)

A small number of respondents express concern about how the services provided will be identified due to the differences between various types of care. They feel that a 'one size fits all' approach could provide confusing or inaccurate responses if the complexity of certain types of care is not suitably noted.

A couple of respondents raise concerns about data protection and privacy, particularly how the information provided on services supporting people in their own homes may be displayed in order to ensure there is no stigmatisation.

3.3.3 Suggestions

Information about who provides the care

A common suggestion from respondents is to detail the name of the provider or the ownership details of the company on the register. A few respondents also feel it would be useful to include any other companies that are subsidiary to the overall owner so that links between groups are clearly displayed. A few respondents suggest that ownership changes and the previous history of a provider's ownership should be included.

"We would want CQC to be able to show in a way that is clear to the public the history of a service where they come under new ownership"

User 766 (Health or social care commissioner)

Some respondents believe the details of any partnerships a provider has entered into should also be displayed. A few respondents, including some providers, feel the details of contracts, who is commissioning services and where the funding is coming from should also be included.

Other suggestions relating to who provides the service are:

- Details of the management and governance structure.
- Names and photographs of directors and managers.
- Shareholders.
- The landlord of where the service is delivered from (if applicable).
- Contact details for key personnel.
- CQC registration numbers or other unique site identifier numbers consistent with other NHS data systems.
- Financial details such as accounts or resources available.
- Any potential conflict of interests.

There are several suggestions that CQC inspection ratings should be included in some format. Some respondents, including many voluntary sector organisations, feel the most recent inspection should be listed, where others feel there should be an average of previous ratings awarded or a full history of all inspections. There is some recognition this could be more challenging for overarching providers but an average of the ratings of organisations under their control could be displayed.

"A summary of overall ratings for groups would be particularly helpful, for example entities such as: X Homes Ltd had X% of their services rated outstanding, X% rated good, X% rated requires improvement and X% rated inadequate."

User 771 (Health or social care commissioner)

A few respondents suggest that other feedback from authorities such as any accreditations an organisation has received or if there have been any sanctions imposed by CQC or other regulatory bodies imposed.

A few respondents feel that feedback from people who have used the service would be beneficial for others considering using the service as well as:

- The number of complaints made against a provider.
- The number of accidents and the number of deaths.
- When they started providing care, previous services they have run and the experience they have accrued.
- Their action plan and/or statement of purpose.
- The clinical outcomes of a service.

Information about the service

The most common suggestion is to display details of the service provided. Several respondents feel there should be specific opportunities to display special considerations a provider can offer to users.

"Also making a point of what the provider is prepared to offer in Special Consideration would be useful if a relative had a particular need. This is not always obvious when searching for help."

User 567 (Member of the public / person who uses health or social care)

Some respondents ask for more information to be provided on the workforce with suggestions including the number of employees, the ratio of staff to clients, turnover rates and diversity information.

Many respondents ask for information to be provided on the level of training and specific skills staff have for dealing with certain types of service users, for example if they have specialist skills in supporting people with dementia.

Other suggestions include:

- any costs or fees that may be charged
- what regulated services they offer
- professional indemnity cover
- complaints procedure
- any sub contracts for services
- their risk assessment
- waiting times
- any alternative providers of the same type of care

Where and to whom the service is delivered

Many respondents feel some information about the service users is important and suggest that the register includes who the service is for with broad age categories or the types of clients.

"It would be useful if the information on the register indicates the main or predominant service user group that it provides for."

User 100038 (Health or social care commissioner)

Many respondents agree it is important to include the location. A few suggest the head office of large organisations should be on the register although most respondents emphasise the need to highlight the location of where care is actually delivered.

Several respondents, particularly with reference to adult social care services, feel the setting in which care is delivered is important so people know if it is provided in a home or in a care centre. Some respondents suggest some information about the size of the facilities available or the number of facilities a provider has available should be included.

Other suggestions

While many suggestions are made about what to include a few respondents express concern that there should not be too much information included to the extent that it over complicates information for the end user. A few respondents specifically say that funding information should not be provided as it is unnecessary and should be held privately.

A few respondents suggest CQC should review how it will display this information and how the register could be viewed to ensure the public can easily search for services relevant to them without being confused by superfluous information.

"All description headers should be capable of search, so if an individual wishes to look at all providers who work in particular age range or with a particular spectrum, for example, it should be possible."

User 767 (Provider trade body or membership organisation)

A small number of respondents make comments about the proposed timetable of changes with concerns that it does not allow long enough to plan and assess the impact of the changes.

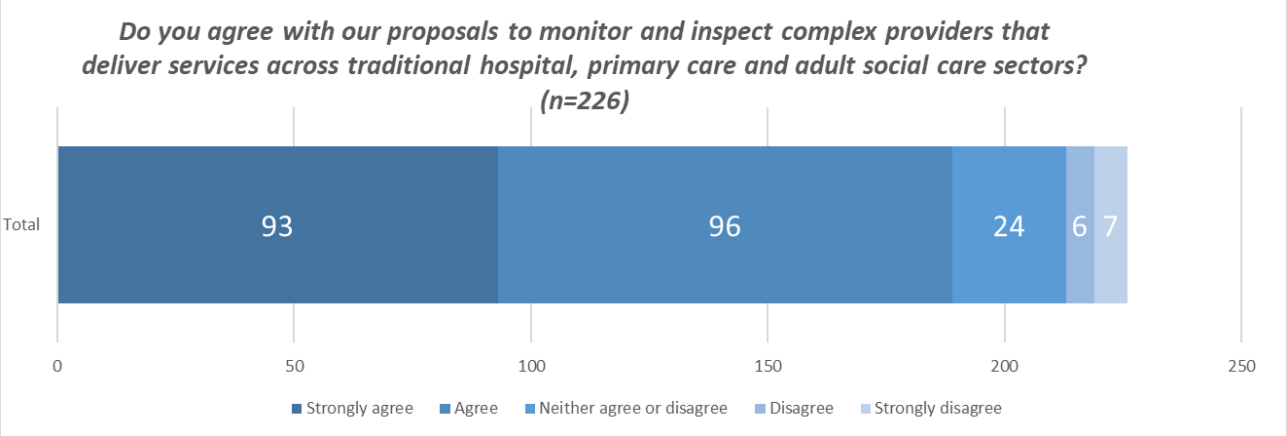
A few respondents request more detail from CQC on:

- What a wider set of criteria to describe a service means.
- What is meant by the phrase, "how much care is provided".
- Further clarification on the "what" section to reflect complexity of types of care.
- What is the purpose of providing this information to the public?

3.4 Responses to question 3a

A total of 236[5] respondents answered the closed question 3a, which asks: ***'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?'*** To answer this closed question, respondents could choose from five options between strongly agree and strongly disagree.

Chart 1 - Responses to question 3a



10 respondents provided irregular responses which did not fit into the above categories. This means that they made some form of response to this question that did not follow the closed categories (i.e. 'strongly agree' to 'strongly disagree'). These responses have been excluded from the chart above and the percentages which follow.

84% of the 226 respondents who answered the closed question 3a agree (42%) or strongly agree (41%) with CQC's proposals to monitor and inspect complex providers. 6% of respondents answering question 3a indicate that they disagree (3%) or strongly disagree (3%) with the proposed approach.

3.5 Responses to question 3b

There were 180[6] responses to question 3b submitted via the webform which states, with reference to question 3a*: '**Please give reasons for your response.'***

Some of the 180 respondents made comments that were more relevant to other questions within the consultation so these comments have been summarised elsewhere in the report. The analysis below summarises comments from 211 respondents in total which includes responses to question 3b via the online consultation as well as responses received by email.

[5] See breakdown: Table A3 - 1: Responses to Q3a by overall respondent category

[6] See breakdown: Table 2-4: Count of respondents by question by "responding as"

3.5.1 Supportive comments

Accountability and transparency

The most common reason that respondents give for supporting the proposals to monitor and inspect complex providers is the importance of holding all the appropriate levels of an organisation to account, particularly for independent sector providers. One respondent notes that registered managers are often the ones held to account when the difficulties that lead to poor standards may be caused by factors above their level of control such as financial budgets.

"The decision makers should not be able to hide behind complex structured organisations if they influence the quality of care"

User 620 (Provider/professional, dentist)

Some respondents also support 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.

Consistency and coordination

Many respondents feel the proposals will bring a more consistent approach to the assessment of providers although one respondent suggests this will require a change in CQC's working culture given the current organisational model of sector-specific directorates.

"Larger providers who have expressed concerns over a lack of consistency in their experience of registration and inspection will welcome an approach which introduces more consistency and economies of scale"

User 787 (Other)

Many respondents also say 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.

Responding to a changing market

Many respondents feel the landscape of health and care provision is changing and agree that CQC needs to adapt its approach to ensure these changes are implemented appropriately.

One respondent notes that CQC's proposals support NHS England's Five Year Forward View and the journey towards integrated services. Another believes that CQC's proposed approach can provide cohesion and reinforce a shared purpose as systems begin to work

together more closely. A few respondents suggest that CQC must ensure that providers expanding into new sectors are aware of the standards of quality and safety required.

Single relationship holder

Many respondents support CQC's proposals to identify a single relationship-holder for complex providers. They say this will reduce duplication, ease the burden of preparing for inspections and make it easier for providers to raise concerns and ask questions.

> *"A focus on continuity of relationships will foster an increased sense of trust, respect and understanding. It will enable the inspectors to deep dive where required as they become more familiar with the leadership and culture of the organisation(s)"*
>
> *User 691 (Voluntary or community sector representative)*

One respondent suggests that relationship-holders will need to take a different approach between organisations that are integrating vertically as a single provider or forming a system made up of several providers. Another says that the relationship-holder should also involve the local CCG and Local Authority where applicable.

Monitoring and inspection

Some respondents believe monitoring throughout the year will enable a more intelligence-driven approach to regulation and encourage improvement. However, one respondent warns that the success of this approach will be highly dependent on the type, quality and currency of the intelligence that is gathered.

Several respondents say that a more coordinated approach to inspections will allow both CQC and providers to build a better picture of patient experience across multiple services and assess the effectiveness of transitions between those services.

> *"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"*
>
> *User 784 (Arm's length body or other regulator)*

Testing

Several respondents say they agree with CQC's proposals to test the new approach to regulating complex providers, recognising the complexity of new models of care that are still evolving.

Support with caveats

A few respondents support the proposal but express concerns which caveat their support. Some comment that they agree with the principles of the proposal, yet express concerns that it will be difficult to implement and therefore a few comment that it needs to be tested in practice.

3.5.2 Issues

System-wide regulation

A few respondents express concern that CQC's approach to regulating emerging systems of health and care provision could duplicate existing assessment programmes such as the new STP ratings:

"The recently published STP ratings already include an assessment of system-wide leadership. In light of this, we would urge CQC to work with NHS Improvement and NHS England to ensure that its approach is aligned with the STP ratings and ensure that providers and their STP partners will not be subject to 'double jeopardy' and multiple judgments"

User 100026 (Provider trade body or membership organisation)

One respondent notes that each provider organisation must continue to be registered and regulated as a separate legal entity and it will prove challenging to reflect the proportion of accountability that each individual provider may have for delivering integrated care within an accountable care system.

Definition of complex providers

Several respondents raise concerns about CQC's definition of a complex provider suggesting that providers of regulated services already have relationships with each other. Some respondents suggest the definition should be expanded to include all three types of multi-speciality community providers and not just those that are fully integrated. Concern is also expressed that the definition omits community child health services which are delivered in child development centres, schools, homes and other outpatient clinics.

Some independent sector providers say CQC should not assume that independent providers are always organised in the same way as NHS services and these differences must be understood and accepted in the regulatory framework.

Complexity

Several respondents say that monitoring and inspection should be simple, clear and equitable and suggest that CQC should avoid making their regulatory systems more complex despite the growing complexity of the provider market.

"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"

User 100047 (Provider trade body or membership organisation)

Monitoring and data

A few respondents are concerned by CQC's increasing reliance on data over inspection as the quality of data available about services is poor in their experience.

"CQC must strike a balance between relying on data and other methods of gathering intelligence, especially where data is known to be inexistent or unreliable. We would also like CQC to ensure that no data, or unreliable data is as much of a flag for concern as data which suggests there are problems."

User 776 (Voluntary or community sector representative)

One respondent suggests that CQC should focus on analysing the data it already holds from previous inspections rather than inventing a new process which they believe will be costly for both CQC and providers.

Inspections

One respondent argues that the benefits of a coordinated inspection programme must be balanced against the risk of leaving a complex provider without any inspections for a long time and that focused inspections should still take place between co-ordinated inspections. Other respondents express concern that a focus on generalist inspections may not provide the information the public would find most valuable when selecting a service.

"I believe the unit of inspection should remain small, easily identifiable to members of the public - a member of the public wants to know what to expect from the bit of the service they will actually use, not the whole entity. if they have a specialist need this may get lost within a larger inspection of a bigger provider entity."

User 522 (CQC employee)

Single relationship-holder

A few respondents question whether relationship-holders will have the appropriate skills and experience to understand the complexity of all the services delivered by a complex provider. Some give examples of problems they have experienced with their existing relationship-holder including significant disruption due to illness or a lack of continuity due to frequent personnel changes. One respondent is also concerned that unannounced inspections will be used less frequently if relationship-holders commit to a planned programme of inspections.

3.5.3 Suggestions

Some respondents make suggestions for improvements or amendments to the proposals which include:

- More focus on medicines management during transitions between services.
- Closer monitoring of changes in key personnel and workforce turnover.
- Focused inspections for patients with a learning disability with specialised KLOEs.
- Better regulation of management services firms operating in the care home sector.
- More unannounced inspections and the use of security cameras to monitor quality and safety in care homes.
- Work with NHS England and NHS Improvement to follow a similar approach for the regulation of the Northumberland Accountable Care Organisation.
- Collaborate with Local Authorities, Clinical Commissioning Groups (particularly the senior executive nurse), Healthwatch and experts by experience.
- More focus on underperforming services.

Queries

The following queries were raised by respondents:

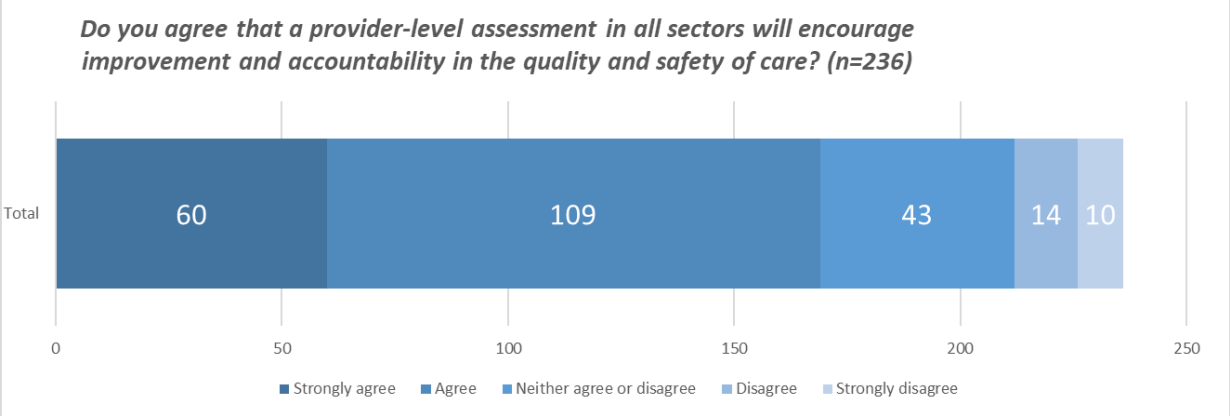
- How will a service's inspection history be presented?
- Will the ratings of organisations involved in testing be comparable with future inspections or will they be discounted?
- How will the annual internal planning meeting be made transparent and how will CQC publish evidence to support their decision?

- How will the assessment of an organisation's leadership be carried out as part of a planned inspection programme i.e. would it be the first step or part way through?
- Will this cover the increasing number of providers who are providing services that support child to adult transitions which are partly regulated by Ofsted?
- Will there be a provision for partial suspension of provision if one element of the care system is not performing to prevent a bottle neck in provision across the rest of the system?

3.6 Responses to question 4a

A total of 240[7] respondents answered the closed question 4a, which asks: ***'Do you agree that a provider-level assessment in all sectors will encourage improvement and accountability in the quality and safety of care?'*** To answer this closed question, respondents could choose from five options between strongly agree and strongly disagree.

Chart 2 - Responses to question 4a



Four respondents provided irregular responses which did not fit into the above categories. This means that they made some form of response to this question that did not follow the closed categories (i.e. 'strongly agree' to 'strongly disagree'). These responses have been excluded from the chart above and the percentages which follow.

72% of the 236 respondents who answered the closed question 4a agree (46%) or strongly agree (25%) that a provider-level assessment in all sectors will encourage improvement and accountability in the quality of safety and care. 10% of respondents answering question 4a indicate that they disagree (6%) or strongly disagree (4%) with the proposed approach.

[7] See breakdown: Table A3 - 2: Responses to Q4a by overall respondent category

3.7 Responses to question 4b

There were 173[8] to question 4b submitted via the webform which states, with reference to question 4a*: '**What factors should we consider when developing and testing an assessment at this level?**'*

Some of the 173 respondents made comments that were more relevant to other questions within the consultation so these comments have been summarised elsewhere in the report. The analysis below summarises comments from 208 respondents in total which includes responses to question 4b via the online consultation as well as responses received by email.

3.7.1 Supportive comments

Many respondents express support for extending provider-level assessment across all sectors of health and care provision. They reiterate many of the reasons described in Section 3.5.1 above, calling for a consistent and proportionate approach to assessment across different sectors and stating that increased accountability and transparency will encourage systemic issues to be addressed and the quality of care to be improved.

Comments on proposed options

Some respondents make specific comments about the four options for provider-level assessment set out in the consultation document.

A few respondents state a preference for Option 1 (a new bespoke assessment framework) suggesting this would be more meaningful than an aggregation approach, allow a comprehensive definition of "what good looks like" and make it easier for the public to gain an overall impression of a provider.

Option 2 (a single well-led assessment framework based on the existing healthcare framework) receives the most supportive comments. The respondents who favour this option say it is clear, simple and practical although a few respondents do express concern about the well-led domain having primacy over the other four key questions. They fear that the other options proposed by CQC may force providers to create increasingly centralised systems which would divert focus from developing locally sensitive services that have the freedom to respond to individual needs.

"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"

[8] Table 2-4: Count of respondents by question by "responding as"

User 799 (Provider trade body or membership organisation)

A few respondents express support for a version of Option 3 (assessing up to five key questions at provider level) including a specific suggestion for bespoke assessment frameworks to be developed for each of the five key questions to ensure they are applicable to a provider-level assessment. There is also a suggestion this option should include the percentage of services rated at each level (outstanding, good etc.) which would avoid the problem of aggregated ratings.

Several respondents express support for Option 4 (adopting the current approach in NHS trusts for other types of provider) as this is a "tried and tested" approach that would bring consistency across sectors and prevent the need to develop a new framework that providers would need to incorporate into their internal systems.

"We believe aggregated ratings of locations across the remaining KLOES would accurately reflect how well a provider is performing. Attempts to inspect at provider level in line with the five KLOES would, we believe, demand a substantial redesign of the KLOE framework"

User 757 (Provider / professional, Adult social care)

They believe that Option 4 will give a "more nuanced and accurate representation" of a provider's performance and note that the current framework for NHS trusts is not well thought of and a poor fit with social care providers.

3.7.2 Issues

Aggregation

Many respondents express 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. A tiered approach to ratings across local, regional and national scales is suggested to address this issue.

"Whilst the full matrix is, of course, available within the inspection reports for all stakeholders to see, inevitably it is the overall rating that determines the response the hospital receives, both in terms of regulatory action, dealings with commissioners (and insurers in the case of independent hospitals), and dealings with staff (including recruitment and retention), patients, and the public.

User 705 (Provider / professional, Legal services)

A few respondents say it will be difficult to find a form of aggregation that is fair and helps people make choices locally. There is concern that the proposed use of professional

judgement to deviate from aggregated ratings could undermine the public's confidence in the ratings as it may not be clear how judgements have been made.

Some respondents question how provider-level ratings will be dealt with in a merger situation where the rating of the acquired services would impact on the provider's overall rating. They also warn that the aggregation of ratings may encourage providers to dispose of poor performing services to ensure their provider-level rating is maintained and discourage providers who specialise in the turnaround of services requiring improvement.

Burden, duplication and value added

Some respondents express concern about the administrative burden and increased cost that a provider-level assessment would cause. They feel that the process will be extremely complicated and potentially heavily contested and some call for a more proportional and supportive approach that is not overly bureaucratic.

A few respondents question whether a provider-level assessment will encourage improvement and accountability in the quality and safety of care or add value for people who use services or their families. Some feel that the current assessment framework is already sufficient for evaluating the overall service provided across a group.

"If, as currently assessed, 80% of all homecare providers are rated 'good' then the chances are the provider-level assessment would also be 'good'.

User 100060 (Provider trade body or membership organisation)

A few respondents suggest that CQC's proposals will overlap and duplicate existing regulatory regimes, specifically mentioning the regulation of housing associations by the Homes and Communities Agency and the regulation of voluntary sector organisations by the Charity Commission.

Capability of CQC inspectors

Some respondents feel that a different skill set will be required to conduct a provider-level assessment across a complex organisational structure compared to existing location inspections. These respondents seek reassurance that inspectors will have the required training, knowledge and skills to assess the new frameworks appropriately.

Some respondents express concern that references to 'professional judgement' will leave too much scope for inconsistencies although some accept that 'professional judgement' will be required. Respondents ask for further detail about the way CQC will manage challenges to such judgements and how providers can appeal ratings they feel are unjustified.

Ease of understanding

Many respondents express concern that provider-level ratings could cause confusion for members of the public who simply want to compare ratings for individual services in their local area.

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

User 780 (Voluntary or community sector representative)

Impact on providers

A few respondents raise concerns that the implications for an entire group to be rated as anything less than good are considerable. They say provider-level assessments could put good companies at risk if companies within the same group receive a poor CQC rating. They fear that investors and insurers in the good company could pull out leaving the good company stranded and unable to continue providing a service.

Some independent sector providers feel that public sector providers are dealt with more favourably than the private sector. They argue that CQC's policy for care homes rated as inadequate and in special measures can result in closure after 12 months but there is no similar policy for NHS services.

Some respondents note that CQC's proposals require organisations to register at each level of their group structure but only frontline services and the highest registered level of the group would be rated. They say this would overlook the organisations at an intermediate level in the structure which are likely to exercise significant control of resources and influence on quality.

A few respondents highlight the specific challenges that would be faced by small providers that may lack the capacity and IT systems to facilitate provider-level assessments.

"The administrative burden associated with responding to regulation is proportionately greater for small organisations because they do not have the support infrastructure available to larger organisations. Smaller organisations should not be unfairly tied up with unnecessary bureaucracy because they do not fit into the regulatory framework designed for larger organisations."

User 100047 (Provider trade body or membership organisation)

Requests for further information and consultation

Several respondents comment that the proposals presented in the consultation document lack sufficient detail for them to make an informed judgement.

A few respondents say there has not been enough consideration of how the proposals would be applied within the adult social care sector, particularly for entities that are not involved directly in providing patient or resident care.

Many respondents feel 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. These include other regulatory bodies such as NHS England, NHS Improvement and the Homes and Communities Agency; commissioners such as CCGs and Local Authorities and patient and carer groups such as Healthwatch and the Carers Trust.

3.7.3 Suggestions

Some respondents highlight the importance of assessing a provider's systems for monitoring and managing internal compliance, governance arrangements and lines of internal reporting, escalation and accountability. They say the assessment should identify the organisation's commitment to safety, how quality is promoted, awareness of staff behaviour and how they deal with and learn from incidents and reporting of errors.

There are suggestions for providers to draw upon commercial quality models, such as EFQM and ISO9001, to help them self-assess and improve quality within their own organic management systems which includes better collection of data.

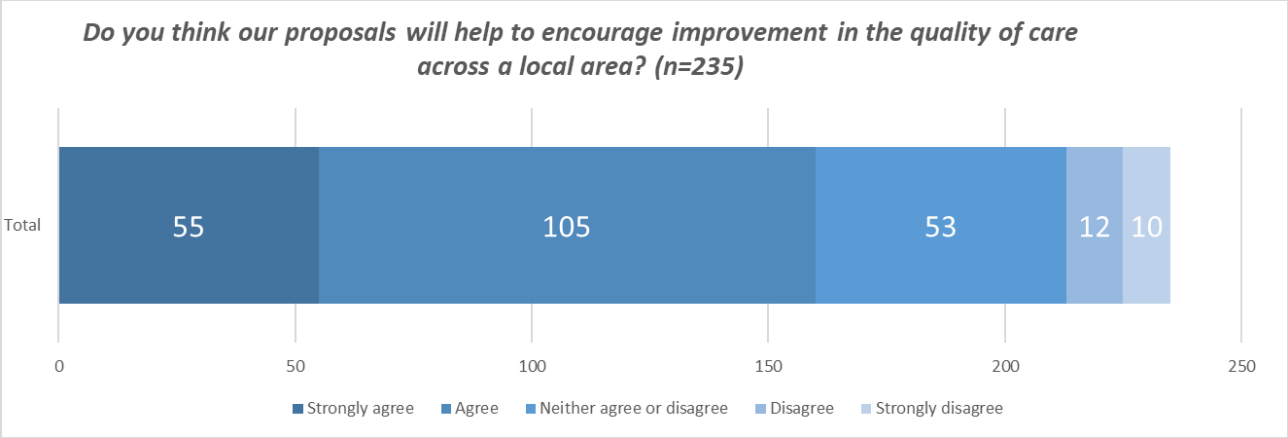
Other factors to consider suggested by respondents include:

- Maximise use of existing data to reduce duplication and burden on providers
- The culture and values of an organisation including the way staff are managed and trained
- The qualifications and experience of directors, the quality of their leadership and their level of responsibility for directing care across the organisation
- The frequency of inspections, particularly for services rated as requiring improvement, and better inspections of GP home visiting services
- Feedback and complaints received from people who have used the services
- Financial sustainability and management of resources
- The size, structure and geographical area covered by an organisation and its plans for expansion into new sectors
- A greater focus on quality of life and person-centred care for older people rather than assessing the standard of short-term acute clinical interventions
- Bespoke assessment frameworks developed in partnership with each provider
- Follow best practice from Scotland and the Ofsted assessment framework.

3.8 Responses to question 5a

A total of 243[9] respondents answered the closed question 5a, which asks: ***'Do you think our proposals will help to encourage improvement in the quality of care across a local area?'*** To answer this closed question, respondents could choose from five options between strongly agree and strongly disagree.

Chart 3 - Responses to question 5a



Eight respondents provided irregular responses which did not fit into the above categories. This means that they made some form of response to this question that did not follow the closed categories (i.e. 'strongly agree' to 'strongly disagree'). These responses have been excluded from the chart above and the percentages which follow.

68% of the 235 respondents who answered the closed question 5a agree (45%) or strongly agree (23%) that CQC's proposals will help to encourage improvement in the quality of care across a local area. 9% of respondents answering question 5a indicate that they disagree (5%) or strongly disagree (4%) with the proposed approach.

3.9 Responses to question 5b

There were 181[10] responses to question 5b submitted via the webform which asks*: '**How could we regulate the quality of care services in a place more effectively?***'*

Some of the 181 respondents made comments that were more relevant to other questions within the consultation so these comments have been summarised elsewhere in the report. The analysis below summarises comments from 214 respondents in total which includes responses to question 5b via the online consultation as well as responses received by email.

[9] See breakdown: Table A3 - 3: Responses to Q5a by overall respondent category

[10] See breakdown: Table 2-4: Count of respondents by question by "responding as"

3.9.1 Supportive comments

Many respondents express general support for the proposals to encourage improvements in the quality of care in a place but only a few provide more detail on the reasons for their support. Some respondents support the proposals but attach caveats to their support. Where issues are raised in these caveats they are summarised in the relevant issues section.

Several respondents support the proposals to take a wider view of quality in a place. They feel this would ensure a greater focus on service users' overall experience of care and help to identify and address system-wide issues or problems arising from the interactions between service providers, including those between primary care and other sectors. It would also encourage greater cooperation between providers and drive local improvements in quality of care. Some respondents comment that it would be useful to understand the service user's journey across the system, and the coordination of different services, as these impact health outcomes.

"We are supportive of the move to assessing the combined quality of services in a place as it is clearly the combination of services and the manner in which they work together which matters most to citizens."

User 787 (Other)

3.9.2 Issues

Some respondents highlight potential issues with the proposal to encourage improvements in the quality of care in a place. A small number of respondents state that they oppose the proposal without expanding in detail their rationale. Additionally, some respondents state that it will only be possible to determine the success of the proposal once the pilots have been completed and assessed. A few express concerns that the proposal will lead to a very health-focused approach to quality of care in a place and suggest that the methodology must consider the importance of social and community health settings. A few participants comment on issues understanding information and the question in the consultation document. Further comments on the consultation document can be found in section 8.

Approach

Some respondents express concerns about the proposed approach, raising issues of cost and increased bureaucracy. They feel that a new review process will increase costs for both CQC and providers whilst attempts to improve quality in a place may duplicate work undertaken as part of the inspection and regulation of individual providers. They also suggest that CQC have only limited resources and that if attempts to improve quality of care in a place removes these resources from other areas then that could prove to be a detrimental step.

"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."

User 712 (Provider / profession, independent healthcare)

One respondent suggests that the 'well led' key question already covers a provider's ability to work effectively with other organisations, and thus that a new review process is not necessary.

Scope

Some respondents comment on the scope of the proposals. They argue 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'.

"There needs to be a change in how care services work together which should be Government led. What is the role of CQC here? Is it the regulator or the care coordinator?"

User 815 (Provider / profession, care home with nursing)

A small number of respondents also question whether a place-based rather than provider-based focus would adequately account for specialist providers or service users requiring specialist care, whilst others feel that the proposals are more focussed on healthcare than social care and small-scale providers.

A few respondents say that improvements in the quality of care in a place must be driven by central government rather than CQC, though one respondent feels that regulation should only apply to NHS services as private entities should be constrained by market forces.

Some respondents comment that pilots are already being undertaken to examine the possible effects that this proposal would have and that these findings can help to inform future decisions as to the utility and effectiveness of encouraging improvements in the quality of care in a place.

3.9.3 Suggestions - Approach

Many respondents make suggestions for improvements or amendments to the proposals. which are wide ranging and often specific in nature. These suggestions have been separated into two separate sections, the first related to CQC's overall approach and the second related to the scope of the proposals.

Several respondents support information sharing and suggest ways in which this can be improved, such as:

- Increased information sharing across national bodies, including NHS Improvement or NHS England.
- Increased information sharing between agencies and providers within a local area.
- Making use of Welsh and Scottish clinical guidance as well as English clinical guidance and advice from National Institute for Health and Care Excellence (NICE).
- Working with stakeholder organisations to triangulate data sources for issues such as dementia and diabetes, and to use this data set to inform use of CQC Insight tool.
- Assessing information flow from hospitals to care homes.

These respondents feel that increased collaboration and information sharing would help to create two-way transfers of knowledge and intelligence, as well as improve relationship management with commissioners and other stakeholder organisations and inform decision making.

Some respondents go on to argue that any such information must be used to support those providers which are found to have shortcomings. They feel that improvement should be encouraged in order to drive up standards rather than simply highlighting areas of bad practice or providers which are struggling within an area.

Inspection across a local area

Some respondents suggest that in order to properly assess quality of care services in a place the existing regulatory framework would need to be amended. In particular, they feel that the framework must focus standards of governance and collaboration, as well as assessing strength of influence for issues which have wider impacts within an area.

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

User 795 (Parliamentarian / councillor)

A small number of respondents also suggest that the development of a new assessment framework would provide an opportunity to better assess quality of care for service users with diabetes or a learning disability.

Several respondents, the majority of whom are members of the public rather than providers or organisations, suggest that inspections should be more frequent and that the inspection schedule should include unannounced inspections and spot checks, as well as evening and weekend visits and 'secret' inspectors.

"I think there should be more visits to clients without providers being informed, there should be face to face visits for families as well without forewarning providers, like spot checks being carried out."

User 615 (Other)

Meanwhile, some respondents, the majority of whom are providers or organisations, say that CQC should adopt a risk-based policy with inspections focused on key issues or areas of concern. They also call for greater consistency across inspections and suggest defining key performance metrics, such as access to GPs, nursing home availability or delayed transfer of care.

Some respondents also comment specifically on CQC inspectors. They suggest using local or specialist inspectors who understand the particular local circumstances and the intricacies of the service they are visiting, as well as the needs of service users who require specialist care. They also suggest training inspectors to improve their skills.

"CQC need to focus on… Inspectors spending time getting to know individual providers, the nature of the services being provided and the context within which the service is being provided, including financial constraints placed on companies through local authority contracts."

User 100060 (Provider trade body or membership organisation)

Feedback

Suggestions for seeking feedback on the quality of care across a local area include:

- Focusing assessment on patients' care pathways and experiences across systems.
- Focusing assessment on service users' outcomes.
- Talking to services users off the premises of registered providers in the presence of an independent advocate to help them express themselves.
- Talking to staff about their experience and understanding of the provision of care.
- Seeking the views of stakeholder organisations, such as Healthwatch groups, to help CQC understand local issues and concerns, both throughout the year and in the lead-up to an inspection.

Some also feel that the transparency of CQC's approach could be improved by making the data gathered for monitoring, inspection and use of CQC Insight tool available publicly and updating it regularly to assist service users in making informed choices, or by publishing key performance data for issues such as dementia care.

3.1.1 Suggestions - Scope

Place-based regulation

Many respondents make suggestions about the implementation of place-based regulation. They feel that this approach to regulation should:

- examine the particular demographics of an area to ascertain the needs of service users;
- examine and understand patient pathways;

- monitor hospital discharges to help understand outcomes for care home residents and reach out to discharged as well as current patients;
- engage with all providers in an area to build an accurate picture of service provision;
- examine the effectiveness of partnership arrangements, with a focus on responsibility and accountability;
- encourage collaboration between providers across a local area for the benefit of service users;
- account for emerging local models of care;
- account for service delivery changes, such as the implementation of the Maternity Transformation Programme;
- Liaise with other inspection regimes, such as for that local pharmacies, to improve knowledge.

Commissioning and governance

Many respondents make suggestions about commissioning and governance.

Most prominently they raise funding issues, arguing that any review of services needs to account for commissioning processes. They feel that consideration must be given to the relationship between funding and outcomes and the impact on service quality and sustainability. For example. a few participants comment that lack of funding may limit the ability for services to work as collaboratively as they would like. They say that reports should recognise and reflect provider experience of commissioning practices.

Other suggestions related to commissioning include:

- Providing an overall CQC rating for boroughs or local authority commissioning areas.
- Ensuring that the contract and funding model for the provision of services meets requirements of service users and their level of needs.
- Greater recognition of users who have no care plan option because of a shortage of homes accepting local authority clients.

Other scope suggestions

When assessing quality of care across a local area, some respondents suggest that CQC's inspections should also cover the following services:

- Voluntary sector organisations who work with providers
- Community-based preventative services
- Rehabilitation services
- Palliative care
- Dentistry
- Schools and children's social care
- Supported living services

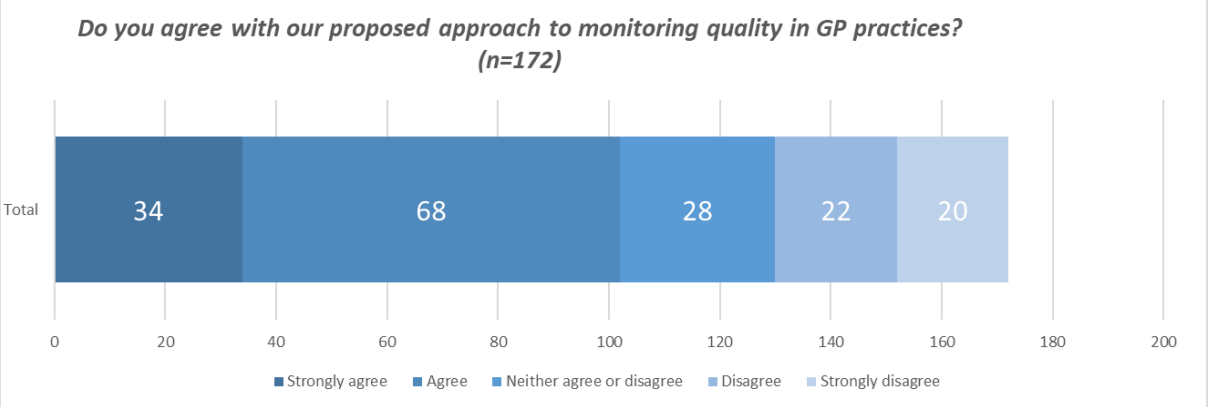
A small number of respondents suggest that inspections should cover the condition of equipment, buildings and the accessibility of providers. Similarly, a few respondents suggest that providers' human resources should be under scrutiny. This includes recruitment, staffing levels and quality of training.

4. Primary medical services

4.1 Responses to question 6a

A total of 179[11] respondents answered the closed question 6a, which asks: ***'Do you agree with our proposed approach to monitoring quality in GP practices?'*** To answer this closed question, respondents could choose from five options between strongly agree and strongly disagree.

Chart 4 - Responses to question 6a



Seven respondents provided irregular responses which did not fit into the above categories. This means that they made some form of response to this question that did not follow the closed categories (i.e. 'strongly agree' to 'strongly disagree'). These responses have been excluded from the chart above and the percentages which follow.

59% of the 172 respondents who answered the closed question 6a agree (40%) or strongly agree (20%) with CQC's proposed approach to monitoring quality in GP practices. 24% of respondents answering question 6a indicate that they disagree (11%) or strongly disagree (13%) with the proposed approach.

The majority of responses came from healthcare providers or professionals, where 44% agree or strongly agree with the proposals. The remainder of respondents which include members of the public, respondents from voluntary organisations and carers are more supportive of the proposals, with 73% agreeing or strongly agreeing to the proposed approach to monitoring quality in GP practices.

[11] See breakdown: Table A3 - 4: Responses to Q6a by overall respondent category

4.2 Responses to question 6b

There were 137[12] responses to question 6b submitted via the webform which states, with reference to question 6a*: '**Please give reasons for your response.'***

Some of the 137 respondents made comments that were more relevant to other questions within the consultation so these comments have been summarised elsewhere in the report. The analysis below summarises comments from 149 respondents in total which includes responses to question 6b via the online consultation as well as responses received by email.

4.2.1 Supportive comments

Need for improvement

Of those respondents who do provide further detail to their support, some welcome the monitoring proposals because they feel there is a need to improve GP services. They emphasise the importance of GP practices as a 'first port of call' but suggest that not all practices are providing an adequate service. A small number of respondents feel they are not able to complain about the service provided by their GP or say there are not available means to do so.

"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 to the care they provide."

User 777 (Voluntary or community sector representative)

Information collection

Many respondents support the introduction of annual online information collection and the submission of information by providers. They suggest it could encourage practices to analyse their own performance and help to highlight areas which require improvement. It could also highlight areas of good practice which can then be shared with other providers. Some also feel it would be 'less arduous' than current pre-inspection submissions and would allow the provider to contribute directly to their assessment.

"Gathering information over an annual period with closer relationship-working appears more open and collaborative. We hope that this will be more effective."

[12] See breakdown: Table 2-4: Count of respondents by question by "responding as"

User 100046 (Provider trade body or membership organisation)

Similarly, a few respondents support the use of data gathered from external sources in the monitoring of general practices, which they feel may 'minimise administration' or ensure 'reduced duplication' of data. One respondent welcomes the proposal to work with local stakeholders year-round.

Some respondents also support the use of the CQC Insight tool in the monitoring of general practices. They feel that this could signpost changes in the quality of care provided by practices. However, one respondent warns that the data must be 'truly comparable' and not place practices operating in challenging circumstances at a disadvantage.

"If the new Insight model alerts inspectors at an early stage to changes in level of care then this again would be positive and would hopefully address any limitations inherent in online self-report."

User 758 (Local Government Authority)

Consistency and transparency

A few respondents suggest that the proposed approach to monitoring will improve the consistency of the regulation and oversight provided by CQC. They feel there is currently some variation in the data which is requested from practices and in the way they are regulated compared to other providers.

Furthermore, a few respondents argue that the proposed approach would improve the transparency of the regulation and inspection process.

"We welcome increased transparency regarding the evidence gathered and how the ratings and judgements relate to the evidence."

User 784 (Arm's length body or other regulator)

Relationship management

A few respondents, primarily respondents from provider trade bodies and membership organisations, specifically mention the plans to improve relationship management as one of the reasons for their support, although one community sector representative questions whether CQC has the necessary resources to carry it out.

"The proposal for strengthened relationship management is highly commendable, one question though is does the CQC have the resources, in terms of people and finance to support this aspiration."

User 817 (Voluntary or community sector representative)

Support with caveats

Some respondents support the proposals but attach caveats to their support. Where issues are raised in these caveats they are summarised in the relevant issues section.

4.2.2 Issues

Burden and bureaucracy

The majority of respondents who express concerns about the monitoring proposals say they would increase the regulatory burden on general practice. They argue that general practice is already at 'breaking point' and that the proposals will add to the workload in a way which is 'unnecessary' and 'onerous'.

"I am sure the CQC must be completely aware of the pressures faced in General Practice today. On a daily basis we are coping with increasing demand, a shortage of GPs, massive transformations plans alongside trying to retain and motivate our doctors and staff."

User 100018 (Provider / professional)

This is because they feel that the requirements for data submission will increase rather than reduce bureaucracy, and duplicate work and information submission which is already being undertaken.

A few respondents specifically argue that this perceived increase in regulatory burden will reduce the amount of time available to providing patient care.

"In relation to the proposed Provider Information Collection (PIC), 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."

User 100020 (Provider trade body or membership organisation)

Information collection

Many respondents directly relate the potential increase in regulatory burden described above to the introduction of annual online information collection. They argue that practices do not have time to submit information annually and already provide information and reports to relevant CCGs, NHSEs and Public Health England.

"Primary care is already under huge pressure to delivery care to its patients without the necessity of annual updating for yet another organization."

User 756 (Provider / professional)

Some respondents also raise concerns about the CQC Insight tool because they feel the data used is not properly contextualised and does not necessarily reflect the issues faced by certain groups, such as those with a learning disability.

Accuracy of monitoring

Some respondents voice concerns about the utility or accuracy of the data which would be collected and used for monitoring. They suggest that if the right questions are not asked then the information gathered will be of little use. They also question the accuracy of information provided by external organisations, with one respondent saying CQC has knowingly published such inaccurate information in the past.

"What guidance will there be to ensure practices provide what the CQC need, and not just tell them what they want to hear?"

User 100069 (Health or social care commissioner)

Furthermore, a small number of respondents argue that the monitoring system would not necessarily account for local issues and variances. They argue that 'external factors' such as the closure of another local surgery could affect the performance of a practice but may not be reflected or acknowledged in the monitoring process.

A few respondents also raise concerns around the idea of practices self-assessing. They argue that this would lead to the submission of 'unverified' or 'subjective' information, or indeed may lead some practices to be dishonest or 'fabricate' their results. Additionally, they feel that a provider which is 'very transparent' could place itself at a disadvantage. One respondent suggests that these providers should be rewarded with 'less onerous inspections'.

Regulatory concerns

Some respondents feel that the proposed measures constitute over-regulation. They argue that practices rated good or outstanding should not have to outline their plans for continuous improvement to CQC and argue that practices attaining a high standard cannot necessarily always continuously improve.

"While it is important for appropriate standards to be maintained, we do not agree that these practices should be asked to describe what they are doing to support continuous improvement - it is not the role of the regulator to pursue continuous improvement in the vast majority of practices already judged to be meeting the regulatory standards."

User 100020 (Provider trade body or membership organisation)

A few respondents also raise costs associated with the monitoring process, either in terms of costs which will be created for practices by the information submission process or the value for money of fees paid to CQC. They argue that costs which practices will accrue from producing annual reports should be accounted for in the fee structure.

One respondent further feels that the proposed approach would be difficult to deliver apolitically given potential 'centrally driven' funding implications.

4.2.3 Suggestions

Many respondents make suggestions for improvements or amendments to the proposals. These suggestions are wide ranging and often specific in nature. They are typically submitted by organisations rather than members of the public.

Several respondents call for particular groups or aspects of care to be incorporated into the monitoring process. These include suggestions that the following aspects of care should be monitored:

- demographics registered to a practice
- the results of GP patient surveys and the ways in which practices take patient feedback into account
- whether a practice has a practice pharmacist
- whether GPs are offering medication to those entitled to it and undertaking comprehensive annual care plan reviews
- whether GPs are diagnosing or referring for dementia and the measures being taken to make GP practices more accessible or usable for patients with dementia
- the skills of individuals and the ability of practices in making adjustments for those with learning disabilities
- the proportion of people with a learning disability registered with their GP
- whether a practice has a high turnover of doctors and practice staff
- practices' willingness to provide services to care homes
- whether a practice has a system in place for managing environmental compliance
- the ability of reception staff and the effect of bad reception staff on patient care.

Some organisations or practices suggest sources from which they believe information or data should be drawn for the monitoring process. These variously suggest:

- using General Medical Council (GMC) data on individual service providers for CQC's assessment of risk

- using National Institute for Health and Care Excellence (NICE) quality standards and indicators as part of CQC's Insight tool
- using independent information rather than information submitted by providers unless specific concerns have been raised
- using intelligence from Clinical Commissioning Groups (CCGs) to understand emerging concerns
- using data from the NHS complaints advocacy services in order to improve data collection regarding people with a learning disability
- providing a facility for organisations to automatically upload data they hold onto CQC systems.

A few organisations suggest stakeholders who they believe should be included in the improved relationship management aspect of the proposals or who they feel should be consulted on key issues. These include:

- the local learning disability team, people with a learning disability, support providers and family carers
- local authority commissioners who commission public health functions.

A few respondents also raise the possibility of sanctions for non-compliance. For example, this may be required if practices under-report or provide inaccurate information. One respondent asks if these could be administered by the GMC rather than CQC.

Some respondents argue that CQC should commit to providing support and advice to practices as part of their ongoing monitoring approach, suggesting this could be done by using online comparison dashboard which allow good practices to be shared and weaknesses to be addressed.

A few respondents suggest that CQC should better engage with Patient Participation Groups (PPGs) in order to both inform patients about standards of care and gather 'softer intelligence' as part of the monitoring process between inspections.

One respondent says that improving the ability of service users to submit their views to CQC would 'drive quality improvements'.

Queries

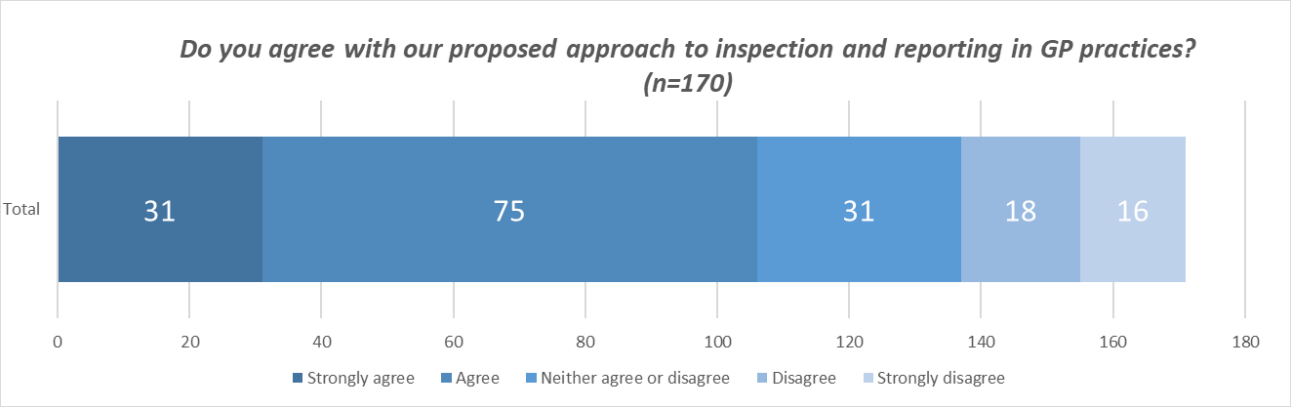
Some respondents raise queries about the proposals or the information provided about monitoring. For example:

- how data on primary care will be captured
- whether diabetes-specific data will be used for the CQC Insight tool
- whether monitoring will examine condition-specific pathways
- clarification of the timescales for the proposals

4.3 Responses to question 7a

A total of 176[13] respondents answered the closed question 7a, which states: ***'Do you agree with our proposed approach to inspection and reporting in GP practices?'*** To answer this closed question, respondents could choose from five options between strongly agree and strongly disagree.

Chart 5 - Responses to question 7a



Six respondents provided irregular responses which did not fit into the above categories. This means that they made some form of response to this question that did not follow the closed categories (i.e. 'strongly agree' to 'strongly disagree'). These responses have been excluded from the chart above and the percentages which follow.

62% of the 170 respondents who answered question 7a agree (44%) or strongly agree (18%) with CQC's proposed approach to inspection and reporting in GP practices. 20% of respondents who answered question 7a indicate that they disagree (11%) or strongly disagree (9%) with this question.

The majority of respondents who answer this question are healthcare providers or professionals, 49% of whom agree or strongly agree with the proposals. Respondents who are not healthcare providers, including those representing voluntary organisations, health and social care commissioners and members of the public are more supportive of the proposals with 73% either agreeing or strongly agreeing with the proposals and only 11% disagreeing or strongly disagreeing.

4.4 Responses to question 7b

There were 119[14] responses to question 7b submitted via the webform which states, with reference to question 7a*: '**Please give reasons for your response.'***

[13] See breakdown: Table A3 - 5: Responses to Q7a by overall respondent category

[14] See breakdown: Table 2-4: Count of respondents by question by "responding as"

Some of the 119 respondents made comments that were more relevant to other questions within the consultation so these comments have been summarised elsewhere in the report. The analysis below summarises comments from 131 respondents in total which includes responses to question 7b via the online consultation as well as responses received by email.

4.4.1 Supportive comments

Inspection intervals

Of those respondents who do provide further detail to their support, several support the introduction of longer periods between inspections for practices which are rated good or outstanding. These responses are typically just a statement of assent or approval, sometimes describing this proposal as 'reasonable' or 'sensible'. Some argue that it is only right that practices offering a good level of service should be inspected less frequently than those which are not.

"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 the CQC is also looking to introduce a new insight model to alert inspectors to changes in the quality of care."

User 100059 (Voluntary or community sector representative)

Some respondents further suggest that having longer periods between inspections will reduce the burden of regulation on doctors and practices and improve efficiency. They feel that this will reduce the duplication of work and 'streamline the process'. A few respondents also argue that the proposed approach is more flexible and will more accurately reflect daily practice.

"We welcome your proposals to be more proportionate and to reduce the burden of regulation by taking a risk-based approach to inspections - for example by varying the frequency of inspections based on the rating an organisation receives."

User 100048 (Arm's length body or other regulator)

Rating updates

In addition, a few respondents support the removal of the 'six month limit' which would allow ratings to be updated at any time following an inspection. A few also believe that ratings should be updated as soon as CQC receives confirmation that areas of concern have been addressed.

Unannounced inspections

Some respondents, all of which are organisational groups including commissioners and voluntary groups, support the use of unannounced inspections. One respondent suggests that it should be clarified that these can be used earlier than five years after inspection and if there are concerns about quality of care.

Reporting

Several respondents support the use of more accessible language and the removal of repetition in reports produced after inspection. They feel that this would help service users understand the standards they should be able to expect, allow comparisons to be made more easily and make the report more accessible for those with a learning disability.

> *"The information published for patients must be easy to understand, in plain English and contain information which is pertinent to patients' needs."*
>
> *User 100047 (Provider trade body or membership organisation)*

A few respondents state their support the faster publication of reports, with one respondent highlighting the risks associated with delayed publication, such as service users making decisions based on outdated information.

A small number of respondents express their support for the proposed evidence table as long as it is accompanied by a narrative on the contents.

Support with caveats

A small number of respondents support the proposals but attach caveats to their support. Where other issues are raised, they are summarised in the relevant issues section.

4.4.2 Issues

Current issues

Several respondents describe the burden which they feel inspections place on practices. They argue that they place a great amount of strain on practices resources and moral, describing their experiences of how inspections have removed staff from patient care and led to appointment cancellations.

Some responses, the vast majority from general practices, argue that inspections, re-inspections and perceived levels of bureaucracy related to inspections place pressure on GPs. They argue that GP numbers are reducing and so the bureaucratic burden placed on them by CQC should be reduced accordingly. One also suggests that a forthcoming inspection can make it harder for management to plan staff leave. On these grounds, some responses argue that inspections are unnecessary or without merit.

Inspection intervals

Some respondents raise concerns that the inspection interval for practices rated good and outstanding will not actually be five years as suggested. They point to the fact that 20% of practices rated good and outstanding are due to be re-inspected.

Furthermore, one respondent argues that although the number of inspections is supposed to reduce for practices rated good or outstanding, in reality the frequency of inspection will remain the same for up to 40% of these practices and that, when combined with the introduction of annual online information collection (covered in Section 4.2), this amounts to an increase in workload.

"…potentially 40% of practices rated good or outstanding are likely to have an inspection at intervals little different to what they would have faced under previous inspection schedules, yet in addition these practices will also have to comply with the proposed annual PIC monitoring arrangement."

User 100020 (Provider trade body or membership organisation)

However, several respondents express concerns about the proposal to extend the inspection interval for practices rated good and outstanding to five years. They suggest that over the course of this period problems may develop which would be picked up by an inspection but which monitoring may not capture.

These respondents say that periods of rapid change may see an increase in patient numbers, practice mergers, changes of ownership, the addition of new services, high staff turnover or key staffing changes. They also argue that practices may routinely be subject to financial restrictions or seasonal pressures. These respondents suggest that it is unclear how this would be handled with longer periods between inspections and that standards may 'slip' due to rapidly changing circumstances or if practices become complacent.

"There 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."

User 764 (Voluntary of community sector representative)

A few respondents feel that the extension of the inspection period to five years appears particularly long when considering that these practices will also be subject to focused rather than comprehensive inspections.

Unannounced inspections

A few healthcare providers and professionals are opposed to the use of unannounced inspections. They argue that inspections create stress or pressure for practices and that the prospect of unannounced inspections would add to this. One practice says that GPs do not have sufficient budget or capacity to cope with the increased pressure created by unannounced inspections.

"Why should CQC have greater flexibility to have unannounced inspections when this would considerably increase stress for practices, without any evidence of overall benefit?"

User 561 (Provider / professional, general practice)

Consistency and relevance

Additionally, a small number of respondents raise concerns about the consistency of the inspection process. They argue that inspectors' views are not always consistent with the regulations and guidance given by CQC and question how inspectors can assign ratings without processes in place for the validation of reports.

One respondent also argues that inspections do not necessarily focus on areas relevant to patient care and thus that there is a danger staff may come to see them as a box-ticking exercise.

Reporting

A small number of respondents raise concerns about the ratings system used in post-inspection reports, which they suggest fails to account for the differences between practices in terms of demographics or resources, as well as failing to highlight areas where excellent care is provided. A few respondents also comment that the 'good' category is too broad.

"As stated before, we do not agree with the existing rating system for healthcare providers. The overall performance rating is simplistic and cannot adequately capture the complexities of delivering healthcare."

User 100020 (Provider trade body or membership organisation)

One respondent also expresses concerns about the data which would be used in an evidence table and says that this must be presented alongside context and a full explanation.

A small number of respondents feel that attempts to make reports more accessible may impact on the quality or details of the report, whilst another says that reports are not necessarily well-publicised and consideration should be given to this.

4.4.3 Suggestions

Inspection

Some respondents raise the frequency of inspection, suggesting amendments to the proposals. They say that practices rated good and outstanding should be restricted to once every five years unless there are significant changes at the practice, or that these practices should be guaranteed four years between inspections unless concerns are raised. Additionally, one respondent argues that the inspection frequency for general practices should be further reduced so that only 10% of providers are inspected each year.

"The reinspection of practices rated as good or outstanding should be limited to once every five years, unless there are specific changes in the practice or its performance that might indicate a reason to reinspect sooner. A practice will want to show itself in a good light and as a result even the best practices will spend a lot of time on preparation for an inspection."

User 811 (Provider / professional, primary or urgent care)

Meanwhile, some respondents say CQC should make it clear what might prompt a good or outstanding practice to be inspected early. This might include, for example, seasonal pressures or staffing changes.

A few respondents describe the need for inspections to be 'proportionate'. They argue that they must reflect the size of the practice and the particular local circumstances which might affect that practice.

"A proportionate and locally responsive approach is required to meet the needs of the practices and population groups. 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."

User 100047 (Provider trade body or membership organisation)

A few respondents say that inspections are not necessary at all, with one respondent suggesting that since all providers have now been inspected there is no need for further inspections. Respondents comment that instead CQC should use stakeholder information and annual provider submissions to determine any deterioration or improvement.

A few respondents give additional suggestions for inspections as follows:

- Inspections should focus in greater detail on how GPs care for people in care homes and people with dementia.
- More should be done by GPs to support development of Patient Participation Groups.

Reporting

Whilst supporting the proposal to use more accessible language in the post-inspection report, one respondent suggests that reports should recognise how local or external factors may influence a practice's rating. A few respondents also suggest that the report could contain an easy-read summary or different sections for different audiences with various degrees of information.

"Perhaps a combination of a shorter summary report as suggested by the proposals, accompanied by a comprehensive report would be most useful."

User 831 (Voluntary or community sector representative)

One respondent suggests that it should be possible in the period between an inspection and the publication of a report for the public to be notified that an inspection has taken place. This would ensure an awareness that the previous rating is subject to possible imminent change.

Queries

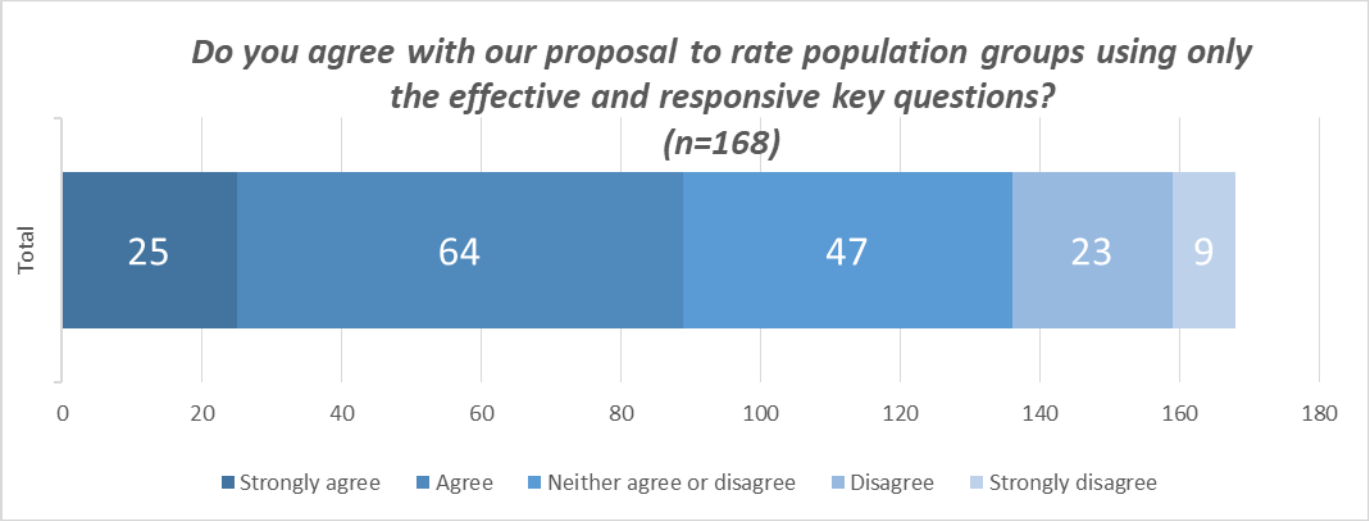
A small number of respondents raise queries about the proposals or the information provided about inspections which include:

- How often practices should submit their quality assurance dataset.
- How these datasets will influence inspections.
- How longer inspection intervals will be applied to independent practices.

4.5 Responses to question 8a

There are 171[15] responses to questions 8a, which states: ***Do you agree with our proposal to rate population groups using only the effective and responsive key questions?*** This was a closed question and respondents could choose from five options between strongly agree and strongly disagree.

Chart 6 - Responses to question 8a



Three respondents provided irregular responses which did not fit into the above categories. This means that they made some form of response to this question that did not follow the closed categories (i.e. 'strongly agree' to 'strongly disagree'). These responses have been excluded from the chart above and the percentages which follow.

53% of the 168 respondents who answered the closed question 8a agree (38%) or strongly agree (15%) with CQC's proposed approach to rating population groups. 19% of respondents who answered question 8a indicate that they disagree (14%) or strongly disagree (5%) with the proposed approach. 28% of respondents neither agree nor disagree, a higher proportion than for other CQC proposals.

50% of responses to this question from healthcare providers or professionals are in support or strong support of the proposals, which is in line with the 56% of all other respondent types who agree or strongly agree with the proposals.

4.6 Responses to question 8b

There were 98[16] responses to question 8b submitted via the webform, which states, with reference to question 8a*: '**Please give reasons for your response.'***

[15] See breakdown: Table A3 - 6: Responses to Q8a by overall respondent category

[16] See breakdown: Table 2-4: Count of respondents by question by "responding as"

Some of the 98 respondents made comments that were more relevant to other questions within the consultation so these comments have been summarised elsewhere in the report. The analysis below summarises comments from 117 respondents in total which includes responses to question 8b via the online consultation as well as responses received by email.

4.6.1 Supportive comments

General support

Many respondents generally support the proposal to rate population groups using only effective and responsive key questions. They comment that as the rating against the key questions safe, caring and well-led is consistent across population groups, it is appropriate that these elements are assessed at a broader practice level, instead of at a population level and several say that this approach is 'sensible', 'simpler', 'clearer' and 'makes logical sense'.

"We believe this will provide much clearer and therefore more useable outputs for stakeholders"

User 100011 (Provider trade body or membership organisation)

A few respondents comment that this approach would result in less repetition in ratings across population groups and therefore demonstrates a better use of time and resources.

"It is good to act on the evidence you have gathered, and as GP providers we do feel that we are being asked the same questions repetitively."

User 750 (Provider / professional, primary or urgent care)

More accurate

Some respondents specify that this proposed method for rating population groups is more accurate than giving a rating by averaging across all groups and that it offers an appropriate structure which uncovers relevant issues. For example, respondents comment that it could highlight where practices are succeeding, where they need support, and how services are improving. A few respondents say that this will help to compare practices for specific population groups.

"We believe this will provide service users with information that is easier to understand. It will be helpful for both providers and service users to be able to understand how services are improving."

User 793 (Provider / professional, adult social care and independent healthcare)

Patient-focused

Several respondents comment that this ratings process for population groups is more patient-focused. Not only do some respondents say that it provides more transparency for service users, allowing them to select a service which is relevant to their needs within a population group, but also some comment that it will create more accountability for service providers which would improve the quality of care overall.

"Population groups are generally only concerned about how the service affects their own group, so this approach makes it easier for them to have relevant information"

User 540 (Arm's length body or other regulator)

Additionally, some respondents support CQC in expressing the caveat that specific population-related concerns would still be considered.

Support with caveats

Some respondents who support this proposal, do so with the caveat that comparisons made between practices are fair, and that those independent doctors who do not care for all population groups are not penalised. Further issues that respondents raise are summarised below.

4.6.2 Issues

The majority of respondents who express concerns about the proposed rating criteria for population groups are general practitioners or respondents from healthcare organisations. Many of these respondents oppose to the omission of the key questions caring, well-led and safe from the assessment of population groups, commenting that it would lead to an inaccurate overall rating, and could result in missing certain issues during inspections.

Ineffective ratings

A few respondents say that the perceived lack of variation in the ratings across population groups for well-led, caring and safe key questions is not good grounds to suggest that these should not be assessed generally at a practice level. Several respondents express concern about the decision to use only the effective and responsive key questions for rating population groups, with a few expressing the concern that this could lead to a lower population group rating overall. Several respondents say that reducing the amount of ratings may result in CQC missing certain issues and opportunities for improvement, which could be picked up for population groups under the safe, caring, or well-led key questions. For example, one respondent suggests that a doctor's approach to care and safety is likely to be

different towards someone with a learning disability. A few respondents comment that the key questions safe or caring should be assessed at population level and effective should be rated at practice level.

"Caring and safety have the potential to be significantly different between different population groups. Although this is not normally the case, if you stop inspecting and rating the quality of care in these two categories then there is the danger that practices that do have these discrepancies are not picked up."

User 823 (Voluntary or community sector representative)

Classification of population groups

Some respondents express concerns about CQC's classifications of population groups. A few comment that when acknowledging specific patient population groups with varying needs, some patients may get left out of these or not appropriately assessed. A few respondents comment that this approach needs to be broadened given variable local population demographics.

'Whilst acknowledging different population groups have different needs, there is a danger that certain groups might lose out'

User 586 (Member of the public / person who uses health or social care services)

A few respondents make suggestions for alternative population groups, including for example, patients with learning disabilities, carers, dementia sufferers and those requiring end-of-life care. One respondent comments that the term 'people whose circumstances might make them vulnerable' is too broad and may need further specification and one respondent comments that the population group for older people should discern between those that have dementia and those that do not.

No benefit to proposal

Some respondents comment that this new ratings system would have little or no benefit to patients or GPs, as for most patients choosing a GP is based on locality rather than ratings and GPs can only influence change in their own practice, not across specific population groups.

A couple of respondents who work in general practice comment that while CQC is proposing a reduction of criteria, this reduction is not enough to lessen the bureaucratic burden and a few respondents comment that these proposed changes will not simplify the ratings system, but instead make it more confusing.

4.6.3 Suggestions

Alternative key questions

A few respondents give specific suggestions for additional assessment questions (other than responsive and effective) which they believe should be applied to population groups. These are summarised as follows:

- The way in which GP practices work with local care homes, nursing homes and at home care services.
- The quality of care delivered for older people, tested through assessing specialist skills training to meet the needs of older people, for example use of 'the Electronic Frailty Index'.
- Adult safeguarding for older patients, more vulnerable patients.

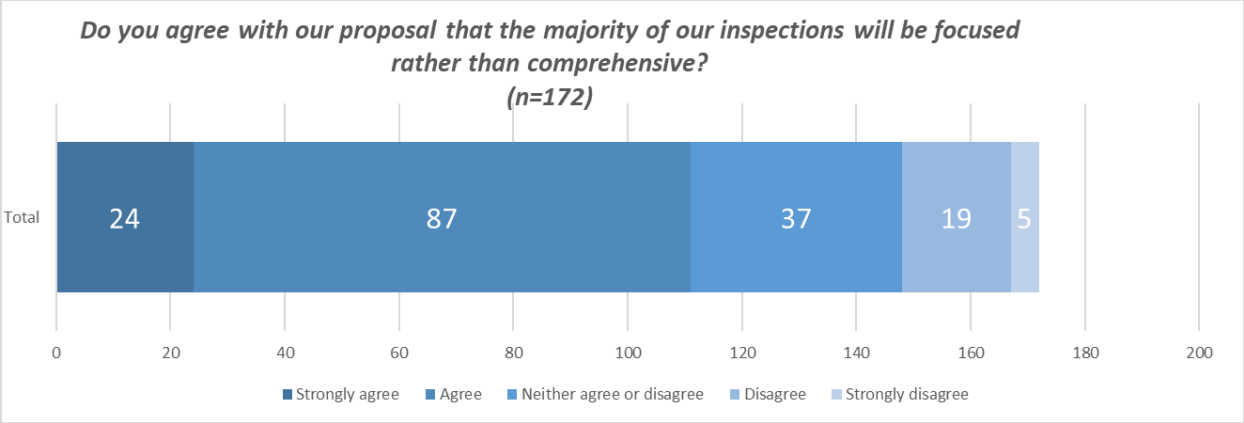
Several respondents ask for increased transparency surrounding the process of rating population groups. A few respondents suggest that the full list of ratings be made public so that patients can use this information to compare practices. One respondent suggests that before any decisions are made about the change in ratings, that this should be discussed with patient groups to determine their understanding of the key questions and other suggests that there should be a shared understanding about what 'good' looks like.

A further suggestion is that the current rating system should remain unchanged and inspectors should be allowed the discretion to not allow issues in a key question to affect the rating of a population group where it does not have a significant impact on that population group.

4.7 Responses to question 9a

A total of 176[17] respondents answered the closed question 9a, which asks: ***'Do you agree with our proposal that the majority of our inspections will be focused rather than comprehensive?'*** This was a closed question and respondents could choose from five options between strongly agree and strongly disagree.

Chart 7 - Responses to question 9a



Four respondents provided irregular responses which did not fit into the above categories. This means that they made some form of response to this question that did not follow the closed categories (i.e. 'strongly agree' to 'strongly disagree'). These responses have been excluded from the chart above and the percentages which follow.

65% of the 172 respondents who answered the closed question 9a agree (51%) or strongly agree (14%) with CQC's proposal for the majority of inspections to be focused rather than comprehensive. 14% of respondents answering this question indicate that they disagree (11%) or strongly disagree (3%) with the proposed approach. 21% of respondents neither agree nor disagree.

4.8 Responses to question 9b

There were 105[18] responses to question 9b submitted via the webform, which states, with reference to question 9a*: '**Please give reasons for your response.'***

Some of the 105 respondents made comments that were more relevant to other questions within the consultation so these comments have been summarised elsewhere in the report. The analysis below summarises comments from 116 respondents in total which includes responses to question 9b via the online consultation as well as responses received by email.

[17] See breakdown: Table A3 - 7: Responses to Q9a by overall respondent category

[18] See breakdown: Table 2-4: Count of respondents by question by "responding as"

4.8.1 Supportive comments

Several respondents offer supportive statements without necessarily expanding in detail on their reasons for their support.

Of those respondents who do give further detail, some argue that focused inspections are preferable because they are targeted on key areas. They suggest that this is preferable to a more 'generalised' inspection and would allow inspectors to carry out 'a more in-depth review' of new services or areas which require improvement.

"It will be good to be more targeted and should allow more in depth inspections to occur where and when they are needed."

User 823 (Voluntary of community sector representative)

Some respondents argue that focused inspections would also be less demanding for practices and reduce 'unnecessary work'.

Furthermore, some respondents feel that the introduction of focused inspections would constitute a better use of resources, both for providers and for CQC. They argue it would allow specialist advisors to be used more appropriately and that after the first round of inspections, further regular comprehensive inspections may not be cost effective.

"Focused interviews are a better use of resources as specialist advisors can be used to focus on their area of specialism."

User 793 (Provider / professional, adult social care and independent healthcare)

Some respondents also argue that focused inspections would place less demand on GPs' time and reduce unnecessary work. They feel this will reduce the burden of inspection and make the process 'less onerous'.

In addition, some respondents say that focused inspections will help to identify issues which would be of regulatory concern and can help to flag up practices which require a more detailed inspection.

A few respondents suggest that focused inspections are flexible, can drive improvements in quality, encourage best practice and can lead to improvements in patient care and services.

4.8.2 Issues

Several respondents express concern that the proposals for focused inspections (particularly those with an inspection interval of five years) may lead to issues being overlooked. They feel that problems can be 'easy to miss' and fear that a deterioration in standards may not be identified if particular areas are not necessarily inspected.

"The concern about the phrase 'focused rather than comprehensive' is that can be interpreted as a euphemism for less scrutiny."

User 697 (Voluntary or community sector representative)

Similarly, some respondents argue that there is a need for comprehensive inspections to be continued or a more holistic approach to be taken. They feel that these are more appropriate or necessary to avoid the 'risk' of missing problems due to a lack of inspection of some areas.

"I think all inspections should be comprehensive as there could be a problem with an aspect of care that isn't on the checklist for inspection if it is too focused."

User 626 (Member of the public / person who uses health or social care services)

Some also raise questions about how the areas of focus would be identified and how this would be communicated to practices. They question the accuracy of the monitoring or intelligence used to select areas of focus, with one CQC employee suggesting that practices will challenge ratings if they do not believe that the focus was appropriate.

"I also consider it likely that we will face significant challenge from providers who do not get the ratings that they wanted, and who will argue that if we had chosen to look at other key questions/population groups we would have found them to be good/outstanding."

User 820 (CQC employee)

One respondent also argues that if inspections are focused on areas of perceived weakness then this means that areas of best practice might not be identified and opportunities for sharing innovative approaches would be lost.

A few respondents raise concerns that focused inspections will not reduce or indeed increase workload for practices.

A small number of respondents oppose inspections, suggesting that they should not be required for practices rated good and outstanding or that they are not necessary at all.

4.8.3 Suggestions

Several respondents make suggestions for improvements or amendments to the proposals. They are typically submitted by organisations rather than members of the public, although a small number of members of the public do make suggestions.

Some respondents suggest an alternative balance of focused and comprehensive inspections to that which is proposed. They suggest:

- Comprehensive inspections should continue for those practices where there has been a high turnover of staff or change of services offered.
- Focused inspections should be used when a practice is re-inspected following a recent inadequate or requires improvement rating to shorten the period before these ratings are lifted.
- Comprehensive inspections should be used for those practices who have had a five-year interval between inspections.
- Focused inspections may trigger follow-up comprehensive inspections or unannounced visits.
- A practice should have to receive a good rating twice before they move to a focused inspection schedule.

Some respondents make suggestions related to the selection of areas of focus. These include:

- Giving advanced notice of areas of focus to allow practices to ensure appropriate staff are available.
- Explaining the rationale for the selection of areas of focus to practices, along with evidence to support this choice.
- Safeguards be put in place to protect patients with a learning disability.

4.9 Responses to question 10a

Question 10a asks

'***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

These were closed question and respondents could choose from five options between strongly agree and strongly disagree.

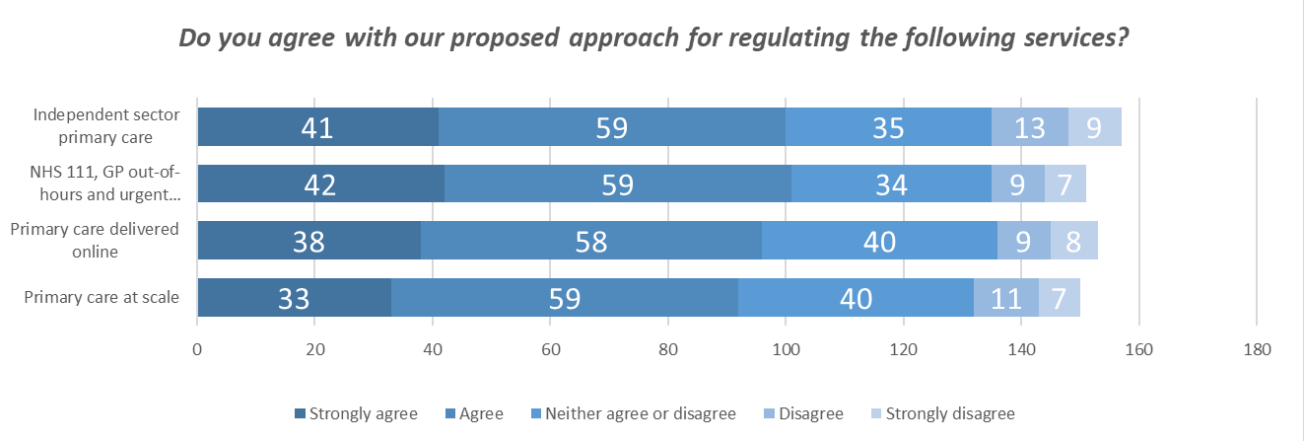
A total of 159[19] respondents answered the closed question 10ai.

A total of 157[20] respondents answered the closed question 10aii.

A total of 157[21] respondents answered the closed question 10aiii.

A total of 156[22] respondents answered the closed question 10aiv.

Chart 8 - Responses to question 10a



Some respondents provided irregular responses, which means that they made some form of response to this question that did not follow the closed categories (i.e. 'strongly agree' to

[19] See breakdown: Table A3 - 8: Responses to Q10ai by overall respondent categoryTable A3 - 1: Responses to Q3a by overall respondent category

[20] See breakdown: Table A3 - 9: Responses to Q10aii by overall respondent category

[21] See breakdown: Table A3 - 10: Responses to Q10aiii by overall respondent categoryTable A3 - 7: Responses to Q9a by overall respondent category

[22] See breakdown: Table A3 - 11: Responses to Q10aiv by overall respondent category

'strongly disagree'). These responses have been excluded from the chart above and the percentages which follow.

Two respondents who answered question 10ai provided irregular responses. 64% of the 157 respondents to question 10ai agree (38%) or strongly agree (26%) with CQC's proposed approach for regulating independent sector primary care. 14% of respondents to question 10ai indicate that they disagree (8%) or strongly disagree (6%) with this question.

Six respondents who answered question 10aii provided irregular responses. 67% of the 151 respondents to question 10aii agree (39%) or strongly agree (28%) with CQC's proposed approach for regulating NHS 111, GP out-of-hours and urgent care services. 11% of respondents indicate that they disagree (6%) or strongly disagree (5%) with this question.

Four respondents who answered question 10aiii provided irregular responses. 64% of the 153 respondents to question 10aiii agree (38%) or strongly agree (27%) with CQC's proposed approach for regulating primary care delivered online. 11% of respondents indicate that they disagree (6%) or strongly disagree (5%) with this question.

Six respondents who answered question 10aiv provided irregular responses. 61% of the 150 respondents to question 10aiv agree (39%) or strongly agree (22%) with CQC's proposed approach for regulating primary care at scale. 12% of respondents to this question indicate that they disagree (7%) or strongly disagree (5%) with this question.

4.10 Responses to question 10b

There were 86[23] responses to question 10b submitted via the webform, which states, with reference to question 10a*: **'Please give reasons for your response (naming the type of service you are commenting on).'***

Some of the 86 respondents made comments that were more relevant to other questions within the consultation so these comments have been summarised elsewhere in the report. The analysis below summarises comments from 92 respondents in total which includes responses to question 10b via the online consultation as well as responses received by email.

4.10.1 Independent sector primary care

Supportive Comments

The majority of respondents who comment on this issue believe that independent healthcare providers should be regulated in the same way as NHS providers. This would ensure that the quality of the service is consistent for patients no matter who the provider is and allow for greater transparency and accountability to the public. One respondent says that it will be

[23] See breakdown: Table 2-4: Count of respondents by question by "responding as"

helpful to publish all provider information on the CQC website and specify which providers CQC is unable to inspect.

"To the public, there is little distinction between NHS and non-NHS providers, and therefore little distinction should be made in terms of quality, including in their regulation."

User 100064 (Arm's length body or other regulator)

Issues

However, a few respondents oppose the regulation of independent healthcare providers in the same way as NHS providers, arguing that it would amount to over-regulation and duplication, especially given the recent work done with CQC and independent healthcare providers to create the independent doctors' handbook, as well as that fact that it may be difficult to define and assess population groups for independent healthcare providers given that they do not serve a particular geographic area. Some of these respondents suggest that the sector should be left to the control of market forces with accountability to customers.

"We agree in principle with the approach but are concerned that the service may be assessed for population groups which the GPs may not necessarily see. There is a lack of clarity about how this will be reflected in the report."

User 793 (Provider / professional, adult social care and independent healthcare)

Suggestions

A few respondents suggest that the independent status of providers must be made clear to the public, specifically how different services (regulated and unregulated) impact one another and the end user.

4.10.2 NHS 111, GP out-of-hours and urgent care services

Supportive comments

The majority of respondents who comment on of NHS 111, GP out-of-hours and urgent care services support the proposals for regulating them, staying that this will improve the consistency of regulation and standard of care across these services, and would result in less 'fragmented' inspections across different times and locations for these services.

"We agree that being consistent in assessment of service whether it is a primary care location or part of a trust will ensure continuity of care provided at the same standard."

User 651 (Provider / professional, hospice services)

One local authority agrees it is a concern that there is no national data available for urgent care services and says that this should be addressed.

Issues

A small number of respondents feel that some services, such as those delivered in the patient's home or out of hours, have not been adequately acknowledged or accounted for.

"This section appears confused as it mentions NHS 111, walk in centres, urgent care centres and MIUs but fails to acknowledge GP extended opening and the drive towards integrated extended access for patients."

User 768 (Other, statutory organisation)

One respondent says that the urgent care sector needs more regulation.

Suggestions

Where relevant, one foundation trust supports an overall provider inspection rather than, for example, primary medical services and ambulance services being assessed separately.

Furthermore, one respondent says that consideration should be given to the development of Integrated Urgent Care Clinical Assessment Units and the way in which they would be assessed, whilst a few respondents suggest that CQC's approach needs to recognise the circumstances of the provider being inspected as well as end users' perspectives.

4.10.3 Primary care delivered online

Supportive comments

The majority of respondents who comment on this issue believe that primary care delivered online is an increasingly important service and support the proposals to bring digital healthcare services into the scope of rating. This would ensure consistency of regulation with other providers and both protect and reassure service users.

"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…"

User 716 (Voluntary or community sector representative)

A few respondents also support assessing digital healthcare providers on whether their service is safe, effective, caring, responsive and well-led until such a time as these providers have been brought into the scope of rating to ensure patient safety in the interim period.

Issues

A few respondents suggest some of the complexities of online healthcare regulation, such as the fact that CQC's jurisdiction only covers England and therefore many areas cannot be covered by the regulatory framework, or the possibility that it may not always be clear to the service user which organisation is providing the services online.

One respondent questions the relevance of some of the Key Lines of Enquiry (KLOEs), such as effective and well led, for online providers.

One online provider raises several detailed concerns about the proposed approach for regulating primary care delivered online, including concerns about a perceived lack of consultation on this issue, as well as a lack of transparency about the regulatory methodology. They feel that digital-only healthcare providers have higher regulatory requirements.

Suggestions

The same online provider also makes numerous detailed suggestions, including:

- communicating all upcoming relevant consultations and regulatory changes to digital healthcare providers
- working with the digital healthcare sector to develop a regulatory methodology for digital healthcare providers
- establishing a team to advise digital healthcare providers on meeting specific regulatory requirements
- reviewing the training of inspectors and ensuring inspections are undertaken by digital healthcare specialists
- a patient identification process more in line with that used in GP practices
- a mechanism by which all patient records can be securely accessed and updated by any registered and regulated healthcare provider
- a digital referral pathway and secure communications channels between independent providers and NHS clinicians.

Another respondent says that if online pharmacy services are given by pharmacists then these should not be regulated by CQC as these services are already regulated by the General Pharmaceutical Council, but if they were provided by other healthcare professionals then CQC regulation would be required.

4.10.4 Primary care at scale

Supportive comments

Some respondents believe that a flexible approach is required for the regulation of primary care at scale due to the rapid evolution of new models of primary care. They support CQC's intention to pilot new approaches in order to better understand the regulation of new models of care and welcome the future publication of the results from these pilots.

"It is important that the revised regime is flexible enough to enable it to adapt to the many different types of emerging models."

User 100047 (Provider trade body or membership organisation)

Issues

A few respondents feel that there is insufficient detail or clarity in the current proposals, or express concerns about what has been proposed.

They feel that individual practices may be unfairly judged based shortcomings elsewhere in the system or which are beyond their control, or that the proposals may duplicate work and create increased pressure for some individual GP practices.

"Regarding primary care at scale, it is important that individual practices are not unfairly judged on the shortcomings of other parts of the system over which they do not have control, or unfairly judged if they are not part of a larger group of practices working at scale."

User 100020 (Provider trade body or membership organisation)

One respondent raises a more general concern that practices are being 'forced' into primary care at scale when this may be detrimental to their performance.

Suggestions

One provider trade body says that CQC would need to co-ordinate their approach to primary care at scale with other regulatory organisations such as the General Pharmaceutical Council, whilst another feels CQC must clearly communicate their regulatory approach to allow complex providers to prepare adequately.

4.10.5 General comments

Supportive comments

The majority of respondents who comment on the proposed regulatory approaches as a whole say that a flexible and pragmatic approach would, across all the services named, improve the consistency of regulation and increase the accountability of providers. They feel that all service providers should be regulated in the same way.

A few respondents also suggest that the proposed approach to regulation will make the process easier to understand for the public.

"As dynamic service models develop, service users need the confidence that the range of services being developed and offered are subject to the same rigorous standards, and where necessary inspections, that are conducted in the traditional model sectors."

User 668 (Provider/professional, adult social care)

Additionally, a small number of respondents welcome the proposals for services that are repeatedly rated as require improvement and improving transparency of enforcement action, including the suggestion to publish details of enforcement action sooner than is currently the case.

A few respondents attach caveats to their support for the proposed approaches, suggesting that the proposals lack detail at this stage or arguing that complacency must be avoided.

Issues

A small number of respondents feel that the proposed measures constitute over-regulation which may detract from patient services and place strain on providers.

Furthermore, one respondent raises the timing of implementation, suggesting that these proposals will be introduced whilst a related consultation is ongoing.

"…the timetable suggests that inspections under the new approach will begin during November 2017, yet we are still waiting for further consultation during the autumn that will relate to independent providers. It is inappropriate to inspect organisations against criteria which are yet to be defined."

User 100036 (Provider trade body or membership organisation)

A local authority also asks if the proposals take account the possible reputation damage which the earlier publication of enforcement action details could cause if the provider is

successful in appealing against that action, whilst another respondent requests consideration of the impact which enforcement action against a practice could have on, for example, a local pharmacy.

Suggestions

Some respondents give additional suggestions about the proposed regulatory approaches as a whole. These include:

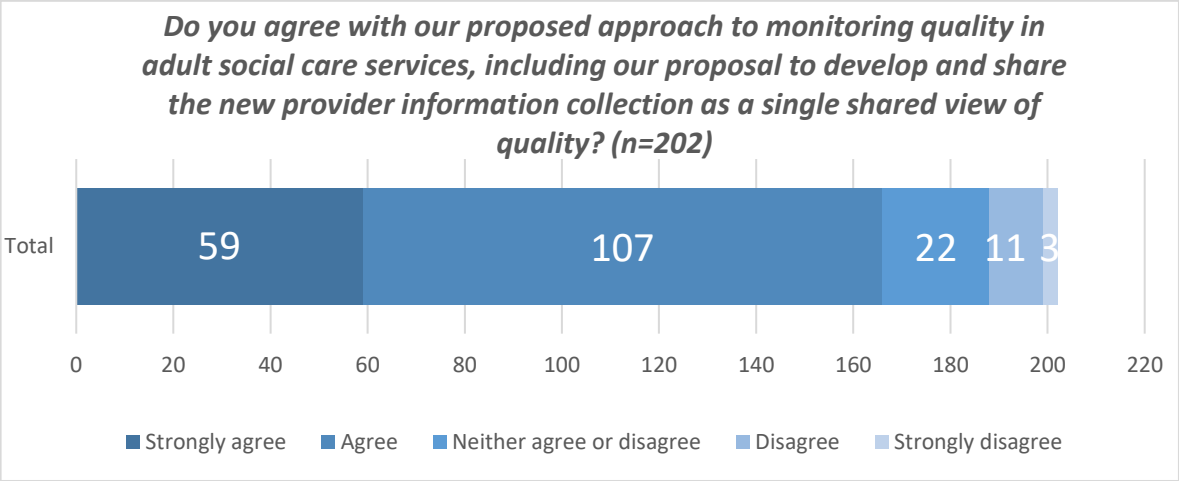
- That a strong focus be put on learning disabilities throughout all of the aforementioned services.
- Ensuring that there is a child-friendly environment for all these services.
- That patient feedback be recognised.
- That service users be made aware not only of ongoing enforcement action against a provider but also a likely resolution date.
- That adequate resources are required for these improvements to be made.

5. Adult social care services

5.1 Responses to question 11a

A total of 209[24] respondents answered the closed question 11a, which asks: '***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?'*** This was a closed question and respondents could choose from five options between strongly agree and strongly disagree.

Chart 9 - Responses to question 11a



Seven respondents provided irregular responses which did not fit into the above categories. This means that they made some form of response to this question that did not follow the closed categories (i.e. 'strongly agree' to 'strongly disagree'). These responses have been excluded from the chart above and the percentages which follow.

82% of the 202 respondents who answered the closed question 11a agree (53%) or strongly agree (29%) with CQC's proposed approach to monitoring quality in adult social care. 6% of respondents indicate that they disagree (5%) or strongly disagree (1%) with the proposed approach.

5.2 Responses to question 11b

There were 139[25] responses to question 11b submitted via the webform, which states, with reference to question 11a*: '**Please give reasons for your response.'***

[24] See breakdown: Table A3 - 12: Responses to Q11a by overall respondent category

[25] See breakdown: Table 2-4: Count of respondents by question by "responding as"

Some of the 139 respondents made comments that were more relevant to other questions within the consultation so these comments have been summarised elsewhere in the report. The analysis below summarises comments from 162 respondents in total which includes responses to question 11b via the online consultation as well as responses received by email.

5.2.1 Supportive comments

Respondents are generally supportive of the risk-based approach to regulation, both in the monitoring and inspection proposals. Many respondents express general support for the monitoring proposals without giving specific reasons for their support. Others focus on the more specific aspects of the proposals below.

Information collection

Respondents are generally supportive of the online provider information return (PIR) process, suggesting that an online system could encourage providers to assess their own performance regularly, and demonstrate continuous improvement of their services. Most respondents also welcome the CQC Insight tool, with some saying that sharing information between providers could facilitate joint working and integration between services. This might be achieved by helping providers to better target service user need.

Reduced burden

Many respondents believe that the long-term proposal to share a single core dataset with other stakeholders is much needed. They say it would be more efficient and avoid duplication, particularly if shared with local authorities. They anticipate this would help to reduce the overall administrative burden on providers.

Some respondents believe that both a 'live' PIR process and CQC Insight would improve inspections by enabling inspectors to see accurate information in context and in real time, and by reducing pre-inspection work for providers.

"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'."

User 100054 (Provider trade body or membership organisation)

Real-time monitoring and comparison of quality

Some respondents believe that one advantage of real-time monitoring would be to allow stakeholders (regulators, commissioners and local authorities, for example) to access up-to date information about providers, thereby allowing a more accurate view. CQC could identify those providers which require the most improvement and, working with local authorities, facilitate the early resolution of poor performance.

Some respondents also believe that having a single shared view of quality would allow for more direct comparison between providers. They suggest this will help providers to take similar approaches to quality improvement, rather than setting their own individual benchmarks, and this may in turn improve quality across the whole sector.

> *"Rating services is a good guide to service users and an incentive to providers however the spectrum for 'good' is so vast those at the higher end feel that their higher standard is not really recognised."*
>
> *User 667 (Provider / professional, adult social care)*

Stakeholder engagement

Several respondents are supportive of the proposal for increased stakeholder engagement between CQC, providers, commissioners and other bodies as a way of improving service monitoring - an issue echoed in responses to other questions. They believe that information-sharing should lead to more targeted intelligence that can be acted upon quickly. One respondent notes this type of engagement is increasingly important as care delivery becomes more complex with the changes arising from Sustainability and Transformation Plans (STPs) and moves towards integrated care.

Support with caveats

A small number of respondents attach a caveat to their support. Where issues are raised in these caveats they are summarised in the relevant issues section below.

5.2.2 Issues

Provider information

Some respondents have reservations about the CQC Insight tool. They express concern about how consistently it will be used by providers and doubt whether it will hold extensive information about every individual service that CQC does not obtain from an initial provider-level registration.

Specific suggestions are made about the PIR which are set out at the end of this section.

Data sharing

Many respondents are concerned about availability of, and access to, data on adult social care services and their performance. A large number of respondents, particularly commissioners, would like existing data to be more accessible than it currently is. They note the long-term plan to develop a single core dataset, but express concern that this still does not exist, and ask when it will be launched. However other respondents express concern about confidentiality and have reservations about how much confidential data will be visible, particularly to the wider public.

Single view of quality

A few respondents express concern that the single view of quality may be misleading. They suggest that some services under a single provider may perform better than others but the overall provider-level rating may hide this variation. Some ask, however, that inspectors do not make assumptions or predictions about outcomes for a given location based on existing results from services in other locations under the same provider.

"This may create issues where one section e.g. children's services does well and another e.g. older person's services fairs poorly. One may mask the other on a single shared view"

User 717 (Provider trade body or membership organisation)

Burden on providers

Some respondents, particularly residential care settings, express concern about the increased administrative burden the new monitoring systems may create, especially from the live PIR process. There is also concern that the process would be complex, especially for small providers with low numbers of administrative staff and often old technology. A few respondents suggest working with and offering training to such providers to help them understand how to manage information returns in this context.

"Members at the workshop were very concerned at the prospect of having to provide further information to CQC on-line, especially smaller localised providers who are currently using paper records - a system that works well for their business"

User 100060 (Provider trade body or membership organisation)

Impact and feasibility

Several respondents question whether the proposals will be feasible, and whether they will have a measurable impact on the quality of adult social care provision. A few respondents note there are fewer sources of data for adult social care than for health care which makes it harder to set a baseline for quality and gain a truly accurate picture of quality of care. A few also discuss the reluctance of some people using services in adult social care to make complaints, which creates further difficulties around assessing quality. This may be a particular issue where providers do not facilitate or encourage complaints and feedback.

Some respondents also note that the usefulness of the data collected depends on intelligence being acted upon. These respondents often make general points about responsiveness, or suggest that CQC should be given more enforcement powers. Some respondents say that stretched finances across services may be a barrier to quality improvement and so scope for enforcement may be limited.

Other respondents believe there is sufficient data available already and that the proposals are unnecessary or that CQC should make better use of existing data.

"However, it remains to be seen how a consensual, shared view of quality will be able to deliver tangible improvements on the ground at a time when social care is in crisis."

User 711 (Voluntary or community sector representative)

Data quality

Several respondents raise concerns about the quality of data that can be collected with some expressing concern that poorly-performing providers may not complete the forms accurately. One respondent argues that some datasets, particularly care at home data, may not be provided in an objective way that is comparable with other data. A few respondents suggest that CQC should focus on identifying key factors that may signal a change in service quality (e.g. staff turnover, management change or a rise in complaints) and ensure that data collection systems pick these up in a timely manner. Measuring some of these could provide early warnings related to quality or trigger early engagement.

Some respondents would also like to know more about the way CQC engages with providers where rating decisions are borderline and would like to see more active reviewing of these providers by CQC. Some also suggest that providers should have a greater ability to update data CQC holds on them that they believe is wrong or out of date.

Some respondents also seek clarity about whether any new information sources for adult social care will be included. Since many say that the availability and quality of adult social care services data is poor, they suggest that new sources of data will be valuable.

"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"

User 735 (Provider / professional, adult social care)

5.2.3 Suggestions

Some respondents raise a wide range of suggestions and queries. These include:

- A request that the proposals are trialled on a small scale to begin with, in a recognised stressed area.
- The introduction of minimum service standards which users of services, families and professionals can understand easily.
- Regular oversight by CQC of commissioning activity.
- That CQC should be able to identify failing providers by gaps in information forthcoming from them.
- That information is shared with landlords of services that are registered within their building.
- One organisation would like to see more cohesion in the quality of data on social, financial and environmental sustainability issues where they relate to resident health and wellbeing and the financial resilience of services.
- Clarification that the regularity of updating a provider statement will not be taken into consideration as part of the regulatory assessment.
- More detail on how night services will be monitored.

A few respondents make suggestions regarding what the online PIR tool should cover. These include:

- Reinstating collection of data that was included within the Learning Disabilities Census
- Data on whether people in services are from the local area or on an out of area placement
- How often the police are called and criminal proceedings brought.
- Deaths in services
- Health and safety procedures
- Safeguarding
- Training

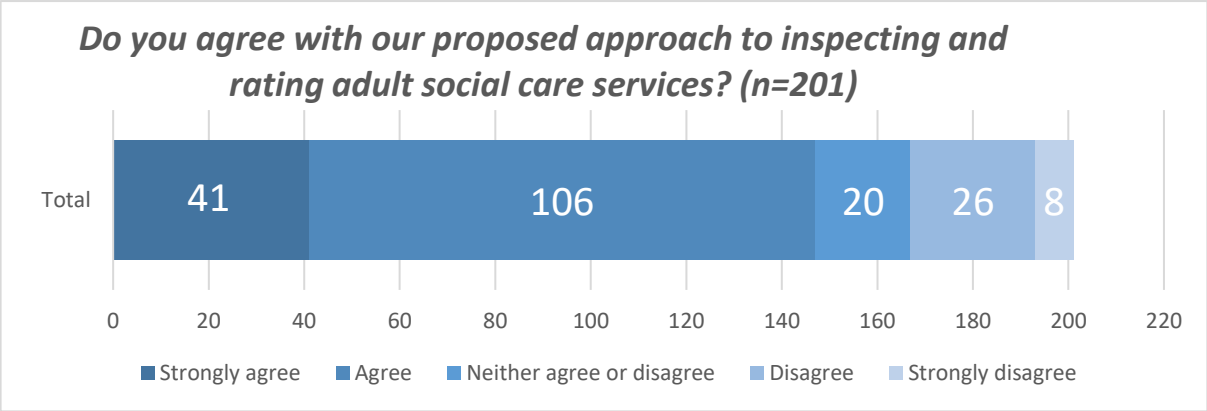
Some organisations suggest information or data which they believe should be used in the monitoring process. These include:

- Diabetes-specific adult social care data
- The British Standards Institution (BSI) standard for adult care services (currently in development)
- National Institute for Health and Care Excellence (NICE) quality standards datasets

5.3 Responses to question 12a

A total of 208[26] respondents answered the closed question 12a, which asks***: 'Do you agree with our proposed approach to inspecting and rating adult social care services?'*** This was a closed question and respondents could choose from five options between strongly agree and strongly disagree.

Chart 10 - Responses to question 12a



Seven respondents provided irregular responses which did not fit into the above categories. This means that they made some form of response to this question that did not follow the closed categories (i.e. 'strongly Agree' to 'strongly disagree'). These responses have been excluded from the chart above and the percentages which follow.

73% of the 201 respondents who answered the closed question 12a agree (52%) or strongly agree (20%) with CQC's proposed approach to inspections and ratings in adult social care. 17% respondents indicate that they disagree (13%) or strongly disagree (4%) with the proposed approach.

5.4 Responses to question 12b

There were 133[27] responses to question 12b submitted via the webform, which states, with reference to question 12a*: '**Please give reasons for your response.**'*

Some of the 133 respondents made comments that were more relevant to other questions within the consultation so these comments have been summarised elsewhere in the report. The analysis below summarises comments from 151 respondents in total which includes responses to question 12b via the online consultation as well as responses received by email.

[26] See breakdown: Table A3 - 13: Responses to Q12a by overall respondent category

[27] See breakdown: Table 2-4: Count of respondents by question by "responding as"

5.4.1 Supportive comments

Comprehensive and focused inspections

Many respondents believe that, overall, the proposals are proportionate in recognising good performance, and focusing on providers rated as requires improvement. Respondents also welcome the flexibility of CQC being able to direct inspection resources where they are needed.

"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"

User 800 (Provider / professional, adult social care)

Frequency of inspections

Many respondents are supportive of the proposed frequency of inspections. Providers which have been rated as good or outstanding argue they have been 'over-inspected' in the past, and that CQC should focus its resources on providers rated as inadequate or requires improvement. The increased time would also allow providers already rated as good to improve further. Nevertheless, several of these respondents also believe that it would be appropriate to have relatively frequent inspections if a recent change, such as new leadership, has taken place. Several also emphasise that monitoring should continue to take place alongside inspections.

"As a consistently good service I feel that the time frame for inspections proposed would be good, as it would take a spectacularly bad manager to bring a service down in that time. But alternatively gives Good service time to work on getting an Outstanding the next time"

User 634 (Provider / professional, adult social care)

The well-led question

Respondents frequently comment that leadership is critical to service quality and they welcome the fact that CQC inspections will continue to always address the well-led key question.

Ratings

Many respondents support the proposals for rating services in adult social care as they believe the system is effective in informing service users about quality. There is wide support for the removal of the 'six-month limit' on seeking rating changes. Respondents that support this believe it will enable ratings to reflect service-improvement more accurately and responsively. They note that waiting six months before a rating can be changed can have a detrimental impact on small businesses and since adult social care providers are often small business, that this has a sector-wide impact.

"It is important to recognise positive changes. It is demoralising for staff to be working in an organisation still rated 'poor ' months after the problems identified in an inspection have been addressed effectively"

User 644 (Voluntary or community sector representative)

Reports

Respondents support the proposal for shorter inspection reports. They believe this will improve communication between inspectors and providers. They support the use of evidence tables and ask that these are made publicly available.

Clear view of care

A few respondents state that the proposals will make the process easier to understand and more transparent. This will give service users a clearer idea of the care they receive.

5.4.2 Issues

Frequency of inspections

Some respondents disagree with the proposals to reduce the frequency of some inspections, seeing it as a backwards step. They note that a service could easily deteriorate in the time between inspections proposed for providers rated as good or outstanding, particularly if management changes. Several raise concerns that information about changes or service deterioration would not reach CQC.

"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"

User 697 (Voluntary or community sector representative)

Reliability and validity of inspections

Some respondents express general concern that the proposals for adult social care inspections will not give a representative and consistent picture of quality of care within a service. There is a specific concern about 'gaming' such as providers only performing well for an inspection and 'covering up' wrongdoings on that day. Some argue for unannounced inspections to overcome this. A few respondents give other reasons for inspections giving a skewed or inconsistent view. These include:

- Ratings depend only on what inspectors see on the day, not accounting for the purportedly uneven nature of services (care at home in particular is viewed as variable in quality).
- Not enough information is received directly from carers.
- Some providers are judged on their approach to dealing with failures in other parts of the local system.
- The practice of inspectors can be variable, and that inspectors are not audited themselves.
- Shortages of inspectors means follow-up inspections cannot happen.

I do know of providers who will 'update the paintwork the night before inspection' so to speak when aware of the date CQC arriving

User 525 (Member of the public)

Use of the well-led question

Some respondents suggest that more clarity is required on the weighting of the well-led question in overall ratings and how this relates to the weightings of the other key questions. They emphasise that inspectors should always take account of the wider context of the service and not over-emphasise results of the well-led question.

Ratings

A couple of respondents express concern about the removal of the 'six-month limit' to rating changes. They believe that it may allow providers rated as poor or requires improvement to 'drift', and that it could increase the fragility of services as progress may not be maintained.

A few respondents raise general issues about the perceived effectiveness of CQC's rating system suggesting it may not accurately reflect a provider's performance in particular services, or that it does not directly support improvements to services.

Several respondents offer suggestions regarding the rating system. These include:

- That ratings are explained clearly to members of the public.
- That more guidance is given on how providers can progress from good to outstanding.
- That more categories of ratings are introduced.

"By only re-inspecting the areas previously identified of concern (and not confirming that areas considered good remain so), CQC will not be getting a complete picture of the provider and things can change significantly in this timeframe"

User 100034 (Provider trade body or membership organisation)

Enforcement

Some respondents comment on how the proposals would be enforced. All believe that enforcement is important, but most would like more detail on how CQC plans to enforce improvement in providers rated as inadequate or requires improvement.

Shorter reports

A small number of respondents raise concerns about the proposal for shorter inspection reports. These relate to the balance which respondents believe must be struck between brevity and detail. They ask for more information about the exact structure of the new reports to understand what information about inspections will remain and how this will help inform readers of the reports.

5.4.3 Suggestions

Some respondents raise specific suggestions. These include:

- Inspections should be more focused on assessing quality of care rather than on documenting care.
- Including details of whether health and safety checks are up to date.
- CQC should publish clearer timescales for re-inspection.
- Faster delivery of inspection reports following an inspection.
- A provision to monitor and inspect dementia training.
- A reduction in the amount of inspection documentation required, to ease the burden on smaller providers.
- Action taken faster with regard to failing services.

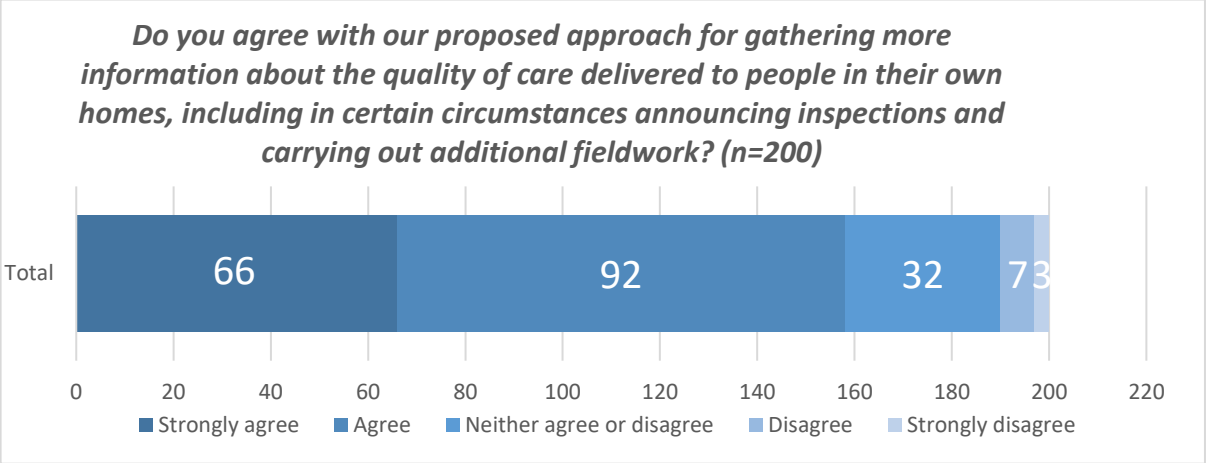
- More coordination of inspection bodies.
- Further evidence should be sought where services accommodate users with severe learning disabilities, such as evidence that the provider has specialist knowledge of such conditions, evidence that individuals are supported to take part in activities, and other specific measures.

5.5 Responses to question 13a

A total of 204[28] respondents answered the closed question 13a, which asks:

'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?' This was a closed question and respondents could choose from five options between strongly agree and strongly disagree.

Chart 11 - Responses to question 13a



Four respondents provided irregular responses which did not fit into the above categories. This means that they made some form of response to this question that did not follow the closed categories (i.e. 'strongly agree' to 'strongly disagree'). These responses have been excluded from the chart above and the percentages which follow.

79% of the 200 respondents who answered the closed question 13a agree (46%) or strongly agree (33%) with CQC's proposed approach to quality of care in people's own homes. 5% respondents indicate that they disagree (3%) or strongly disagree (2%) with the proposed approach.

5.6 Responses to question 13b

There were 137[29] responses to question 13b submitted via the webform, which states, with reference to question 13a: ***'Please give reasons for your response.'***

Some of the 137 respondents made comments that were more relevant to other questions within the consultation so these comments have been summarised elsewhere in the report. The analysis below summarises comments from 157 respondents in total which includes

[28] See breakdown: Table A3 - 14: Responses to Q13a by overall respondent category

[29] See breakdown: Table 2-4: Count of respondents by question by "responding as"

responses to question 13b via the online consultation as well as responses received by email.

5.6.1 Supportive comments

Supporting quality improvement

Many comments generally welcome the introduction of CQC inspections for services providing care to people in their own homes, noting that the variation in quality of care in this sector is widely recognised.

Respondents generally feel that more information about care in this setting will be extremely helpful, and that more focus on safeguarding people receiving care at home is crucial as it is a relatively "hidden" form of care.

Better insights

Some respondents say that the approach proposed by CQC will help inspectors to gain a good insight into the quality of care at home services and will bring adult social care regulation closer to the way other types of care are regulated. Some believe that this will help address purported variation in quality of care in this sector.

"This would mean the CQC could get a better look at some community services, where it is difficult to observe or understand the care provided as it is provided in patients' homes. It would also show how care is coordinated across providers".

User 806 (Provider/professional, NHS trust)

Announced inspections

Several respondents welcome announced inspections of care at home, given the practical difficulties of interviewing staff and service users in this setting. They believe that being given sufficient time to prepare for inspections is particularly important for this reason, as staff will need sufficient time to participate and service users may need tailored support to engage fully with inspectors.

"…[We] welcome the recognition that home based services are different and may need different approach to get the best from them."

User 786 (Provider/professional, adult social care)

However, similar numbers raise concerns about the loss of the 'surprise' element of unannounced inspections, and other methodology issues – these comments are discussed in Section 5.6.2 below.

User involvement

Many respondents welcome the emphasis of user involvement within CQC's approach to care at home inspections. Some make suggestions to develop this, and these are discussed in Section 5.6.3 below.

Other supportive comments

A few respondents noted the following positive aspects of the proposals:

- A greater focus on the leadership of providers of care at home, suggesting that this is crucial in understanding the drivers of high quality or poor quality care.
- A robust approach to inspection will enable more people to choose to receive care at home, allowing more people to choose the care that is best for them.

5.6.2 Issues

Announced versus unannounced inspections

Several respondents comment on the "announced" element of the proposals to inspect care at home. Views on this are mixed; a handful of respondents are clearly opposed to announced inspections. These respondents mention issues such as providers covering up evidence of poor care and potential risk of "gaming" inspections. The rest of the comments tend to welcome announced inspections but note the associated methodological problems around gaining a clear picture of care. A few respondents prefer unannounced inspections but note the practical issue of having sufficient time to talk to service users, carers and staff in this setting.

Many comments touch upon the practical implications and trade-offs of announced versus unannounced inspections. Some suggest there should be a mixture of announced and unannounced inspections; others support the unannounced element to support rigour but suggest ways to make these visits manageable.

We feel that retaining the unannounced nature of inspections would enable the most rigorous quality monitoring in addition to having time to gather the views of service users and their families".

User 831 (Voluntary or community sector representative)

However, some respondents feel that unannounced inspections would be difficult to arrange, and potentially waste inspector time if managers are not available.

Other comments point to specific measures that inspectors could take to improve understanding of services, such as making time to accompany care workers on visits to observe their day-to-day work.

Provider context

Some respondents note that the nature and structure of inspections in care at home settings should depend on the provider's context. Many therefore welcome the introduction of the 'toolkit' to support inspectors to tailor their approach. However, some request further detail on what the toolkit might look like, and offer their support in helping to develop it. Some comments suggest that the proposed toolkit should be consulted upon, particularly through gathering service user input – noting the ongoing difficulty of gaining accurate insights into the experiences of service users. However, most comments welcome the concept in principle. Some also felt that it would help inspectors to be more flexible in their approach, and conscious of a provider's overall context.

"…We would like the detail of [the toolkit] to be consulted upon and trialled […] to ensure that the administrative burden is appropriate, and determine how an announced inspection works in practice".

User 713 (Provider trade body or membership organisation)

Methodology

Some respondents discuss methodology more generally, and the information used by CQC in inspections and monitoring. Comments mention the importance of using as wide a variety of evidence sources as possible, particularly in light of announced inspections which may give a 'hygienic' view of care. They also note the challenges in gathering and using certain types of evidence. For example, one respondent discusses inspector's contact with the relatives of service users:

"When you do the inspections you only speak to whoever is on the premises when it comes to relatives, why do you not invite relatives to come in and discuss the home and care with you, sometimes as you say the person receiving the care finds it difficult to put across their views".

User 567 (Member of the public / person who uses health or social care services)

They also suggest that CQC could use existing sources of information more effectively, though none made specific suggestions.

Service user engagement

Other respondents suggest that CQC continue to develop their methods for engaging service users in their inspection processes, and potentially focus the approach more on service

users than other parts of the inspection process. They generally accept that care at home services are complicated to inspect, and therefore feel that a service user-focused approach will be important in addressing any difficulties.

However, some respondents note the problems inspectors may face in gathering information from people who use services and staff, for example low response levels to CQC inspector queries and the limited amount of time inspectors have available for inspections.

"E.g. In a DCS providing a service to 300 people [we would get feedback from] 10% (30 people). If we visited 6 a day that would take 5 days and require staff from the agency to also be free for that amount of time. Currently local stakeholders rarely respond to our requests for feedback as they always require the name of the person who receives the service, to access their records".

User 522 (CQC employee)

Other comments

A few respondents also raise additional points:

- Some note the long timescales needed to gather some types of information in this setting and the potential distraction that extended inspections could pose to provision of care.
- One comment notes that aspects of care that are not registered, such as supported living services that do not provide personal care, would be out of scope of the regulation.
- A few respondents raised concerns about moving providers rated good or outstanding to longer inspection cycles in the care at home setting. These respondents feel that this presents too high a risk, given the complexity of assessing the quality of care in such settings.

5.6.3 Suggestions

Suggestions raised by some respondents include the following:

- The impact that "publication of failure" may have on providers and their viability, especially given that some evidence may later be discounted.
- The need to address fragmentation in care, namely when those receiving care at home are transferred to hospital for a given reason. Some note that their experiences of this have not been positive.

- In addition to more service user involvement – particularly in the development of the "toolkit" – the need for ongoing stakeholder engagement (i.e. with providers) in the development of inspection approaches in care at home settings.
- Use of mystery shopping in the different inspection methods used in relation to care at home.
- Monitoring of the cleanliness of care at home settings and hygiene practices and training of care staff.
- Encouraging the use of quality management methods and standards such as ISO9001.
- More overt consideration of end of life care in CQC's approach.

Several comments discuss the role of Healthwatch and the potential for them to collect more data about care at home services when gathering public views however this may not necessarily align with the role and experience of Healthwatch. Some respondents request further detail on some aspects of the proposals including:

- How service users would be encouraged to speak about their experiences without fear of reprisal.
- More detail on the exact methods used to gain information from service users receiving care at home.
- A more detailed description of what constitutes "additional fieldwork".
- Whether CQC might explore hybrid approaches to care at home inspections, with some elements of the inspection being announced, and others unannounced.
- Specific details about what the "toolkit" will comprise.
- How the inspection methods will be tested for risk of bias.
- When CQC would start to produce 'evidence table' in judgements.
- Details of the evidence that CQC has considered around what frequency of inspections is most appropriate in this care setting.

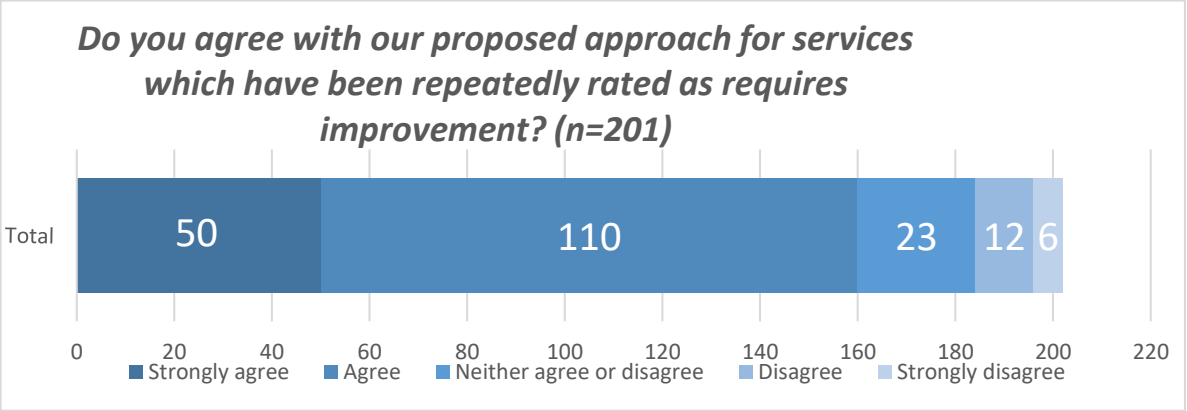
5.7 Responses to question 14a

A total of 206[30] respondents answered the closed question 14a, which asks:

[30] See breakdown: Table A3 - 15: Responses to Q14a by overall respondent categoryTable 2-4: Count of respondents by question by "responding as"

'Do you agree with our proposed approach for services which have been repeatedly rated as requires improvement?' This was a closed question and respondents could choose from five options between strongly agree and strongly disagree.

Chart 12 - responses to question 14a



Five respondents provided irregular responses which did not fit into the above categories. This means that they made some form of response to this question that did not follow the closed categories (i.e. 'strongly agree' to 'strongly disagree'). These responses have been excluded from the chart above and the percentages which follow.

79% of the 201 respondents who answered the closed question 14a agree (54%) or strongly agree (25%) with CQC's proposed approach to services which have been repeatedly rated as requires improvement. 9% respondents indicate that they disagree (6%) or strongly disagree (3%) with the proposed approach.

5.8 Responses to question 14b

There were 131[31] responses to question 14b submitted via the webform, which states, with reference to question 14a: ***'Please give reasons for your response.***

Some of the 131 respondents made comments that were more relevant to other questions within the consultation so these comments have been summarised elsewhere in the report. The analysis below summarises comments from 151 respondents in total which includes responses to question 14b via the online consultation as well as responses received by email.

5.8.1 Supportive comments

Respondents are generally supportive of the new approach for services which have been repeatedly rated as requires improvement. Many respondents express general support for the proposals without giving specific reasons for their support. A few respondents do provide reasons for their support which fall into the following categories.

[31] See breakdown: Table 2-4: Count of respondents by question by "responding as"

Leadership and accountability

Some respondents are pleased that CQC's overall approach to regulation will focus more on the role of leadership and provider-level action to increase accountability and encourage improvement in providers rated as requires improvement. These respondents tend to believe that leadership is a crucial factor in the success and performance of providers.

"Important to hold corporate level leadership accountable as this may be where the root of problems are in constantly failing services e.g. due to lack of investment, resources, support".

User 781 (Voluntary or community sector representative)

Consistency

A few respondents welcome the consistency they feel will be brought by CQC's proposed approach. Some respondents comment that services sometimes perceive inconsistencies in the way they are rated and that these changes should help

Stringency

Some comments support more stringency around providers rated as requires improvement, noting the impact on people who use services of poor or inadequate care. Many say 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.

"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 fully support where needed to increase their rating in a supportive manner".

User 767 (Voluntary or community sector representative)

5.8.2 Issues

Stringency of approach and poor performance

Several respondents feel that the proposals do not go far enough in terms of stringency, or that they are too similar to the existing approach. Many also say that action with regards to underperforming providers should be taken sooner and that these providers should produce action plans in response to their ratings (see "Suggestions" below). They also note that underperformance means that vulnerable adults receive low-quality care, and for this reason CQC's interventions should be early and stringent.

"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".

User 526 (Member of the public / person who uses health or social care services)

Several respondents discuss problems with enforcing better practice in providers rated as requires improvement. They express concerns about perceived poor accountability mechanisms, and often say that regulatory action is not stringent enough and can extend over several years. Some consider whether ratings of requires improvement should be given on multiple occasions without serious intervention, as opposed to an approach which prioritises early intervention.

"Given that services that require improvements are inspected annually, three RI ratings in a row is effectively 3 years of less than adequate care being provided to people using a service".

User 776 (Voluntary or community sector representative)

Some comments on the responsiveness of CQC to providers rated as requires improvement suggest that CQC should enforce requirements around information submission. They suggest that some providers are ignoring some aspects of PIRs, and this may be preventing early intervention.

Gaming and the effect of ratings

Other concerns about enforceability of good practice mention the risk of providers improving 'for the rating' but not upholding the same standards once the inspection and rating process is complete. Such concerns are raised specifically in relation to adult social care, as several respondents are concerned about high financial pressures on this sector compared to others creating negative incentives.

Some suggestions are mentioned to address this, ranging from engaging more with service users to inspect more accurately, to tightening definitions underlying CQC's rating categories

so that it is clear what type of poor practice led to a rating. These respondents feel that some terms and ratings are subjective, because the rating of requires improvement may come about from apparently minor errors around providing information, as well as serious breaches of care.

Engagement with providers

Some respondents support stringency in relation to providers rated as requires improvement, but equally they feel that the process following this rating could be improved and engagement with providers increased, potentially as a way to support improved quality. They also note the pressure that public attention can place on providers, and that, in some cases, this might distract from improvements if providers are given little time to engage with CQC and understand how to improve before public attention gathers.

"Within extra care as the housing provider who is at the forefront of public attention when hosting a failing service we would like to see an appropriate formal involvement and information sharing at the earliest opportunity. Whilst an action plan is shared with the provider's commissioners as arrangements currently stand the [provider is often] excluded from any knowledge of actions or the progress of such reviews".

User 773 (Provider/professional, adult social care)

Transparency

Some respondents comment on the negative impact of the early publication of results from inspections where poor quality is found, though some welcome transparency for the public in principle. One respondent points out that publication of enforcement activity might therefore take place while the appeals process is still open. Some comments on this issue ask for clarity around the complaints process related to CQC's publication of enforcement activity for services rated as requires improvement. In general, there were mixed views about transparency being helpful for the public and patients, but balancing this with treating providers in a fair and proportionate way.

A small number of comments highlight the risk that appeals from providers, could delay the publication of inspection outcomes where there is strong disagreement with the process followed by CQC.

Ratings

Several comments raise concern about how the proposals around provider-level registration relate to the requires improvement rating. Some comments seek clarity on what happens in

the events of mergers and acquisitions, suggesting that there is a risk that acquiring providers could avoid accountability in some circumstances:

"Under this proposal, a care provider with no Requires Improvement rated care homes could acquire a provider with a much larger number …it is not clear whether the formal [process] and potential provider-level sanctions would be applied across the whole of that providers' CQC regulated operations, or those more recently acquired".

User 769 (Provider / professional, adult social care)

Commissioner involvement

Several respondents feel that commissioners should be more involved in developing CQC's approach. For example, they suggest that local authorities and commissioners should be notified when improvement notices had been served, and that if commissioners have a better understanding of assessments and of monitoring activity, then this will help them to plan in terms of capacity and funding.

CQC methodology

CQC's methodology around the requires improvement rating is the subject of some comments. These tend to address the balance between stringency and taking a more risk-based approach, as well as the extent to which CQC should be flexible to provider context.

Views on these issues vary – for example, respondents talk about the importance of stringent enforcement for upholding confidence in CQC's methods, but also about the proportionality of CQC's approach. Some mention balancing a 'rules-based' approach with a process based on monitoring improvements in outcomes and in care. In relation to this, one respondent queries how the rating of one service as requires improvement will impact on a provider as a whole, pointing out different impacts on small versus large providers.

Consistency of approach is an element that some mention as crucial to maintaining confidence. For some respondents, a clearer definition of what "requires improvement" means would support this, as well as more details provided around expected timescales for enforcement action. An example provided demonstrates how some find the definition of 'requires improvement' unclear:

"If a home has several requires improvement that would/should be viewed differently than where there is only one area requiring improvement."

User 812 (Other)

5.8.3 Suggestions

Some respondents suggest that further information should be included in CQC's proposals, including:

- How, and whether, the requires improvement rating will reflect providers' context more than in the current CQC approach.
- How local intelligence, including from Healthwatch reports, will be used by CQC.
- Clarity on what action CQC takes regarding data on abuse, or alleged abuse, in cases where the Crown Prosecution Service decides not to prosecute.
- More face-to-face contact between CQC and providers around ratings of requires improvement, rather than written correspondence.
- The introduction of rules requiring providers rated as 'requires improvement' to produce clear action plans for how they will improve.
- More detail from CQC about the sources of support available to providers rated as poor or requires improvement, beyond the availability of examples of good practice.
- What amount is indicated by the term 'repeatedly'.

Other suggestions include:

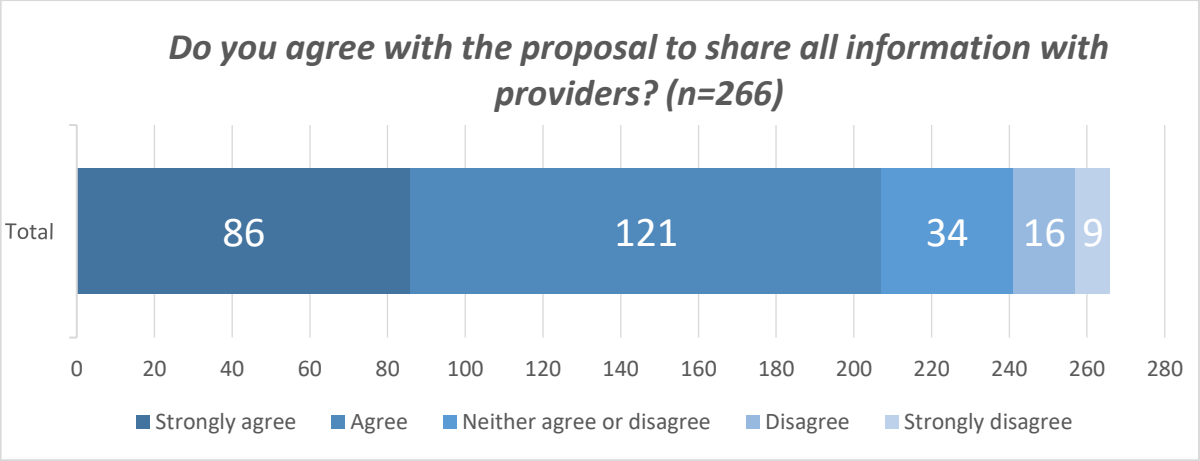
- CQC providing underperforming providers with a clear list of provider-level conditions to work towards to improve their ratings.
- Involving Experts by Experience in Multi-Agency Risk Meetings; also, ensuring the highest level of provider leadership is involved in these.
- The potential to take more urgent action, before Multi-Agency Risk Meetings, where evidence of poor care is particularly compelling.
- More specific emphasis on end of life care.
- More emphasis on root- cause issues that may lead to poor services e.g. corporate culture, local commissioning arrangements, and the local employment market.

6. Fit and proper persons requirement

6.1 Responses to question 15a

A total of 269[32] respondents answered the closed question 15a, which asks: '***Do you agree with the proposal to share all information with providers?'*** To answer this closed question, respondents could choose from five options between strongly agree and strongly disagree.

Chart 13 - Responses to question 15a



Three respondents provided an irregular response which did not fit into the above categories. This means that they made some form of response to this question that did not follow the closed categories (i.e. 'strongly agree' to 'strongly disagree'). These responses have been excluded from the chart above and the percentages which follow.

78% of the 266 respondents who answered the closed question 15a agree (32%) or strongly agree (45%) with CQC's proposal to share all information with providers. 9% of respondents answering question 15a indicate they disagree (6%) or strongly disagree (3%) with the proposed approach.

6.2 Comments about the proposal to share all information with providers

Although 15a is a closed question and did not ask for further comments, several respondents provided comments on the proposal to share information with providers under the nearest questions in the webform (15b and 16), as well as in submissions via email.

[32] See breakdown: Table A3 - 16: Responses to Q15a by overall respondent category

6.2.1 Supportive comments

While several respondents reiterate their answer to the closed question with a high-level comment, some respondents go on to explain the rationale for their support. Respondents highlight how sharing information of concern from third parties will lead to improved transparency. Some of these respondents also link the potential transparency to improving the accountability of senior staff and prevention of mismanagement or misconduct.

"This will improve accountability and promote transparency throughout. It will enable providers (and particularly directors) to hold a comprehensive view over their shortcomings and challenges and will enable them to respond with the processes they have put in place, which will enable CQC to identify gaps and make well-educated analyses about whether an investigation or assessment needs to be undertaken."

User 777 (Voluntary or community sector representative)

6.2.2 Issues

A few respondents highlight potential issues with the proposals to share all information with providers. This include the potential increase in administrative burden, though this is covered in more detail below in response to question 15b. In relation to this, some respondents believe that CQC's existing means of sharing information are adequate, and that the changes suggested in the proposal are not needed.

Respondents also highlight the potential risk the proposal poses to people who speak up given that these individuals may often be the source of information. These respondents, mostly voluntary or community sector representatives, request that confidentiality and protections are maintained.

"Given that CQC is often reliant on whistle-blowers to identify any inconsistencies in the information provided by a nominated individual or to highlight potential failings of a director to be considered a 'fit and proper person', then the CQC must show a duty of care and confidentiality to them."

User 100061 (Voluntary or community sector representative)

A small number of respondents express concern that by asking providers to detail their current processes they may be able to 'game' the system. This could be through falsifying the information or by hiding mismanagement and misconduct.

A few respondents request more detail or information on the proposal. These include:

- the type of information is considered irrelevant
- more information on cybersecurity/data protection
- whether CQC has capacity to implement the proposal
- whether only limited liability partnerships (LLPs) or other types of organisations will be affected by the proposal

6.2.3 Suggestions

Respondents make a variety of suggestions on the proposal to share information. This includes:

- linking the proposal to Duty of Candour
- trialling the proposal to test its success before rolling it out nationally
- allowing providers to request further information on directors from CQC

6.3 Responses to question 15b

There were 138[33] responses to question 15b submitted via the webform, which states*:* ***'Do you think this change [sharing all information with providers] is likely to incur further costs to providers?'***

Some of the 138 respondents made comments that were more relevant to other questions within the consultation so these comments have been summarised elsewhere in the report. The analysis below summarises comments from 142 respondents in total which includes responses to question 15b via the online consultation as well as responses received by email.

6.3.1 Likely to incur further costs

High-level comments

There are 67 respondents who explicitly state that the change is likely to incur further costs. The majority of these respondents are providers, professionals and their trade bodies or membership organisations. Although question 15b is an open question, due to its phrasing many respondents answered with a simple high-level comment such as 'yes' or 'costs will increase'. Some respondents went on to explain why they believe costs will increase. This is covered by the following two subheadings.

[33] See breakdown: Table 2-4: Count of respondents by question by "responding as"

Further costs are manageable or justified

Of the respondents who believe the costs are likely to increase, several providers/professionals do not see this as a significant issue. These comments often describe the potential increases as 'minimal' or 'manageable', in the belief that the change will not cause an undue administrative burden for providers or CQC. Other respondents make a different argument, not about the amount of increased cost but about why it is justified. They argue that the potential benefits of sharing information outweigh the potential burden of increased cost. The detail of these benefits can be found above at 6.2.1.

"We believe this proposal is likely to lead to additional costs the providers, because it is increasing activity that organisations need to undertake. However, [our] view is that it will improve the process around the fit and proper persons requirement, so despite any additional costs, it is something we support."

User 100011 (Provider trade body or membership organisation)

Potential burden of further costs

Some respondents comment that the change is likely to incur further costs, and as a result negatively impact providers and/or service users. In terms of impacts on providers, respondents highlight the potential increase in time spent reading and responding to the shared information. A few of these respondents comment that this will have a particular impact on smaller providers due to their smaller administrative capacity, while others highlight the existing perceived burden of regulation.

"Yes it will, as providers will be asked to detail current processes and this is time consuming. Practices are already at breaking point in terms of administrative burden."

User 801 (Other)

Respondents also link the potential cost burden to wider perceived issues in the health and social care sector such as financial constraints, care home closures and limited information technology.

In terms of cost impacts on service users, a few respondents express the concern that providers will not absorb the increased costs; they are concerned that instead, providers may pass these costs onto service users. A small number of these respondents request that this is not allowed to happen.

6.3.2 Not likely to incur further costs

High-level comments

There are 34 respondents who explicitly state that the change is not likely to incur further costs. As above at 6.3.1, the majority of these respondents are providers, professionals and their trade bodies or membership organisations. Although question 15b is an open question, due to its phrasing several respondents answered with a simple high-level comment such as 'no' or 'costs will not increase'. Some respondents went on to explain why they believe costs will not increase. This is covered by the following subheading.

Cost efficiencies

Several respondents, mostly providers/professionals, argue that costs are not likely to increase as cost efficiencies can be made to mitigate the changes. Some of these comments suggest that providers should be able to absorb any increased costs either through existing good management or future improvements.

"Not necessarily, orgs are required to produce information for a number of commissioning organisations so it is likely they will need to adapt current processes."

User 807 (Health or social care commissioner)

Respondents also comment on the potential for CQC to prevent potential further costs. These comments vary from being supportive of the proposals, arguing that they will streamline regulation and so save money, to critical, suggesting that while the proposal would increase burden CQC should absorb further costs.

6.3.3 Other comments on costs

High-level comments

There are 30 respondents who state that they are unsure whether the change is likely to incur further costs. Although question 15b is an open question, due to its phrasing a few respondents answered with a simple high-level comment such as 'maybe' or 'I'm not sure'. Some respondents went on to explain the conditions uncertain which could determine whether costs would increase or not. This is covered below.

Conditions for potential further costs

Some respondents argue that costs may or may not increase due to different conditions. One of these conditions is the volume and/or type of data which is shared. Respondents, mostly providers/professionals, state that if data is of poor quality, inaccurate or vexatious in nature this could waste resource. Similarly, respondents comment that if data is contentious

or of a particularly serious nature, they may have to pay for legal advice and/or external consultants.

"It may, in some circumstances, be necessary or desirable to appoint external investigators to evidence transparency, this would have cost implications."

User 778 (Provider / professional, housing with care / extracare housing)

Respondents also highlight that the efficiency of provider management may influence the potential for further costs. This is similar to the point made above at 6.3.2. under 'Cost efficiencies' but emphasising that while some well-run providers may be able to prevent further costs, poorly managed providers may see further costs.

A small number of respondents state that potential costs increases are dependent on information or details that they do not yet have access to. This includes the details of what information CQC holds on managers, how costs will be managed and a 'regulatory impact assessment'.

6.4 Responses to question 16

There were 137[34] responses to question 16 submitted via the webform which states*:* ***Do you agree with the proposed guidance for providers on interpreting what is meant by "serious mismanagement" and "serious misconduct"?***

Some of the 137 respondents made comments that were more relevant to other questions within the consultation so these comments have been summarised elsewhere in the report. The analysis below summarises comments from 168 respondents in total which includes responses to question 16 via the online consultation as well as responses received by email.

6.4.1 Supportive comments

High-level comments

There are 102 respondents who explicitly mark their support for the proposed guidance. The majority of these respondents are providers, professionals and their trade bodies or membership organisations. Although question 16 is an open question, due to its phrasing many respondents answered with a simple high-level comment such as 'yes' or 'I agree'. Some respondents went on to explain their rationale for support. This is covered by 'potential benefits' below.

A further 22 respondents mark support for the proposed guidance with caveats. Similarly, a large proportion of these respondents answered with a simple 'yes' or 'I agree'. Some of

[34] See breakdown: Table 2-4: Count of respondents by question by "responding as"

these respondents went on to explain the proposals' potential benefits, covered below, and/or their potential issues (see 6.4.2).

Potential benefits

Several respondents highlight the proposals' potential for increased clarity and accessibility. Some of these respondents identify specific aspects of how the proposals may improve clarity. This includes the provision of examples of mismanagement and misconduct, clarifying the distinction between these types of professional breaches and how these relate to management responsibilities.

"We agree with the proposed guidance (Annex A, at 61 of the consultation document), as it will offer greater clarity about the obligations and responsibilities of those holding such roles."

User 100011 (Provider trade body or membership organisation)

Some respondents, mostly providers/professionals, go further to suggest that the proposed guidance may improve the quality of health and social care. They argue that the guidance will help maintain standards of professionalism and hold management accountable.

6.4.2 Issues

High-level comments

There are ten respondents who explicitly mark their opposition to the proposed guidance. Although question 16 is an open question, due to its phrasing a few respondents answered with a simple high-level statement such as 'no' or 'I do not agree'. The remaining respondents went on to explain why the oppose the guidance. This is covered by 'potential benefits' below.

Interpretation

One issue respondents raise is potential misinterpretation of the proposed guidance. Respondents criticise the perceived ambiguity of the language, citing examples such as 'reasonable' and questioning how one can accurately measure an individual's performance against this term. There are two broad reasons for concern; the first is that the guidance may be used too punitively against members of staff for minor acts of mismanagement or misconduct; the second is that providers may use the guidance in a 'creative' of 'fluid' manner to hide poor practice.

"The suggested drafting in 'mismanagement' needs to be tighter. The drafting included in the draft guidance is very wide and very subjective which could lead to the provisions being widely interpreted."

User 712 (Provider / professional, acute or single specialty hospital)

Implementation

Some respondents express concerns about how the proposed guidance may be implemented. These concerns include potential administrative burden, legalistic language preventing it from being applied simply and CQC working beyond its remit. In relation to the last point, one observation is that the guidance may not align with existing HR guidance within organisations. A small number of respondents suggest that the guidance would need a statutory basis for it to be implemented successfully.

A few respondents believe that the guidance could be implemented punitively, putting off potential director candidates, opening managers up to vexatious claims and punishing them for working under stressful conditions.

"Some of the examples of mismanagement could happen to managers under pressure, or be difficult to prove that they had not occurred."

User 724 (Health or social care commissioner)

More detail or information required

Some respondents suggest that more detail or information is required for the proposal to be acceptable. While several of these comments are high-level comments asking for more detail in general, some respondents have more specific questions:

- whether the reference to convictions includes protected convictions
- whether investigations closed without action be considered
- how elected members relate to the guidance
- to what extent the rehabilitation for previous mismanagement/misconduct is considered
- how the guidance will apply to partnerships and sole traders

6.4.3 Suggestions

Respondents make a variety of suggestions on how the guidance could be altered. Some of these comments suggest that the guidance should widen its scope. This includes examining:

- previous employment
- potential conflicts of interest
- membership of organisations linked to intolerance/prejudice

- safeguarding concerns

Similarly, respondents also suggest a more proactive approach:

- Guidance should be applied to all staff dismissals;
- Guidance should be applied to staff cleared of allegations by other regulators;
- Guidance should have the power to remove people from their posts;
- Guidance should consider the factors which lead to serious mismanagement and serious misconduct.

Other suggestions focus on how the guidance could support members of staff:

- face to face briefings on the guidance
- a mentor to discuss the guidance with
- use ISO 9001, NICE and SCIE guidance to aid good management and care

The General Medical Council and Nursing and Midwifery Council state that their own standards/code need to align with the guidance. Similarly, a few respondents highlight how the checks required by the Charity Commission for trustees may overlap and should be aligned with CQC's proposed guidance.

Two more technical suggestions are replacing the term 'management' with 'governance' and including case histories or vignettes to illustrate examples of mismanagement and misconduct.

7. Other comments from consultation events

CQC held ten consultation events between June and July 2017 including meetings with providers, stakeholder organisations and members of the public. The number of attendees varied for each event, as did the topics that were the focus of conversation. The key themes arising from each event are summarised below.

For the public, events were organised to reach a broad spectrum of the population including seldom heard communities to ensure they could inform CQC's 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. The provider events described below were used to further refine the proposals and provide timely updates to key stakeholders across the sectors.

7.1 Speak Out Events

Speak Out is a national network of community groups representing people from seldom heard communities. CQC organised four different Speak Out events during the consultation period to seek the views of healthcare organisations and members of the public in a variety of locations. The events consisted of three focus groups and a workshop which included 12 Speak Out groups. They commented on the following aspects of CQC's proposals.

Regulation in a changing landscape

Participants supported the inclusion of all organisations with accountability for care on CQC's register. They commented that this would encourage senior managers to take more responsibility for monitoring and improving care at all levels within their organisation. Participants also supported the proposals to assess quality across local systems.

Comments on primary medical services

Gathering views from users: Attendees stated that post-appointment text messages may encourage feedback to CQC and providers. They also suggested that CQC should continue to engage with Patient Participation Groups (PPGs) to ensure they are as effective as possible at collecting feedback from patients.

Reporting and inspection: Some participants stated that CQC should focus on providers with known problems. In contrast, others felt five years between inspections is too long. Participants also requested information on waiting times and what service providers offer. They expressed concern around their accessibility for those with learning difficulties.

Comments on adult social care

Gathering views from users: The participants from one focus group stated that it was important to include information from care workers. They explained that these staff members would understand the situations best. Attendees expressed concerns around giving feedback and how it might impact on their care. As an alternative, they suggested using

modern technology such as smartphone apps or Skype calls although they also recognised the barrier of varying levels of IT literacy.

Reporting and inspection: Attendees expressed concern around less frequent inspections. They stated that this may lead to complacency around care quality. Considering this, some attendees suggested more frequent inspections. They also suggested that if inspections are less frequent, they should be more thorough. Participants stressed the importance of clear and concise reports. As with primary medical services above, participants expressed concern around their accessibility for those with learning difficulties.

7.2 Experts by Experience (ExE) and online community

Two workshops were held in Birmingham for Experts by Experience to discuss CQC's proposals for regulating primary medical services and adult social care. Additional feedback on these two aspects of the proposals was obtained through public online community tasks.

Comments on primary medical services

Approach to registration: Some attendees supported the proposals as they felt they would lead to more accurate ratings and make clear where accountability lies. Some believed the proposals are unnecessary as they are only interested in the level of care provided at the services they have used. Participants also supported including the name of the provider who is accountable on the register and stressed that this information needed to be clearly visible.

Gathering views from users: Participants suggested various possibilities using different methods of communication. This included:

- online and paper forms
- attending on days when more people are at a practice but not necessarily ill (e.g. flu clinic)
- asking people who have responded in the past
- mystery shoppers.

Reporting and inspection: Attendees stated that five year gaps between inspections could be problematic as quality can change. Instead, they suggested more regular inspections to help promote best practice and supported the proposals for more focussed inspections. They requested easy to read and non-repetitive reports free from jargon.

Wider context: Participants expressed concern about quality of care and barriers to new models of care. They alleged that staff from Primary Care Trusts brought poor culture into CCGs. The group commented on the impact of budget cuts on services and waiting times. They believed that with pressure on services and without enough resources, services will fail.

Comments on adult social care

Gathering views from users: For domiciliary care, participants suggested that communication should be designed with service users. They stated that this would ensure it is suitable for

the individual user and that it asks the right questions. Participants also suggested utilising various methods beyond questionnaires. This included focus groups, workshops and telephone calls to get a wide range of feedback. Attendees also discussed using provider intelligence to improve monitoring such as how often people contact CQC or other organisations.

Encouraging improvement: Attendees stated that there should be forums for providers to share best practice. Instead of an inspection report, they suggested that CQC could give providers examples of what best practice looks like. They felt that it is important to give timeframes and identify areas for improvement. If there is no improvement, participants felt there should be penalties and enforcement actions. They did caution against adopting a universal approach given varying contexts. Managers may be doing a good job but lack support. Large providers may face different challenges to small providers.

Wider context: Some participants highlighted the effectiveness of their local services. Others described negative experiences. Attendees also suggested more connections between health and social care to increase effectiveness. This included hospitals providing offices to social workers to smoothen service user pathways.

7.3 GP co-production meeting

The meeting included a mix of providers, commissioners, public and provider representative organisations and Experts by Experience. The discussion centred on CQC's proposals for primary medical services.

Monitoring: Participants queried how CQC will engage with PPGs. Some expressed concern that the provider information collection (PIC) could be biased and manipulated by providers and suggested that questions should not be geared towards simple answers to avoid this. Participants also stated that CQC should collect information every two years. Attendees suggested that CQC should ask providers to be specific about the issues they face and how they are dealing with them. They believed this will help ensure there is a wider context to information collected.

Reporting and inspection: Participants generally agreed with focused rather than comprehensive inspections and suggested that CQC's default position should be that most GPs are giving a high level of quality care. However, they did support CQC in identifying those who are performing badly and taking action. They stated that ‘good’ as a rating of care is too broad of a category. They did not believe this gives a clear view of provider quality or how it can improve to ‘outstanding’. Attendees supported only rating population groups in the effective and responsive key questions.

Participants supported changing CQC's reports. Attendees believed that they could be more accessible and explain why providers meet standards or not. In relation to accessibility, participants queried how to best share reports with patients. They also requested an example of what high quality care looks like for each key question and a glossary for key terms.

7.4 LGBT Consortium

In partnership with the LGBT Consortium, CQC held two focus groups in Manchester and Brighton with people identifying as LGBT. The discussions focused on what ‘good’ care in primary medical services looks like in practice.

Gathering views from users: Participants supported the use of PPGs and other groups to ensure representation of minorities. They stated that it was important both to be anonymous and encourage feedback.

Reporting and inspection: Attendees agreed with the proposed frequency of inspections with two caveats; quality assurance processes must be robust, and it must be more than a cost-saving exercise. They stated that it is important for reports to be accessible for a wide range of people. Participants also suggested that meeting people where they use services may ensure accurate and timely feedback.

Wider context: Participants made general comments on what 'good' care should look like. This included patient-focused care, direct communication, and adapting care for different people.

7.5 Dental reference group

The meeting included providers, provider representative organisations, defence unions, NHS England, Healthwatch and other regulators. The discussion focused on the proposals about the structure of the register.

Approach to registration: Some participants supported the proposals. They stated that it may reduce the burden faced during registration. Others expressed concern about the potential burden for providers due to the amount of information they may need to provide. They observed that new partners with strong track records would be low risk. As a result, they suggested that CQC should reduce the amount of information they need on these individuals.

7.6 Adult social care co-production

The meeting included providers, charities, public and provider representative organisations, the Social Care Institute for Excellence, Skills for Care and Experts by Experience. The discussion focused on CQC’s proposals for a provider-level assessment.

Provider-level assessment: Some participants stated that CQC should not lose focus on the local level as individual service managers are the ones that “make the policies real”. They queried how the corporate level assessment would influence the local level assessment and the impact this could have on an organisation’s brand. Attendees also suggested that CQC should learn from the new standards recently introduced in Scotland.

8. Other comments about CQC and wider context

It is common in consultations for respondents to make comments outside the scope of the specific questions. For this consultation, respondents often commented on the wider environment in health and social care, general views about CQC or the way in which the consultation was presented and conducted. These comments are summarised below.

Criticism of the consultation

Some respondents challenge the way the consultation has been conducted with a range of comments stating that the consultation documentation is unclear, difficult to read, lacking in detail or overly complex and technical.

A few respondents suggest that the consultation process is not meaningful. One respondent suggests that the previous fees consultation is an example of CQC turning 'a resolutely deaf ear' and calls for their views to be given more consideration in this consultation.

Some respondents, including members of the public and respondents from provider trade body or membership organisations, also comment on the methods available to engage with the consultation. They argue that a reliance on technology can mean that some people are excluded with some respondents suggesting that they were unable to use online comment boxes in the way they would have liked.

Overall comments about CQC

Many respondents express a general view about CQC as an organisation or its role in the wider health and social care system. Most of those who make comments about CQC outside the scope of the questions make negative comments, though some organisations make positive comments.

Respondents who are critical of CQC describe it variously as 'ineffectual', 'pointless', 'impersonal' or 'not fit for purpose'. They feel that CQC does not effectively perform its role as regulator and argue there is no evidence to suggest that CQC contributes to improving patient care. They are also critical of the regulatory burden imposed by CQC, the cost of CQC to providers and their current regulatory approach.

Those who comment positively are typically organisations rather than individuals, who say that they have a good relationship with CQC and welcome the opportunity for future cooperation.

Some organisations call for improved cooperation or engagement between CQC and their organisation, including greater collaboration on issues such as data sharing and reducing administrative burden for providers. Some also welcome CQC's proposals for improving their engagement with other national bodies such as NHS England and local groups including Clinical Commissioning Groups (CCGs) and Patient Participation Groups (PPGs).

Criticism of CQC approach and perceived poor practice

Several respondents criticise CQC's current practice. They raise incidents in which they feel general practice has been unfairly criticised, where they feel that poor advice has been given by CQC or inspectors, or where the regulations have been applied inconsistently across different practices.

They are also critical of the ratings system used by CQC, arguing that an outstanding rating requires a level of service beyond that which could be reasonably expected, or suggesting that one overall rating cannot adequately reflect the complexities of healthcare delivery.

General approach to inspection

Several respondents suggest that inspections should be more frequent and the inspection schedule should include unannounced inspections and spot checks, as well as evening and weekend visits and 'secret' inspectors.

Some respondents, most of whom are providers or organisations, say that CQC should adopt a risk-based policy with inspections focused on key issues or areas of concern. They also call for greater consistency across inspections and suggest defining key performance metrics, such as access to GPs, nursing home availability or delayed transfer of care.

A few respondents discuss perceived problems with the consistency of inspections and inspector approaches. Some mention that they have challenged decisions, and feel that information in reports may not always be current or up to date.

Bureaucracy and burden

Several respondents comment on the burden which they feel CQC regulation places on providers. They argue that the perceived high level of regulation reduces the amount of time for the care or treatment of service users and places staff, most often GPs, under an increased level of stress. A few respondents believe that CQC is over-regulating and another layer of regulation may lead to unnecessary burden and expense for providers.

Provider fees

Some respondents comment on CQC's operating costs, arguing it is too expensive and that the cost of regulation falls on providers and the NHS at a time when funding is not readily available. A few respondents are concerned that provider fees will increase as a result of the various proposals.

Service pressures and funding for health and social care

Many respondents comment on the financial pressures facing the wider health and social care services, with most suggesting that underfunding and a lack of resources contributes to poor or sub-standard performance across the healthcare system.

One respondent argues that there is a correlation between general practices receiving less funding per patient and being awarded lowing ratings.

Some respondents question whether CQC has enough resources to deliver the proposals in this context of tightened finances both for themselves and the wider health and social care sector.

Protecting and supporting specific population groups

A few respondents call for greater focus on the protection or support of particular groups within health and social care services, such as the elderly and people with dementia or a learning disability. They call for the regulatory framework to be developed in such a way as to afford these groups proper consideration.

Data and IT systems

A small number of responses also express concern about the availability and utility of data relating to healthcare, the security and effectiveness of IT policy and systems.

Suggestions

Many respondents make wide-ranging suggestions about CQC operations or issues within the wider health service. These include:

- Prioritisation of resources allocation to services receiving a rating of ‘requires improvement’.
- Better information about how to contact CQC.
- Provision of comment cards for consultation responses;
- A dentistry-specific consultation response form.
- Preventing legal entities without a legally acceptable base in England from registering as a service provider with CQC.
- Measures to ensure appropriate prescription and use of medicines.
- Abolishment of private care homes and transfer to local council control.

Appendix 1: Consultation questions

PART 1: REGULATING IN A COMPLEX CHANGING LANDSCAPE

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

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?

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?

1.2 Monitoring and inspecting new and complex providers

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?

[*Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree*]

3b Please explain the reasons for your response.

1.3 Provider-level assessment and rating

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

[*Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree*]

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

1.4 Encouraging improvements in the quality of care in a place

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

[*Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]*

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

PART 2: NEXT PHASE OF REGULATION

2.1 Primary medical services

6a Do you agree with our proposed approach to monitoring quality in GP practices? [*Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree*]

6b Please give reasons for your response.

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

[*Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree*]

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.)

[*Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree*]

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?

[*Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree*]

9b Please give reasons for your response.

10a Do you agree with our proposed approach for regulating the following services? [*Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree*]

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).

2.2 Adult social care services

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?

[*Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree*]

11b Please give reasons for your response.

12a Do you agree with our proposed approach to inspecting and rating adult social care services?
[*Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree*]

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?
[*Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree*]

13b Please give reasons for your response.

14a Do you agree with our proposed approach for services which have been repeatedly rated as requires improvement?
[*Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]*

14b Please give reasons for your response.

PART 3: FIT AND PROPER PERSONS REQUIREMENT

15a Do you agree with the proposal to share all information with providers?
[*Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree*]

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”?

Appendix 2: Coding framework

Below is a key to acronyms used within the codes to analyse the responses to the consultation:

ASC	Adult social care
C	Context (wider NHS, CQC organisational issues)
CO	Consultation process
CP	Complex providers
FPP	Fit and proper persons requirement
OTH	Other (includes codes such as ‘no comment’ and ‘refer to other comment’)
PLA	Provider-level assessment
PM	Primary medical services
QCP	Quality of care in a place
R	Registration

ASC - Care at home - announced - comments
ASC - Care at home - announced - oppose
ASC - Care at home - announced - suggestion
ASC - Care at home - announced - support
ASC - Care at home - announced - support/suggestion
ASC - Care at home - depends on provider context
ASC - Care at home - engagement is important
ASC - Care at home - issue - announced
ASC - Care at home - issue - burden
ASC - Care at home - issue - fragmentation of care
ASC - Care at home - issue - improvement needed
ASC - Care at home - issue - information used
ASC - Care at home - issue - inspectors/ inspection methodology
ASC - Care at home - issue - leadership
ASC - Care at home - issue - methodology
ASC - Care at home - issue - methods
ASC - Care at home - issue - more service user engagement needed
ASC - Care at home - issue - more stakeholder involvement needed
ASC - Care at home - issue - practical issues
ASC - Care at home - issue - publication of failure
ASC - Care at home - mixed view
ASC - Care at home - more detail needed
ASC - Care at home - negative - methodology
ASC - Care at home - negative - use of existing information
ASC - Care at home - no sentiment expressed
ASC - Care at home - positive - impact on standards/improvement
ASC - Care at home - positive - information
ASC - Care at home - positive - level playing field
ASC - Care at home - positive - methodology
ASC - Care at home - positive - patient benefit
ASC - Care at home - positive - protecting people
ASC - Care at home - positive - support for providers
ASC - Care at home - positive - user involvement
ASC - Care at home - query

ASC - Care at home - rate - support
ASC - Care at home - risk - burden
ASC - Care at home - suggestion
ASC - Care at home - support
ASC - Care at home - support for home-based care
ASC - Care at home - support proposals
ASC - Example(s)/case study provided
ASC - General - positive - improvement needed
ASC - General - positive - supporting choice
ASC - General - service user engagement
ASC - General comments
ASC - General comments - quality of care issues
ASC - General suggestion
ASC - Information - needs more detail
ASC - Information - risk - gaming
ASC - Inspect - positive - focused inspections
ASC - Inspect - announced - comments
ASC - Inspect - frequency of inspections
ASC - Inspect - frequency of inspections - no reduction
ASC - Inspect - issue - enforceability
ASC - Inspect - issue - reports
ASC - Inspect - issue - standards
ASC - Inspect - need more detail
ASC - Inspect - negative - inconsistent
ASC - Inspect - negative - insufficient
ASC - Inspect - negative - weighting
ASC - Inspect - neutral/mixed view
ASC - Inspect - oppose
ASC - Inspect - positive - clear view of care
ASC - Inspect - positive - fairness
ASC - Inspect - positive - focus on failing providers
ASC - Inspect - positive - focused inspections
ASC - Inspect - positive - practical/proportionate
ASC - Inspect - positive - reduced inspection burden
ASC - Inspect - positive - shorter reports
ASC - Inspect - positive - transparent
ASC - Inspect - provider management/leadership
ASC - Inspect - publication of failure
ASC - Inspect - query
ASC - Inspect - risk - announced/planned
ASC - Inspect - risk - burden
ASC - Inspect - risk - gaming
ASC - Inspect - risk - impact
ASC - Inspect - risk - inspectors and issues with
ASC - Inspect - risk - skewed view
ASC - Inspect - suggestion
ASC - Inspect - suggestion - follow up
ASC - Inspect - suggestion - stakeholder engagement
ASC - Inspect - supplement with monitoring
ASC - Inspect - support
ASC - Inspect - support with caveats
ASC - Issue - stakeholder or service user engagement
ASC - Issue - support for carers

ASC - Monitor - enforcement
ASC - Monitor - inspections are important
ASC - Monitor - issue - continuous assessment
ASC - Monitor - issue - CQC Insight
ASC - Monitor - issue - data quality
ASC - Monitor - issue - enforcement
ASC - Monitor - issue - PIR issues
ASC - Monitor - issue - provider-CQC engagement
ASC - Monitor - issue - quality of data
ASC - Monitor - need more detail
ASC - Monitor - negative - burden
ASC - Monitor - negative - CQC Insight
ASC - Monitor - negative - data quality
ASC - Monitor - negative - disproportionate
ASC - Monitor - negative - duplication
ASC - Monitor - negative - effective insights
ASC - Monitor - negative - preventing tragedies
ASC - Monitor - negative - risk of gaming
ASC - Monitor - negative - self-certification
ASC - Monitor - negative - single view of quality
ASC - Monitor - negative - too complex
ASC - Monitor - negative - unfair comparison
ASC - Monitor - neutral/mixed view
ASC - Monitor - oppose
ASC - Monitor - positive - avoids duplication
ASC - Monitor - positive - benefits inspections
ASC - Monitor - positive - consistency
ASC - Monitor - positive - consistency of care/variation
ASC - Monitor - positive - consistent/clear approach
ASC - Monitor - positive - CQC Insight
ASC - Monitor - positive - improved standards
ASC - Monitor - positive - info/ detail
ASC - Monitor - positive - informs service users
ASC - Monitor - positive - real-time monitoring
ASC - Monitor - positive - see quality of whole provider/service
ASC - Monitor - positive - single/shared view of quality
ASC - Monitor - positive - stakeholder engagement
ASC - Monitor - positive - supports integration
ASC - Monitor - positive - transparency
ASC - Monitor - query
ASC - Monitor - risk - abandon individuals
ASC - Monitor - risk - data sharing
ASC - Monitor - risk - feasibility
ASC - Monitor - risk - impact
ASC - Monitor - suggestion
ASC - Monitor - suggestion - data collected
ASC - Monitor - suggestion - early intervention/recs
ASC - Monitor - suggestion - lack of data warning sign
ASC - Monitor - suggestion - support for providers
ASC - Monitor - support
ASC - Monitor - support with caveat
ASC - Monitor - support with caveats
ASC - PIR - Issue - information sharing/burden

ASC - Proposals should include (X)
ASC - Rate - negative - inadequate
ASC - Rate - positive - informs service users
ASC - Rate - positive - rating changes
ASC - Rate - query
ASC - Rate - risk - impact
ASC - Rate - six-month limit
ASC - Rate - suggestion
ASC - Rate - suggestion - consistency
ASC - Rate - support
ASC - Registration - query
ASC - Registration - support
ASC - Report - oppose
ASC - Req, imp. - issue - commissioner involvement
ASC - Req. imp. - issue - CQC methodology
ASC - Req. imp. - issue - depends on provider context
ASC - Req. imp. - issue - enforceability
ASC - Req. imp. - issue - leadership
ASC - Req. imp. - issue - responsiveness
ASC - Req. imp. - issue - thresholds
ASC - Req. imp. - issue - transparency (and public sharing of failure)
ASC - Req. imp. - issue - user involvement
ASC - Req. imp. - oppose - current approach wrong
ASC - Req. imp. - oppose - more stringency needed
ASC - Req. imp. - positive - addresses failure/supports improvement
ASC - Req. imp. - positive - impact on patients
ASC - Req. imp. - positive - transparency
ASC - Req. imp. - similar to current approach
ASC - Req. imp. - support stringency
ASC - Req. imp.- more detail needed
ASC - Req. imp.- proportionate approach needed
ASC - Req. imp.- query
ASC - Requires improvement - issue - concept
ASC - Requires improvement - issue - implementation
ASC - Requires improvement - issue - improvement, impact on
ASC - Requires improvement - issue - inspectors and issues with
ASC - Requires improvement - issue - published information
ASC - Requires improvement - issue - risk
ASC - Requires improvement - need more detail
ASC - Requires improvement - positive - provider engagement
ASC - Requires improvement - positive - reporting
ASC - Requires improvement - positive - supports accountability/transparency
ASC - Requires improvement - query
ASC - Requires improvement - risk - gaming
ASC - Requires improvement - Services need more support/info
ASC - Requires improvement - suggestion
ASC - Requires improvement - support
ASC - Requires improvement - support with caveat
ASC - Requires improvement - unnecessary
ASC - Requires improvement - urgent action needed
ASC - Suggestion
ASC - Support proposals
ASC - Wider funding/policy context

ASC - Wider policy/funding context
C - Comments on current GP monitoring
C - Comments on problems in services/care
C - Context
C - CQC - Aims/goals of org
C - CQC - bureaucracy/burden/doubt methods
C - CQC - cost
C - CQC - cost of regulation
C - CQC - criticise current practice
C - CQC - criticism of current practice
C - CQC - effective
C - CQC - expertise of inspectors
C - CQC - How CQC gathers feedback/info
C - CQC - ineffective
C - CQC - Inspectors
C - CQC - internal issues
C - CQC - negative general view
C - CQC - positive comment
C - CQC - previous consultation
C - CQC - provider fees concern
C - CQC - ratings and inspections general
C - CQC - relationship with patient groups
C - CQC - reports and information
C - CQC - resource allocation
C - CQC - scope of work
C - CQC - suggestion
C - Integration of services
C - ISO 9001
C - NHS - general practice
C - NHS - hospitals
C - NHS - integration
C - NHS funding/policy
C - Pressure on GPs
C - Proposals - general concern
C - Proposals - general positive comment
C - Proposals - general positive comments
C - Proposals - general positive with caveat
C - social care - underfunding
C - Social care funding
C - Suggestion
C - Wider issues (health policy and other)
C- NHS - contracting
CO - Challenge/criticism
CO - Consultation documentation - comment/criticism
CO - Event feedback
CO - Info/materials - omission/vague
CO - more information needed
CO - Omission/vague
CO - Q10 - Challenge/criticism
CO - Q10 - Request further engagement
CO - Q11 - Info/materials - omission/vague
CO - Q13 - Info/materials - omission/vague
CO - Q16 - Challenge/criticism

CO - Q1a - Request further engagement
CO - Q1b - Request further engagement
CO - Q2 - Request further engagement
CO - Q3 - Info/materials - omission/vague
CO - Q3 - More information needed
CO - Q3 - Request further engagement
CO - Q4 - comment/criticism
CO - Q4 - Info/materials - omission/vague
CO - Q4 - more information needed
CO - Q4 - Request further engagement
CO - Q5 - Info/materials - omission/vague
CO - Q5 - Request further engagement
CO - Q6 - Challenge/criticism
CO - Q6 - Info/materials - omission/vague
CO - Q6 - Request further engagement
CO - Q7 - Challenge/criticism
CO - Q7 - Readability
CO - Q8 - Request further engagement
CO - Q9 - more information needed
CO - Q9 - Readability
CO - Q9 - Request further engagement
CO - Readability
CO - Request further engagement
CO - Scope (ASC)
CO - Suggestion
CP - Concern - ACS/STP
CP - Concern - bureaucracy/burden
CP - Concern - complexity
CP - Concern - cooperation
CP - Concern - cost
CP - Concern - data
CP - Concern - definition
CP - Concern - effectiveness
CP - Concern - independent providers
CP - Concern - inspections
CP - Concern - lack of detail
CP - Concern - single relationship-holder
CP - Concern - turnaround
CP - General - neutral
CP - General - oppose
CP - General - query
CP - General - suggestion
CP - General - suggestion - feedback
CP - General - support
CP - General - support with caveats
CP - Support
CP - Support - accountability
CP - Support - best practice
CP - Support - collaboration
CP - Support - consistency
CP - Support - coordination
CP - Support - improvement
CP - Support - independent providers

CP - Support - inspections
CP - Support - monitoring
CP - Support - quality/safety
CP - Support - responding to change
CP - Support - service user choice/trust
CP - Support - single relationship-holder
CP - Support - system effectiveness
CP - Support - testing
CP - Support - transparency
CQC - Areas for improvement
CQC - Data sharing
CQC - Fees
CQC - How CQC gathers feedback/information
CQC - Issues with inspection
CQC - Patient advocacy
CQC - Query
CQC - Relationship with PPGs
CQC - Relationship with providers
CQC - Scope of CQC's work
CQC - Stakeholder engagement
FPP - Costs - (maybe) depends on level/type of data
FPP - Costs - (maybe) depends on provider quality
FPP - Costs - (no) efficiencies can/should be made
FPP - Costs - (no) would streamline process
FPP - Costs - (yes) burden on providers
FPP - Costs - (yes) burden on service users
FPP - Costs - (yes) increase justified
FPP - Costs - (yes) would be manageable
FPP - Costs - more info/detail required
FPP - Costs - no
FPP - Costs - oppose/minimise further costs
FPP - Costs - unsure/maybe
FPP - Costs - yes/probably
FPP - Guidance - benefit - clear/easy to understand
FPP - Guidance - benefit - will improve care
FPP - Guidance - issue - burden
FPP - Guidance - issue - implementation
FPP - Guidance - issue - interpretation
FPP - Guidance - issue - needs more work/details
FPP - Guidance - issue - open to vexatious claims
FPP - Guidance - oppose
FPP - Guidance - suggestion
FPP - Guidance - support
FPP - Guidance - support with caveats
FPP - Guidance - unsure
FPP - Information - issue - burden
FPP - Information - issue - gaming
FPP - Information - issue - prefer existing/existing is adequate
FPP - Information - issue - protection for people who speak up
FPP - Information - more info/detail required
FPP - Information - positive - transparency/better data
FPP - Information - suggestion
FPP - Information - support/importance of

OTH - No comment
OTH - Refer to corporate level
OTH - Refer to other document
OTH - Refer to previous comment
OTH - Refer to previous consultation
OTH - Respondent's context
PLA - Concern - aggregation
PLA - Concern - bureaucracy/burden
PLA - Concern - complexity
PLA - Concern - context
PLA - Concern - CQC - capacity
PLA - Concern - CQC - inspectors
PLA - Concern - ease of understanding
PLA - Concern - improvement
PLA - Concern - local commissioning
PLA - Concern - providers - capacity
PLA - Concern - providers - care homes
PLA - Concern - providers - commercial impact
PLA - Concern - providers - large
PLA - Concern - providers - overseas
PLA - Concern - providers - small
PLA - Concern - providers - sub-contractors
PLA - Concern - quality
PLA - Concern - service managers
PLA - Concern - subjectivity
PLA - Concern - turnaround
PLA - Concern - value added
PLA - General - neutral
PLA - General - oppose
PLA - General - query
PLA - General - support
PLA - General - support with caveats
PLA - General - oppose
PLA - Option 1
PLA - Option 2
PLA - Option 3
PLA - Option 4
PLA - Suggestion - bespoke framework
PLA - Suggestion - best practice
PLA - Suggestion - collaboration
PLA - Suggestion - commissioners
PLA - Suggestion - consistency
PLA - Suggestion - culture
PLA - Suggestion - data
PLA - Suggestion - enforcement
PLA - Suggestion - executive responsibility
PLA - Suggestion - experience
PLA - Suggestion - fairness
PLA - Suggestion - feedback
PLA - Suggestion - financial planning
PLA - Suggestion - framework
PLA - Suggestion - funding
PLA - Suggestion - geography

PLA - Suggestion - home visiting services
PLA - Suggestion - inspections/ratings
PLA - Suggestion - internal monitoring
PLA - Suggestion - learning/communication
PLA - Suggestion - lies/gaming
PLA - Suggestion - older people
PLA - Suggestion - organisational size/structure
PLA - Suggestion - outcomes
PLA - Suggestion - population health
PLA - Suggestion - proportionality
PLA - Suggestion - quality/safety
PLA - Suggestion - resources/equipment
PLA - Suggestion - response to errors
PLA - Suggestion - responsibility
PLA - Suggestion - risk
PLA - Suggestion - simplicity/clarity
PLA - Suggestion - social care
PLA - Suggestion - staff management
PLA - Suggestion - sustainability
PLA - Suggestion - systems/process
PLA - Suggestion - testing
PLA - Suggestion - training
PLA - Suggestion - transparency
PLA – Well-led
PM - Focused - Concern - areas of focus
PM - Focused - Concern - burden / duplication
PM - Focused - Concern - comprehensive inspection needed
PM - Focused - Concern - consistency
PM - Focused - Concern - inspections not needed
PM - Focused - Concern - issues overlooked
PM - Focused - Oppose/Concern
PM - Focused - Query
PM - Focused - Suggestion
PM - Focused - Suggestion - Mix of focussed and comprehensive
PM - Focused - Suggestion - more holistic approach needed
PM - Focused - Support
PM - Focused - Support - flexible
PM - Focused - Support - targeted / accurate
PM - Focused - Support - time / resources / burden
PM - Focused - Support - will encourage improvement
PM - Focused - Support - will locate problem areas
PM - Focused - Support with caveats
PM - General - Suggestion
PM - Inspect - Concern - box ticking / irrelevant
PM - Inspect - Concern - consistency
PM - Inspect - Concern - duplication / burden / bureaucracy
PM - Inspect - Concern - inspections not needed
PM - Inspect - Concern - lighter touch
PM - Inspect - Concern - longer period between inspections
PM - Inspect - Concern - pressure on GPs
PM - Inspect - Concern - rapid changes
PM - Inspect - Concern - timings
PM - Inspect - Concern - unannounced inspections

PM - Inspect - Oppose/concern
PM - Inspect - Query
PM - Inspect - Suggestion
PM - Inspect - Suggestion - assess once implemented
PM - Inspect - Suggestion - notice / timing
PM - Inspect - Support
PM - Inspect - Support - accountability
PM - Inspect - Support - accuracy
PM - Inspect - Support - benefits patient
PM - Inspect - Support - consistency
PM - Inspect - Support - efficiency
PM - Inspect - Support - flexibility
PM - Inspect - Support - highlight areas that need improvement
PM - Inspect - Support - joint inspections
PM - Inspect - Support - longer period between inspections
PM - Inspect - Support - Need for GP practices to be monitored
PM - Inspect - Support - ratings
PM - Inspect - Support - reduce burden
PM - Inspect - Support - unannounced inspections
PM - Inspect - Support with caveats
PM - Monitor - Concern - accuracy of monitoring
PM - Monitor - Concern - annual reporting
PM - Monitor - Concern - cost
PM - Monitor - Concern - data from other sources
PM - Monitor - Concern - duplication / burden
PM - Monitor - Concern - local issues
PM - Monitor - Concern - over-regulation
PM - Monitor - Concern - regulator independence
PM - Monitor - Concern - self-assessment
PM - Monitor - Concern - use of Insight
PM - Monitor - Oppose/concern
PM - Monitor - Query
PM - Monitor - Suggestion
PM - Monitor - Suggestion - co-operation
PM - Monitor - Suggestion - patient focus
PM - Monitor - Support
PM - Monitor - Support - annual reporting
PM - Monitor - Support - consistency
PM - Monitor - Support - data from other sources
PM - Monitor - Support - efficiency / use of resources
PM - Monitor - Support - highlight areas that need improvement / or good practice
PM - Monitor - Support - improve relationship management
PM - Monitor - Support - need for GP monitoring
PM - Monitor - Support - provider information
PM - Monitor - Support - transparent
PM - Monitor - Support - use of Insight
PM - Monitor - Support with caveats
PM - Population groups - Concern - bad definition of population groups
PM - Population groups - Concern - burden / bureaucracy
PM - Population groups - Concern - no benefit
PM - Population groups - Concern - not considering patient needs
PM - Population groups - Concern - should assess caring
PM - Population groups - Concern - should assess safety

PM - Population groups - Concern - should assess well-led
PM - Population groups - Concern - some groups might lose out
PM - Population groups - Concern - transparency
PM - Population groups - Oppose/concern
PM - Population groups - Query
PM - Population groups - Suggestion
PM - Population groups - Support
PM - Population groups - Support - all qs for comp. inspections
PM - Population groups - Support - consistency
PM - Population groups - Support - effective/ targeted
PM - Population groups - Support - effective/ targeted/simpler
PM - Population groups - Support - patient centred
PM - Population groups - Support - ratings
PM - Population groups - Support - simpler
PM - Population groups - Support - transparent
PM - Population groups - Support with caveats
PM - Regulation - Independent primary care - oppose/concern
PM - Regulation - Independent primary care - suggestion
PM - Regulation - Independent primary care - support
PM - Regulation - NHS 111, GP OOH, etc. - oppose/concern
PM - Regulation - NHS 111, GP OOH, etc. - suggestion
PM - Regulation - NHS 111, GP OOH, etc. - support
PM - Regulation - Online - identity verification
PM - Regulation - Online - oppose/concern
PM - Regulation - Online - suggestion
PM - Regulation - Online - support
PM - Regulation - Online - support/need case
PM - Regulation - Oppose/concern
PM - Regulation - Primary care at scale - oppose/concern
PM - Regulation - Primary care at scale - suggestion
PM - Regulation - Primary care at scale - support
PM - Regulation - Query
PM - Regulation - Suggestion
PM - Regulation - Suggestion - enforcement
PM - Regulation - Support
PM - Regulation - Support - accountability
PM - Regulation - Support - consistency
PM - Regulation - Support - flexible
PM - Regulation - Support - repeatedly require improvement
PM - Regulation - Support - safety/patient welfare
PM - Regulation - Support - will reduce duplication
PM - Regulation - Support with caveats
PM - Report - Concern - accessibility / relevance / readability
PM - Report - Concern - data
PM - Report - Concern - duplication / burden / bureaucracy
PM - Report - Concern - publishing ratings/enforcement action
PM - Report - Concern - quality
PM - Report - Suggestion
PM - Report - Support
PM - Report - Support - accessible language
PM - Report - Support - faster publication
PM - Report - Support - timeframe
PM - Suggestion - cost saving

QCP - approach - assessment framework
QCP - approach - collaboration
QCP - approach - concern
QCP - approach - information sharing
QCP - approach - inspection consistency
QCP - approach - inspection frequency
QCP - approach - inspectors
QCP - approach - monitoring
QCP - approach - ratings
QCP - approach - support providers
QCP - approach - targeted
QCP - approach - timetable
QCP - approach - transparency
QCP - benefit - STPs
QCP - benefit - wider view of quality
QCP - feedback - experts by experience
QCP - feedback - Healthwatch
QCP - feedback - relatives
QCP - feedback - staff
QCP - feedback - stakeholders
QCP - feedback - users
QCP - general - more information required
QCP - general - neutral
QCP - general - oppose
QCP - general - support
QCP - general - support with caveats
QCP - scope - access/buildings/equipment
QCP - scope - accountability/governance
QCP - scope - commissioning/LAs
QCP - scope - concern
QCP - scope - human resources
QCP - scope - independent healthcare
QCP - scope - partnerships/place-based
QCP - scope - specific sectors/provider types
R - Criteria - benefit - clarity
R - Criteria - benefit - clear accountability
R - Criteria - benefit - improve care
R - Criteria - benefit - logical/fair
R - Criteria - benefit - mid management regulated
R - Criteria - benefit - transparency
R - Criteria - concern - accountability
R - Criteria - concern - change of ownership
R - Criteria - concern - complex group structures
R - Criteria - concern - cost/increased fees
R - Criteria - concern - deter involvement
R - Criteria - concern - grey areas
R - Criteria - concern - hedge funds interference
R - Criteria - concern - inconsistency between providers
R - Criteria - concern - individuals/commissioners not accountable
R - Criteria - concern - joint ventures
R - Criteria - concern - new models of care
R - Criteria - concern - overseas providers
R - Criteria - concern - regulatory burden

R - Criteria - concern - resources
R - Criteria - concern - unnecessary
R - Criteria - neutral
R - Criteria - oppose
R - Criteria - request more detail
R - Criteria - suggestion
R - Criteria - support
R - Criteria - support - Care Act 2014
R - Criteria - support with caveats
R - Incl acc - benefit - accurate ratings
R - Incl acc - benefit - change in provider
R - Incl acc - benefit - clarity
R - Incl acc - benefit - clear accountability
R - Incl acc - benefit - company policies
R - Incl acc - benefit - consistency
R - Incl acc - benefit - general
R - Incl acc - benefit - improve care
R - Incl acc - benefit - monitoring/enforcement
R - Incl acc - benefit - protect residents
R - Incl acc - benefit - reduced regulatory burden
R - Incl acc - benefit - responding to change
R - Incl acc - benefit - transparency
R - Incl acc - concern - benefits unclear
R - Incl acc - concern - clarity
R - Incl acc - concern - complex group structures
R - Incl acc - concern - cost/increased fees
R - Incl acc - concern - criteria
R - Incl acc - concern - deter involvement
R - Incl acc - concern - individuals/commissioners not accountable
R - Incl acc - concern - new models of care
R - Incl acc - concern - overseas providers
R - Incl acc - concern - regulatory burden
R - Incl acc - concern - resources
R - Incl acc - concern - turnaround
R - Incl acc - concern - unnecessary
R - Incl acc - neutral
R - Incl acc - oppose
R - Incl acc - request more detail
R - Incl acc - suggestion
R - Incl acc - support
R - Incl acc - support with caveats
R - Info - concern - costs/increased fees
R - Info - concern - defining care provided
R - Info - concern - duplication
R - Info - concern - geographical limits
R - Info - concern - Implementation
R - Info - concern - keep up to date
R - Info - concern - privacy
R - Info - concern - regulatory burden
R - Info - concern - resources
R - Info - concern - SOP checking
R - Info - feedback - accidents/deaths
R - info - feedback - authorities

R - Info - feedback - clinical outcomes
R - Info - feedback - CQC rating
R - Info - feedback - last inspection
R - Info - feedback - no. of complaints
R - Info - feedback - sanctions
R - Info - feedback - service users
R - Info - general - clear display/IT suggestions
R - Info - general - less info required
R - Info - general - oppose
R - Info - general - request more detail
R - Info - general - site identifier numbers
R - Info - general - support
R - Info - general - support with caveats
R - Info - general - complaints procedure
R - Info - management structure
R - Info - ownership changes
R - Info - provider - accountable provider name(s)
R - Info - provider - action plan/SOP
R - Info - provider - conflicts of interest
R - Info - provider - contact details
R - Info - provider - contract details
R - Info - provider - finances
R - Info - provider - funding source
R - Info - provider - landlord
R - Info - provider - other corporate activities
R - Info - provider - ownership changes
R - Info - provider - partnerships
R - Info - provider - photos
R - Info - provider - previous services
R - Info - provider - responsibilities
R - Info - provider - shareholders
R - Info - provider - start date/experience
R - Info - provider - sub-contract regulation
R - Info - services - location
R - Info - services - alternative providers
R - Info - services - clients
R - Info - services - cost/fees
R - Info - services - location
R - Info - services - opening hours
R - Info - services - regulated activity
R - Info - services - risk assessment
R - Info - services - service type(s)
R - Info - services - setting of care
R - Info - services - size/number of facilities
R - Info - services - special considerations
R - Info - services - waiting times
R - Info - staff - management structure
R - Info - staff - manager
R - Info - staff - professional indemnity cover
R - Info - staff - skills/training
R - Info - staff - ways of working
R - Info - staff - workforce

Appendix 3: Responses to closed questions by respondent category

Table A3 - 1: Responses to Q3a by overall respondent category

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Total
Arm's length body or other regulator	2	3				5
Carer	5	2				7
CQC employee	3	5	1	1	1	11
Health or social care commissioner	5	8	2			15
Member of the public / person who uses health or social care services	21	3	1		2	27
Other	6	7	1	1	1	16
Provider / professional	29	47	13	3	3	95
Provider trade body or membership organisation	8	10	3			21
Voluntary or community sector representative (including Healthwatch)	13	11	3	1		28
Parliamentarian / councillor	1					1
Grand Total	**93**	**96**	**24**	**6**	**7**	**226**

Table A3 - 2: Responses to Q4a by overall respondent category

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Total
Arm's length body or other regulator	2	2	1			5
Carer	4		3			7
CQC employee	1	6	3		1	11
Health or social care commissioner	1	13	1			15
Member of the public / person who uses health or social care services	14	8	2	1	2	27
Other	6	8	2	2		18
Provider / professional	21	46	17	9	6	99
Provider trade body or membership organisation	2	15	7	1	1	26
Voluntary or community sector representative (including Healthwatch)	9	10	7	1		27
Parliamentarian / councillor		1				1
Grand Total	**60**	**109**	**43**	**14**	**10**	**236**

Table A3 - 3: Responses to Q5a by overall respondent category

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Total
Arm's length body or other regulator	1	4				5
Carer	4	1	2			7
CQC employee	2	5	4			11
Health or social care commissioner	2	11	3			16
Member of the public / person who uses health or social care services	10	9	5	1	2	27
Other	5	7	6	1	1	20
Provider / professional	21	44	20	6	5	96
Provider trade body or membership organisation	5	8	9	2	1	25
Voluntary or community sector representative (including Healthwatch)	5	15	4	2	1	27
Parliamentarian / councillor		1				1
Grand Total	**55**	**105**	**53**	**12**	**10**	**235**

Table A3 - 4: Responses to Q6a by overall respondent category

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Total
Arm's length body or other regulator		4				4
Carer	4		1	1		6
CQC employee		3	1			4
Health or social care commissioner	2	8	1	1		12
Member of the public / person who uses health or social care services	10	8	2	1	1	22
Other		3	2		1	6
Provider / professional	11	25	13	17	16	82
Provider trade body or membership organisation	2	3	4	2	1	12
Voluntary or community sector representative (including Healthwatch)	5	13	4		1	23
Parliamentarian / councillor		1				1
Grand Total	**34**	**68**	**28**	**22**	**20**	**172**

Table A3 - 5: Responses to Q7a by overall respondent category

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Total
Arm's length body or other regulator	1	3				4
Carer	3	2		1		6
CQC employee		2	1	1		4
Health or social care commissioner	1	9	1	1		12
Member of the public / person who uses health or social care services	10	6	6		1	23
Other		4	1		1	6
Provider / professional	8	30	16	11	13	78
Provider trade body or membership organisation	2	8	1	1	1	13
Voluntary or community sector representative (including Healthwatch)	5	9	5	3		22
Parliamentarian / councillor		2				2
Grand Total	**30**	**75**	**31**	**18**	**16**	**170**

Table A3 - 6: Responses to Q8a by overall respondent category

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Total
Arm's length body or other regulator	1	3				4
Carer	2		3	1		6
CQC employee		2		2		4
Health or social care commissioner	2	8	1			11
Member of the public / person who uses health or social care services	3	8	6	3	1	21
Other		4	3			7
Provider / professional	10	29	21	12	6	78
Provider trade body or membership organisation	2	4	5	1	1	13
Voluntary or community sector representative (including Healthwatch)	5	6	7	4	1	23
Parliamentarian / councillor			1			1
Grand Total	**25**	**64**	**47**	**23**	**9**	**168**

Table A3 - 7: Responses to Q9a by overall respondent category

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Total
Arm's length body or other regulator		2	1			3
Carer	1	2	1	2		6
CQC employee		2	3			5
Health or social care commissioner		9	1	2		12
Member of the public / person who uses health or social care services	4	7	4	5	1	21
Other	1	2	3			6
Provider / professional	13	41	19	7	2	82
Provider trade body or membership organisation	3	8	1		1	13
Voluntary or community sector representative (including Healthwatch)	2	13	4	3	1	23
Parliamentarian / councillor		1				1
Grand Total	**24**	**87**	**37**	**19**	**5**	**172**

Table A3 - 8: Responses to Q10ai by overall respondent category

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Total
Arm's length body or other regulator	3	1	1			5
Carer	4		1	1		6
CQC employee		4				4
Health or social care commissioner	2	7	1	1		11
Member of the public / person who uses health or social care services	7	5	6		3	21
Other		2		4		6
Provider / professional	11	26	21	6	6	72
Provider trade body or membership organisation	5	6	2			13
Voluntary or community sector representative (including Healthwatch)	9	8	2	1		20
Parliamentarian / councillor						0
Grand Total	**41**	**59**	**35**	**13**	**9**	**157**

Table A3 - 9: Responses to Q10aii by overall respondent category

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Total
Arm's length body or other regulator	2	2	1			5
Carer	4		1		1	6
CQC employee		3	1			4
Health or social care commissioner	5	5			1	11
Member of the public / person who uses health or social care services	9	7	4			20
Other		2	2	2		6
Provider / professional	12	24	21	5	5	67
Provider trade body or membership organisation	2	8	2	1		13
Voluntary or community sector representative (including Healthwatch)	8	8	2	1		19
Parliamentarian / councillor						0
Grand Total	**42**	**59**	**34**	**9**	**7**	**151**

Table A3 - 10: Responses to Q10aiii by overall respondent category

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Total
Arm's length body or other regulator	1	2	2			5
Carer	4		2			6
CQC employee		3	1			4
Health or social care commissioner	2	6	1		1	10
Member of the public / person who uses health or social care services	8	6	6			20
Other		1	3	1	1	6
Provider / professional	13	27	18	5	6	69
Provider trade body or membership organisation	1	7	5			13
Voluntary or community sector representative (including Healthwatch)	9	6	2	3		20
Parliamentarian / councillor						0
Grand Total	**38**	**58**	**40**	**9**	**8**	**153**

Table A3 - 11: Responses to Q10aiv by overall respondent category

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Total
Arm's length body or other regulator	1	3	1			5
Carer	4		2			6
CQC employee		4				4
Health or social care commissioner	2	6	1	1		10
Member of the public / person who uses health or social care services	7	6	6	1		20
Other		1	3	2		6
Provider / professional	9	22	23	6	7	67
Provider trade body or membership organisation	2	8	3			13
Voluntary or community sector representative (including Healthwatch)	8	9	1	1		19
Parliamentarian / councillor						
Grand Total	**33**	**59**	**40**	**11**	**7**	**150**

Table A3 - 12: Responses to Q11a by overall respondent category

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Total
Arm's length body or other regulator	4	1				5
Carer	4	1	1	1		7
CQC employee	1	9	1	1		12
Health or social care commissioner	1	9	1			14
Member of the public / person who uses health or social care services	10	9	5	1		25
Other	8	7				15
Provider / professional	24	47	5	6	2	84
Provider trade body or membership organisation	1	9	4	2		16
Voluntary or community sector representative (including Healthwatch)	6	14	5		1	26
Parliamentarian / councillor		1				1
Grand Total	**59**	**107**	**22**	**11**	**3**	**202**

Table A3 - 13: Responses to Q12a by overall respondent category

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Total
Arm's length body or other regulator	3	2				5
Carer	2	3	2			7
CQC employee	2		2	6	1	11
Health or social care commissioner	1	8	1	1		11
Member of the public / person who uses health or social care services	7	9	4	1	2	23
Other	3	9	1		2	15
Provider / professional	18	51	5	9	2	85
Provider trade body or membership organisation	1	13	2	1		17
Voluntary or community sector representative (including Healthwatch)	4	10	3	8	1	26
Parliamentarian / councillor		1				1
Grand Total	**41**	**106**	**20**	**26**	**8**	**201**

Table A3 - 14: Responses to Q13a by overall respondent category

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Total
Arm's length body or other regulator	4					4
Carer	5	1	1			7
CQC employee	1	6	4	1		11
Health or social care commissioner	3	4	4			11
Member of the public / person who uses health or social care services	14	4	4	1	1	24
Other	7	6	2			15
Provider / professional	19	46	15	2	2	84
Provider trade body or membership organisation	3	12				15
Voluntary or community sector representative (including Healthwatch)	10	12	2	3		27
Parliamentarian / councillor		1				1
Grand Total	**66**	**92**	**32**	**7**	**3**	**200**

Table A3 - 15: Responses to Q14a by overall respondent category

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Total
Arm's length body or other regulator	3	2				5
Carer	2	3	1		1	7
CQC employee	2	8	2			12
Health or social care commissioner	5	5	1			11
Member of the public / person who uses health or social care services	10	6	5	2	1	24
Other	3	8	1	1	1	14
Provider / professional	18	51	10	5	2	86
Provider trade body or membership organisation	1	11	1	1	1	15
Voluntary or community sector representative (including Healthwatch)	6	15	2	3		26
Parliamentarian / councillor		1				1
Grand Total	**50**	**110**	**23**	**12**	**6**	**201**

Table A3 - 16: Responses to Q15a by overall respondent category

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Total
Arm's length body or other regulator	3	2				5
Carer	4	2	1			7
CQC employee	1	3	3	3		10
Health or social care commissioner	5	12	1			18
Member of the public / person who uses health or social care services	13	7	4	4		28
Other	7	4	2			13
Provider / professional	40	65	19	6	6	136
Provider trade body or membership organisation	7	14	1	1	2	25
Voluntary or community sector representative (including Healthwatch)	6	11	3	2	1	23
Parliamentarian / councillor		1				1
Grand Total	**86**	**121**	**34**	**16**	**9**	**266**

Appendix 4: List of organisations responding

A New Angle Ltd (trading as Independent Home Living)
Accord Housing Association
Action on Hearing Loss
Adult Care Service and Herts Care Providers Association
Age UK
Agincare
Albion Street Surgery
Alzheimer's Society
Ambitious about Autism
Archer Business Solutions
ARCO (Associated Retirement Community Operators)
Ark Home Healthcare Ltd
Ashwood Residential Home
Association of Dental Groups
Association of Directors of Adult Social Services (ADASS) and Local Government Association (LGA)
Association of Independent Healthcare Organisations
Autism Alliance UK
Barchester Healthcare
Bedford Hospital NHS Trust
Bere Regis Surgery
Bevan Brittan
Black Swan International Limited
British Dental Association
British Geriatrics Society
British Medical Association
British Red Cross (Adult Social Care)
British Standards Institution
Bupa UK
Camphill Village Trust
Care England
Care UK
Careport
Carers FIRST
Carers' Resource
Carers Trust
Carers UK
CareTech
Caring Homes Group
Central London Community Healthcare NHS Trust
Certitude
Challenging Behaviour Foundation
Cheshire and Wirral Partnership NHS Foundation Trust
Classic Care Homes Ltd (Devon) and Devon Care Kite Mark
Combine OpCo Limited (trading as The Hospital Group)
Community Therapeutic Services
Consortium of Lancashire & Cumbria LMCs
Cygnet House
Dementia UK
Devon County Council
Diabetes UK

Dimensions
Durham County Council
Earl Mountbatten Hospice
East & North Hertfordshire CCG
East Leicestershire and Rutland CCG
East Sussex County Council
Elizabeth Finn Homes Limited
Elysium Healthcare
Essex Partnership University NHS Foundation Trust
everythingCQC.com
Frome Medical Practice
Fylde and Wyre CCG
Guinness Care and Support Limited
Hampshire Hospitals
Hanover Housing Association
Hartlepool Borough Council
Hartlepool Borough Council's Audit and Governance Committee
Health Education England
Healthwatch Cambridgeshire and Peterborough
Healthwatch Cornwall
Healthwatch Coventry
Healthwatch Darlington
Healthwatch England
Healthwatch Northumberland
Healthwatch Sheffield
Healthwatch Staffordshire
Healthwatch Suffolk
Healthwatch West Sussex
Healthwatch Worcestershire
Hesley Group Ltd
Home Group Ltd
Home Counties Carers
Home Instead Senior Care UK Ltd
Home of Comfort for Invalids
Hospice UK
IDF
Improving Prospects Ltd (trading as Manor Community)
Independent Age
Interserve Healthcare
Jewish Care
John Hampden Surgery PPG
Lancashire Care Association
Lancashire County Council
L'Arche
Leicestershire County Council
LGBT Consortium
Local Government and Social Care Ombudsman
London Borough of Bexley and Bexley CCG
London Borough of Bromley
London Borough of Hillingdon's External Services Scrutiny Committee
London Borough of Newham
London Councils
London Health and Care Strategic Partnership Board
Londonwide LMCs
Manchester Local Medical Committee

Marie Curie
Meadowside Care Home, N12
Mencap
MHA
Mid Essex CCG
Midland Heart
Millennium Care Services
Milton Abbas Surgery
MioCare Group
Moordown Medical Centre
National Association of Care Catering
National Autistic Society
National Care Association
National Care Forum
National Institute for Health and Care Excellence
National LGB&T Partnership
Newton Chinneck Ltd
NFA group
NHS Clinical Commissioners
NHS Digital
NHS Improvement
NHS Partners Network
NHS Providers
Nursing and Midwifery Council
North West Surrey CCG & GP Practices
Northumberland, Tyne & Wear NHS Foundation Trust
Notting Hill Housing Trust
Nuffield Health
OmerCare
Orione Care
Our Health Partnership
Patients Association
Plymouth Hospitals NHS Trust
Priory Group
Professional Record Standards Body
Provide CIC
Push Doctor Ltd
RAF Benevolent Fund
RCPCH
RDB Star Rating
Reach Supported Living
Reading Borough Council
Real Life Options
Registered Nursing Home Experience
RightPath4 Limited
Rowcroft Hospice
Royal Association for Deaf People
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Midwives
Royal College of Nursing
Royal College of Physicians of Edinburgh
Royal College of Psychiatrists
Royal College of Surgeons of Edinburgh
Royal Devon & Exeter NHS Foundation Trust

Royal Pharmaceutical Society
Runwood Homes Ltd
Sanctuary Group
Scope
Sheffield Health and Social Care NHS Foundation Trust
Solent NHS Trust
Somerset Partnership NHS Trust
South Eastern Hampshire CCG and Fareham & Gosport CCG
South Western Ambulance Service NHS Foundation Trust
Spire Healthcare
St Alban's Medical Centre
St Dominic's
St Helena Hospice
Stockton on Tees Borough Council
Straight Road Surgery
Sue Ryder
Sunderland GP Alliance
Surrey Autism Partnership Board
Surrey Choices
Surrey County Council
Talbot Medical Centre
Tecologica
The Birchwood Practice
The Coroners' Society of England and Wales
The Crane Surgery
The Exchange Surgery
The General Medical Council
The Gold Standards Framework Centre in End of Life Care
The Lighthouse Medical Practice
The Parks Medical Centre
The Relatives and Residents Association
The Royal College of Ophthalmologists
The Sustainable Development Unit
The Treloar Trust
The Wellbridge Practice
United Kingdom Accreditation Service
United Kingdom Homecare Association
University of South Manchester NHS Foundation Trust
Voluntary Organisations Disability Group
Walsingham Support
Waltham Forest CCG
Wessex Local Medical Committees
West End Surgery
West Moors Group Practice
Which?
Wiltshire Clinical Commissioning Group
Wirral Community NHS Foundation Trust
Worcestershire County Council