

Response to the consultation on our
provider handbooks

**NHS acute hospitals,
Community health services and
Specialist mental health services**

September 2014

The Care Quality Commission is the independent regulator of health and adult social care in England

Our purpose:

We make sure health and social care services provide people with safe, effective, compassionate, high quality care and we encourage care services to improve.

Our role:

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care.

Our principles:

- We put people who use services at the centre of our work.
- We are independent, rigorous, fair and consistent.
- We have an open and accessible culture.
- We work in partnership across the health and social care system.
- We are committed to being a high performing organisation and apply the same standards of continuous improvement to ourselves that we expect of others.
- We promote equality, diversity and human rights.

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Foreword

From 9 April to 4 June 2014, we consulted on our plans for regulating, inspecting and rating NHS acute hospitals, community health services and specialist mental health services. These set out radical changes to the way we regulate and inspect, in line with our April 2013 consultation, *A New Start*.

For the consultation we published our draft handbooks for providers to use – to understand how we will regulate and inspect in each sector, from registration and monitoring through to inspection and ratings.

Over the last 18 months we have co-produced our proposals with people who use services, providers, our staff and representatives from charities, trade associations, Royal Colleges, local Healthwatch and voluntary groups and other government departments.

We have also tested our new approach, using larger and more specialist teams of inspectors and experts, in a number of waves of inspections. An evaluation programme – incorporating feedback from CQC inspectors, Experts by Experience and specialist advisers and providers – has been in place across all sectors.

I would like to thank everyone who has taken the time and effort to respond to the consultation, participate in the co-production work, and work with us during our test inspections to help us develop our new approach.

We have listened closely to what people have told us. This document sets out the detail of what people said during the consultation and our responses. Overall, the respondents:

- Stressed the importance of CQC ensuring that its assessment framework supports consistent regulatory judgements and, to underpin this, the need for an expert, well-trained inspection workforce.
- Queried whether our proposed ratings principles and the level at which we would set outstanding care were tough enough.
- Made various suggestions for changes to the key lines of inquiry and ratings characteristics, to ensure greater clarity and focus in reaching our judgements.

We recognise the need to ensure consistency for both providers and inspection teams in how we measure quality and what good care looks like. Our intention therefore is not to change the core elements of our assessment framework – key lines of enquiry, characteristics of good care and other rating levels, and ratings principles – until all services in a sector have been comprehensively inspected and rated at least once. We may update prompts, evidence sources, and inspection methodology and tools when and where necessary, as we continue to listen, learn and engage with providers, partners and people who use services and improve our regulation and inspection approach.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Section 1: Our consultation

Introduction

From 9 April to 4 June 2014, CQC consulted on our 'provider handbooks' that set out our proposals for inspecting and rating providers of health and adult social care services. This consultation on our new approach built on our 2013 consultation, *A new start*, which proposed radical changes to the way we inspect and regulate health and adult social care.

We published provider handbooks for consultation for each sector - this report sets out the responses from our handbooks on NHS acute hospitals, community health and specialist mental health services.

The consultation documents (the provider handbooks) outlined how we will carry out inspections, which includes gathering information and engaging with people who use services and the public beforehand, the inspection visit itself, and our process for awarding a rating, where appropriate.

They included a standard set of key lines of enquiry (KLOEs), which our inspection teams will use to direct the focus of their inspection. The KLOEs directly relate to the five key questions we ask of services – are they safe, effective, caring, responsive and well-led? Our proposals on how we will rate services included detailed descriptions of the characteristics we will use to decide whether a service is outstanding, good, requires improvement or inadequate, the principles that we will use to apply these ratings and the review process for providers to challenge ratings.

Section 2 of this document sets out the key things that we are changing as a result of both the learning from the first inspection waves and from the consultation. Section 3 sets out the themes of the consultation, the key points from the feedback and our response.

Alongside this consultation, we continued to test, evaluate and develop the new approach through pilot (wave) inspections. These started in September 2013 for NHS acute hospitals, and January 2014 for specialist mental health and community health services.

Incorporating learning from our first wave of inspections

We have embedded evaluation within each new wave of inspections for every sector. This has incorporated a range of methods including surveys, interviews and focus groups with providers, CQC staff and associate inspectors (specialist advisors and Experts by Experience) and observations from the inspections themselves. We used the findings to inform changes to policy, process and practice from wave to wave, and before full implementation. We have also commissioned independent

evaluation projects to supplement our internal programme for the acute and mental health sectors.

To evaluate our first Wave of NHS acute hospital inspections using our new and evolving approach, CQC commissioned a team from Manchester Business School and The King's Fund, led by Professor Kieran Walshe. The evaluation looked at how our new approach to acute hospital inspection works, how well it measures hospitals' performance, how it is implemented and what impact it has. This was through work with the NHS trusts and foundation trusts that we inspected between October 2013 and April 2014. Following this evaluation, we have made many changes to the inspection process. This external evaluation was then supplemented by a range of mechanisms to gather internal learning throughout the testing period, including workshops and surveys. This helped ensure real time learning to enable us to make immediate changes.

How we engaged and who we heard from

To gather feedback about our consultation we organised nine events across the country for providers of NHS acute hospital services, community health and specialist mental health services, members of the public and CQC staff (see Appendix B for details). These were attended by 261 people.

We held a series of face-to-face workshops and events with stakeholders and providers during the consultation period. These included:

- Four provider consultation events in London, Preston, Bristol and Nottingham. Each event was attended by approximately 50 providers from across acute, mental health and community services. They were hosted by senior members of CQC staff and included presentations followed by table discussions focusing on different aspects of the consultation document.
- A meeting with 14 members of the Independent Mental Health Services Alliance on 3 June hosted by Deputy Chief Inspector of Hospitals with responsibility for mental health, Paul Lelliott.
- A workshop on 28 May with members of the NHS Confederation and Foundation Trust Network community health networks. This event was hosted by members of our community health policy team and included presentations and table discussions.
- A joint event with NHS Confederation and the Foundation Trust Network on 14 May attended by over 100 people from across acute, mental health and community health services. The event included breakout sessions which focused on different questions from the consultation document.

In addition to these events, the consultation questions were included for discussion on the agenda of the regular meetings of our community health advisory group (1 May) and mental health advisory group (7 May). These meetings included table discussions about specific aspects of the consultation relating to those services.

Response to the consultation on our provider handbooks: NHS acute hospitals, community health services and specialist mental health services

As well as the forms completed online during the consultation, we also received 103 written submissions from a range of organisations (see appendix A).

We organised two Q&As on Twitter as part of the consultation – an innovative way of capturing the views of people who wished to engage with the process in this way. CQC also monitored and responded to tweets throughout the consultation. We received 49 tweets with 218 re-tweets. The tweets brought up some interesting themes and good suggestions that correlated with ideas from other elements of the consultation. Tweets were analysed and views were taken into account as part of the consultation.

We also asked members of the public to use social media to send photographs of themselves holding up boards with their own definitions of what good care looks like. We analysed the comments on the photographs and took these views into account as part of the consultation. This was an excellent way of publicising the consultation and engaging the public in a creative way.

There were 26 specific events run to gather feedback on the specialist mental health part of the consultation. These included focus groups with people who are classified as hard to reach, Service User Reference Panel (SURP) events, and meetings with Experts by Experience, SpeakOut and Coventry AIMHS. Views from all of these events have been used in the section of this report on specialist mental health.

We used our regular communications channels to promote the consultation with providers and professionals, including:

- Monthly newsletters to all registered healthcare providers.
- Our online community for providers and professionals (around 7,500 members). Our Twitter accounts.

Engagement events with CQC's online communities:

We held a series of online engagement events during the consultation period. These included:

Provider community:

- A live Q&A on our consultation for acute healthcare providers. On Tuesday 13 May, our Deputy Chief Inspector of Hospitals, Ted Baker, took questions from the community.
- A comment/discussion thread on 'Consultation on our new approach to regulating, inspecting and rating healthcare services' (posted on 9 April).
- A live Q&A chat with healthcare providers on 'Speaking out safely – raising concerns'. We held this on 3 June with James Titcombe, CQC's National Advisor for Patient Safety, and Helene Donnelly, Cultural Ambassador for Change at Staffordshire and Stoke-on-Trent Partnership Trust.

- All of the materials for consultation, which were shared at the events, were used to consult providers and professionals on the online community during the consultation period. The material was broken down into themed mini-reviews:
 - Consultation review 1 (acute healthcare) – patient groups, ratings characteristics, and key lines of enquiry (16 May 2014).
 - Consultation review 2 (acute healthcare) – Mental Capacity Act, gathering people’s views, and rating weighting (27 May 2014).
 - Consultation review 3 (acute healthcare) – ratings, shared learning, and the review process (2 June 2014).
 - Consultation review for specialist mental healthcare services (3 June 2014).

Public community

- All of the materials for consultation, which were shared at the events, were used to consult the public on the online community during the consultation period. The material was broken down into two reviews:
 - Acute and community (44 responses)
 - Specialist mental health (13 responses).
- A comment/discussion thread on ‘What does good look like?’ (posted on 14 May).

Other research

We also used two other sources of public comment in considering our responses:

- Public research defining ‘good’ in healthcare, carried out by Research Works Ltd on behalf of CQC. Research Works interviewed 24 people about proposals for inspection in community health services and 12 about mental health services. Where applicable to a particular sector, findings from this have been included.
- Focus groups with a range of people who are classified as hard to reach due to their circumstances, carried out on behalf of CQC by an advocacy organisation, which relate to all sectors.

How we analysed feedback from the consultation

We commissioned Quality Health, an independent healthcare consultancy, to support the consultation process. Quality Health have reviewed, analysed and reported on all the feedback collected from all aspects of the consultation.

Please note that, due to the complex nature of this consultation across a number of sectors and engagement channels, the consultation questions used in this response document have been collated and summarised from the various versions used throughout the engagement process.

Section 2: Key changes to our approach to inspecting

Our provider handbooks, which were the subject of this consultation between April and June 2014, set out in detail how will regulate, inspect and rate NHS acute hospitals, community health services and specialist mental health services.

In response to what we heard during the consultation and what we learned during the testing of our new approach, we have made improvements throughout the handbooks to clarify and confirm the inspection process.

The detailed feedback from the consultation and our responses are set out in Section 3 under the different themes of the consultation. The following are the key specific changes we are making to our original proposals:

1. Assessment framework (key lines of enquiry (KLOEs), prompts and ratings characteristics)

- We have rationalised some of the KLOEs and prompts to reduce areas of duplication in the assessment framework. Our pilot work has also helped us to identify where some of elements of the framework needed to be set out more clearly. For example, we have made much clearer the distinction between what is covered in our assessment of 'effective' and 'responsive'.
- We have introduced new KLOEs, and refined others, to reflect specific areas that did not have the right level of focus. For example:
 - The Mental Capacity Act, DoLS and best interests decision making were previously referred to in different prompts under safe, effective and caring. We have now introduced a single KLOE on consent, under effective, which brings together all these issues.
 - We have introduced a KLOE for information sharing and revised the KLOE for effective multi-disciplinary working. By doing this, we have ensured that we give sufficient focus both to how well information is used and made available to support delivery of effective care and treatment, and how well staff, teams and services coordinate the planning and delivery of care for the benefit of people who use services.
- We have made sure within the KLOEs and prompts for 'safe' and 'well-led' that we can more effectively assess providers for their compliance with the forthcoming duty of candour and the fit and proper person requirements for directors.
- We have reviewed the format of the prompts and changed them from short bullet points to questions. This is so that they provide more detail and clarity about which topics are covered by each KLOE.
- We have reviewed the language of the KLOEs and prompts to make sure that we are using terms that reflect current practice and that we don't use jargon.

- We received feedback that the characteristics of a ‘good’ rating included at KLOE level were too specific. Also in places they duplicated the ratings characteristics at key question level. We have removed the characteristics of good at KLOE level and transferred any appropriate material to either the prompts or the key question ratings characteristics.
- We have made sure that the characteristics of outstanding truly demonstrate outstanding care, so that our approach to ratings provides the necessary challenge.

2. Scope of the core services

- We have clarified and refined the scope of the core services to make it clear what is and is not covered by each, and to describe our approach to inspecting them. For example:
 - For specialist mental health services the core services are now clearly divided between community and hospital services.
 - For acute hospitals we have changed the names of some core services so that the breadth of services covered is clearer. We have also introduced a specific focus on diagnostic imaging.

3. Focused inspections

- We have developed our focused inspections to have a better understanding of what one means, and clarified the circumstances under which a focused inspection might take place. We have also provided more detail on the way a focused inspection might influence a change to a location’s or a provider’s ratings. We will undertake a focused inspection for two reasons: to focus on an area of concern or where certain changes in a provider occur. A focused inspection is not an opportunity to review a rating where there are no concerns.

4. Ratings principles

- Many respondents felt that there needed to be at least three outstanding ratings (out of five) at key question level for an overall outstanding rating to be given. Our testing of this principle through our waves of test inspections has shown that this would result in very few outstanding services. Evidence also shows that setting outstanding at a very high level would have minimal impact on encouraging providers to strive towards it, if the numbers achieving it were very low and it was seen to be unattainable.
- Similarly, if we set the bar too high there are likely to be many more services rated as good. This would make it harder for the sector to identify and learn from best practice and potentially difficult for the public to know who provides truly outstanding care.

- We have therefore clarified that:
 - For a service to be rated outstanding overall, there normally needs to be at least two outstanding ratings at key question level and the other three key questions need to be rated as good.
 - After we have rated everywhere at least once, we may consider whether we should raise the bar for outstanding.
- In terms of aggregating individual ratings that may result in overall ratings of inadequate or requires improvement, we have clarified the proportions of each rating that we will apply to do this.

Section 3: What you told us and our response

Gathering and using information, including from people who use services and the public

What we said in our consultation

A key principle of the approach to inspecting hospitals is to seek out and listen to the experiences of the public, including people who use services and their relatives, friends or carers. This includes the views of people who are in vulnerable circumstances or those who are less likely to be listened to by policy makers.

We propose to gather information in a number of ways – both by talking and listening to people in person at listening events and focus groups and by asking for their views in writing on comment cards and on our website.

Consultation questions

- **During our inspections, we will use a number of methods to gather information from the public about their views of the services provided. Do you agree that the proposed methods of gathering information are the right ones to use?**
- **Will they enable us to gather views from all the people we need to hear from?**
- **We have provided samples of evidence we may collect during our inspections. Do you agree that this is the right kind of evidence for us to look at? Is there other evidence we could use?**
- **How confident are you that the sources of information we will look at will identify risks of poor quality care and good practice?**

What you said

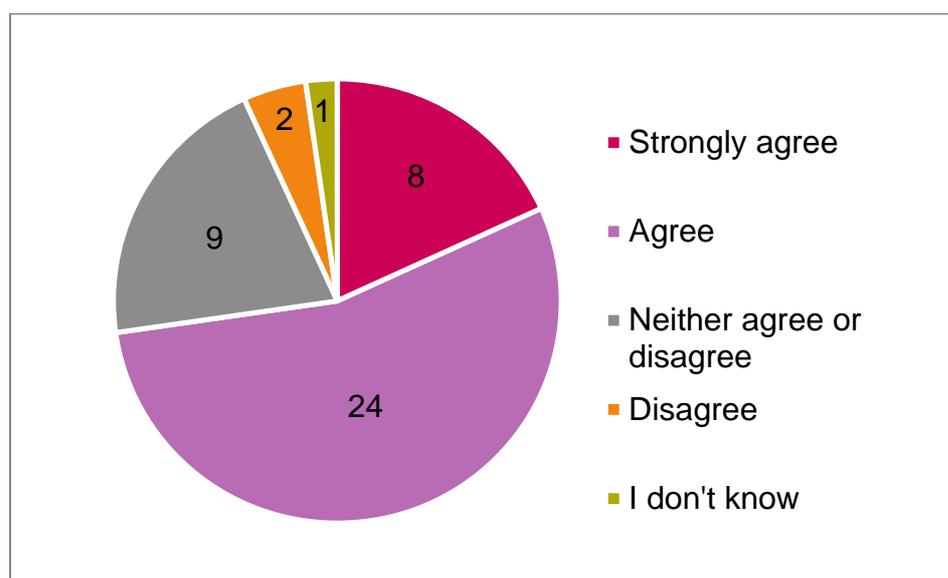
NHS acute hospitals

- The majority of respondents felt that the methods for gathering feedback from the public would be effective.
- Many representative organisations stressed the need to gather views from less heard or hard to reach groups of people.
- People specifically mentioned gathering views from Patient Advice and Liaison, Healthwatch, clinical commissioning groups, patient engagement groups, Action Against Medical Accidents and Experts by Experience.
- Some responses didn't agree that the ways of gathering information were effective, as they felt that CQC should talk to more people who "aren't prepared" for the inspection.
- Some felt that there was a bias in favour of talking to patients with negative views. It was highlighted that carers and relatives have a different and sometimes more critical perspective of care than patients do.
- There was value in talking to patients while they were in hospital, but also after they had been discharged, when they have had time to reflect.
- CQC could consider talking to staff who may well use services themselves, or care for somebody who does. Views of staff need to be gathered in a safe and confidential way, as some staff are not confident to answer freely.
- The vast majority of respondents agreed or strongly agreed that we are looking at the right kind of evidence during inspections.
- Some respondents highlighted the importance of corroborating evidence and the need for a balance between the objective and subjective evidence being considered, and between evidence provided beforehand and that collected during the visit.

Community health services

- Most of those that responded online agreed or strongly agreed with the methods we intended to use to gather feedback from the people who use services and those close to them (see figure 1 below).

Online responses: Do you agree that the proposed methods of gathering information are the right ones to use for community health services?



- Respondents thought that CQC should develop a collaborative approach by working with all groups representing people who use services, particularly those with national networks.
- Many voluntary organisations have systems and processes in place to gain views from the public, and all offered to help CQC with this.
- Most people thought that the best ways to get feedback were through an anonymous questionnaire/postal survey and through feedback forms. This was followed by email or web surveys and then face-to-face interviews, home visits and telephone calls.
- Respondents from CQC's public online community felt that the most effective ways to gather the experiences of people in their own homes are through anonymous questionnaires and interviews, either by phone or face-to-face, or online.

Specialist mental health services

- There was general support that CQC's proposed methods of gathering feedback from people who use services and those close to them would be effective.
- Respondents said that CQC needs to speak with people using services, including detained patients, but not put them under pressure to answer. CQC needs to ask people who use services for evidence of what compassionate care looks like.
- Nearly all online respondents agreed that the information listed is the right kind of evidence for CQC to look at during an inspection.

- However, more than half were not sure that this information would identify risks of poor quality care and half were not sure whether it would identify good practice.
- A provider commented that they would be concerned if the number of complaints was seen as a negative indicator, as a more useful indicator would be the number of complainants not satisfied with the response to their complaint.

Our response

- We use four main sources of evidence to plan and inspect a provider and reach a judgement and rating. These are: Intelligent Monitoring; ongoing gathering local information; pre-inspection information gathering; and onsite inspection visits.
- We will use multiple sources of evidence, where these exist, to corroborate our findings and make a judgement about the quality and safety of care provided. As we conduct more inspections, we will continue to review the evidence we use.
- We are pleased that there was support for our methods of gathering feedback from people using services, their relatives, friends or carers. We are continuing to develop these and learn from our evaluation.
- We will offer people, including people with mental health problems who are detained, the opportunity to speak with Experts by Experience or other members of the inspection team. People can also use our comment cards or the 'tell us about your experience' form on our website. In addition, we will continue to use other methods during an inspection, such as structured observations, focus groups and assessing involvement in care planning.
- Our listening events provide an opportunity away from the hospital environment for people who use services and the public to tell us about their experiences.
- We are clear that, by themselves, the number of complaints does not give an indication about quality or risk. For example, high complaint numbers could reflect an open culture where complaints are encouraged, and low numbers the opposite.
- We recognise that we need to look beyond the numbers at the detail. We need to look at whether there are any common themes that need to be explored, along with any other supporting evidence. One of our key lines of enquiry under 'responsive' (R4) makes sure that our inspection teams identify the way the provider responds to complaints.
- Identifying good and outstanding practice is an important part of our inspection, so we will always encourage people to tell us about their positive experiences and stories.

- We will continue to work with other bodies to make best use of the information they hold and data that already exists. These are important sources of evidence for the inspection.
- The views of staff are vital to our inspection and making a judgement on the quality of care. Our inspection includes methods for gathering staff's views, including focus groups, interviews and giving staff the opportunity to speak to us confidentially.
- A key principle of our approach is to seek out and listen to experiences of care and the voice of staff. We will therefore continue to evaluate and refine our approach to gathering this evidence.
- Our inspection teams include specialist advisors and Experts by Experience. The mental health inspection teams also include specialist mental health services inspectors and Mental Health Act (MHA) reviewers (formerly MHA commissioners).
- We are developing our Intelligent Monitoring indicators for mental health and will continue to improve our provider information request (PIR).
- For community health services, we recognise that there is only very limited national data available about the quality of care. This means that we will rely more on: information supplied directly by providers about quality of care; other risk and performance information; and information about the systems and governance arrangements that providers have in place.
- For community health services we will also seek feedback from other local agencies, the public and groups that represent people who use services. Where we use this type of information, we will take account of the source and the quality of information we have received. For example, we will take into account what level of assurance there is about the quality of data received from a provider.
- For community health services and community-based mental health services, we agree that it will be difficult to get feedback and to assess the quality of care that people receive in their homes. As a result, we have confirmed that we will always include shadowing of home visits as part of our inspections, with consent from the people who use services.
- This will not enable us to speak to large numbers of people, but it will give an opportunity to get very meaningful feedback. We will also be able to observe if the arrangements in place help staff to provide good care and meet people's needs.
- We will further develop our use of telephone calls, surveys and comment cards to gather feedback from a wider range and larger numbers of people who receive care in their homes.

Core services

What we said in our consultation

We will not be inspecting all the services within an NHS acute hospital, community health service or mental health service. We have identified a set of 'core services' for each type of provider that we will always inspect where they are provided. They were selected as they are seen as the ones that have a greater potential for risk to people who use services and cover the majority of services that people use. Our inspections will not be limited to these core services. If we identify particular services, specialties or pathways of care where we have concerns, or where we believe the quality of care could be outstanding, we will look at them in detail and report on them.

Consultation questions

- Do you understand how we have defined each of the core services?
- Do you agree that these are the right services for us to look at?
- Do you agree that we should rate and report on each of these services?

What you said

NHS acute hospitals

The eight core services in acute hospital trusts were:

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients.

We also proposed to focus on specific patient groups during an inspection. For example, people with a learning disability or mental health condition, or people with dementia and diabetes. We would assess whether the provider understands and meets the needs of these specific groups.

- 35 of 46 online respondents understood the definitions of each core service and agreed that these should be the services that CQC looks at.
- However, some felt there were some services missing, including transportation (ambulance or other provider), and pharmacy services.
- The vast majority of respondents supported our proposals for focusing on specific patient groups and their care pathways as well as core services. But there was also a worry that patients with complex multiple illnesses may not be captured by the categories of patient groups.

Community health services

The four core services proposed for community health services were:

- Community health services for adults.
- Community health services for children, young people and families.
- Community health inpatient services.
- End of life care.

We also said that we were considering adding specialist dental services as a core service.

- The concept of core services and the definitions were broadly accepted, although providers at events were keen to understand where each of the various types of community health services fitted into this approach, for example, which of the core services do various services fall under.
- Providers felt that the four core services listed were correct, but other core services could also be included, such as prison-based services, sexual health services, pharmacy services and a range of other community services, such as podiatry, speech and language, and audiology.
- The public understood the core services and agreed they were the right ones to inspect. They thought they were all equally important, and that they should cover all stages of life. Nearly all respondents thought the core services should be rated and reported on.
- The overlap of services could pose a challenge for inspections, for example, community health and mental health services.

Specialist mental health services

The 11 core services proposed for mental health services were:

- Acute wards
- Psychiatric intensive care units
- Health-based places of safety
- Forensic inpatient and secure units
- Long stay/rehabilitation wards
- Child and adolescent mental health services
- Services for older people
- Inpatient wards for people with learning disabilities or autism
- Community-based crisis services
- Other adult community-based services
- Specialist eating disorder services.

- Almost all responses from the public online community, providers and those responding online understood the core services and agreed that they were the right ones to inspect.
- However, there was some confusion as to why certain services were included as a core service and others weren't, such as drug and alcohol services, assessment units and early intervention.
- Also, combining services under one rating could make it difficult to differentiate between services – for example, older people's services, which have differences between inpatient and community services.
- People using services felt that GPs were critical in the care pathway, as they are the gatekeepers to mental health services.
- There was broad support for focusing on care pathways and agreement that the pathways listed were the right ones. Providers submitting written responses valued the care pathway approach.

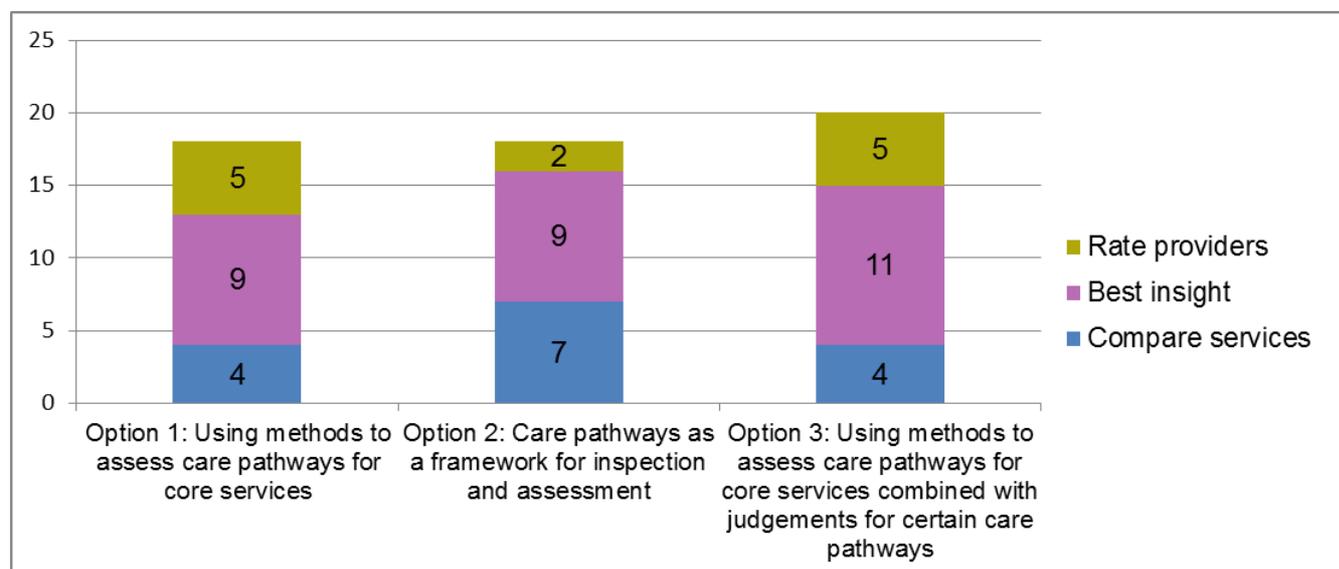
We asked online responders to help us decide which of the three options is most appropriate, please let us know which of the three options would give us the best insight into the quality of service provision for assessing care pathways, consistency of approach and the basis for ratings.

Option 1: Using methods to assess care pathways for core services

Option 2: Care pathways as a framework for inspection and assessment

Option 3: Using methods to assess care pathways for core services combined with judgements for certain care pathways

Spread of option between those responding online



Our response

NHS acute hospitals

- As a result of our learning and the responses from the consultation, we have clarified the definition of our core services. We have also reflected on the title of some of these so that they more accurately reflect the scope of the service.
- Our core services for acute are:
 - Urgent and emergency services
 - Medical care (including older people's care)
 - Surgery
 - Critical care
 - Maternity and gynaecology
 - Services for children and young people
 - End of life care
 - Outpatients and diagnostic imaging.
- During an inspection, if we identify any concerns in particular services, specialist areas or pathways of care, or where we have found that the quality of care could be outstanding, we will look in more detail and include details in our report on the service.

- As part of our inspection of acute services, we are committed to including a focus on care pathways and particular patient groups. This could include, for example, people with dementia or with a learning disability.
- When looking at care pathways, we will ‘track’ people’s journey through care. This means that we will form a judgement about the points in a care pathway, and use this to inform our ratings of the core services.

Community health services

- The four core services set out in the consultation have been confirmed.
- Community dental services will not be a core service. However, if such a service represents a significant part of a provider’s activity, because of expenditure, volume of activity or risk, we may inspect that service and rate and report on it in the same way as a core service.
- We have refined our definition of the core services to be clearer about what is, and what is not, in the scope of each of them. Some specific areas we have clarified are outlined below.
- Services such as physiotherapy and podiatry services are not registered with CQC where they are the only service that the provider offers. For example, an organisation that only provides physiotherapy is not required to be registered with CQC. However, where these services are offered by a community health provider, they will be included in our inspections of relevant core services. This is because they often form a key part of a care pathway, where staff work as part of a multidisciplinary team.
- Community pharmacy services are not required to be registered with CQC and so are not covered by our inspections.
- Following feedback from our events, sexual health services will be included in the scope of the community health services for children, young people and families. Many felt that it fit into this core service better, although we recognise that these services are not limited to young people.
- Some community health and other large providers, including NHS trusts, provide healthcare services in prisons. We do not have a remit to inspect these services, so they will not be inspected directly as part of our comprehensive inspections. However, we inspect these services through a separate inspection programme that we conduct jointly with other relevant inspectorates.
- We are reviewing the approach to inspecting healthcare in prisons. Part of this is to work through how we make sure that relevant information is shared across CQC to inform our understanding of the providers as a whole.
- We recognise that community health services for adults and community health services for children, young people and families are particularly wide ranging. We will assess quality across the core service using our approach to sampling services. We will also aim to include enough information in inspection reports to identify where we have specific concerns in a core service, or where a core service is providing very high-quality care.

Specialist mental health services

- We have reviewed the consultation responses, as well as the learning from our wave inspections to date. We have now separated out community and inpatient older adults and child and adolescent mental health services (CAMHS). We no longer regard eating disorder services as a core service, but may inspect it as a specialist service. We have also categorised substance misuse services as a specialist, rather than a core, service for the following reasons.
- We decided the categories of our core services based on:
 - **Volume:** substance misuse is not a service that is provided by every provider.
 - **Risk:** in general substance misuse services can be considered a low risk service type and there are robust quality indicators available to support Intelligent Monitoring.
 - **Vulnerability of people using services:** although people using substance misuse services often have vulnerable backgrounds and situations, we did not consider this group to be the most vulnerable of those using mental health services.
- As part of our inspection of specialist mental health services, we are committed to looking at care pathways and transitions between services. For example, this could include the children and adolescent mental health services (CAMHS) urgent care pathway. This service is for children and young people who experience a crisis and need intensive support to prevent an admission to hospital or timely access to an inpatient mental health bed, including out of hours.
- We will assess care pathways in relation to the cores services we inspect through the questions that we ask and the methods that we use, including following people through their care pathway. We will form a judgement about the points in a care pathway and use this to inform our ratings of our identified core services
- We have included a key line of enquiry to focus on transitions between services and we are also developing our approach to integrated care.

Key lines of enquiry (KLOEs)

What we said in our consultation

Our inspection teams will use a standard set of key lines of enquiry (KLOEs) that relate to the five key questions – are services safe, effective, caring, responsive and well-led. Having a standard set of KLOEs helps to ensure consistency and transparency in what we look at and provides a basis for a credible and comparable rating. Inspection teams will gather and record evidence to answer each KLOE to enable them to reach a rating.

Consultation questions

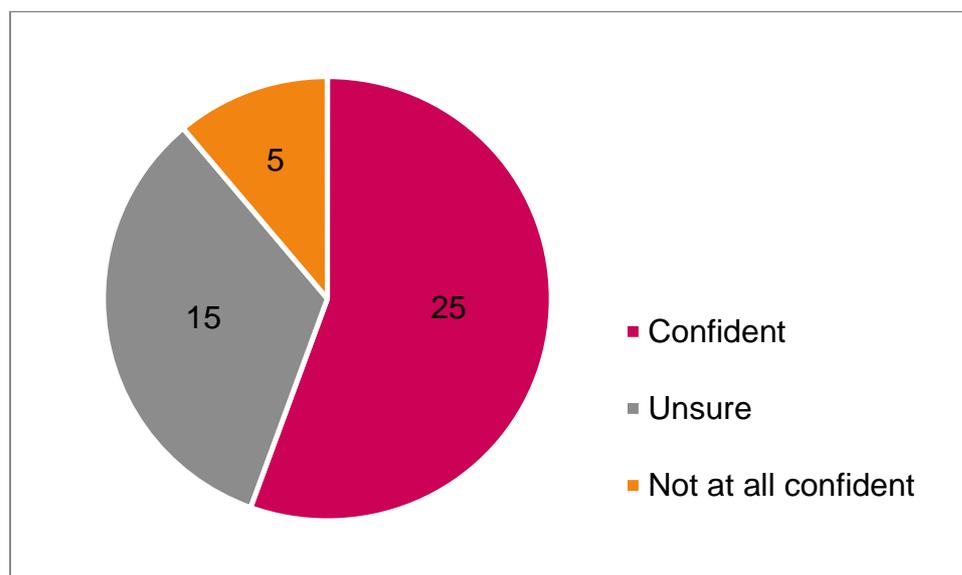
- Do you feel confident that the key lines of enquiry and the list of prompts will help our inspectors to judge how safe, effective, caring, responsive and well-led services are? Is there anything missing?
- What works well, what is missing and what could we improve on?
- Our key lines of enquiry, prompts and ratings characteristics are generic. Do you agree that they can be applied to all of the core services?
- Do you feel confident that a generic approach covers the issues most important for each core service? Is there anything missing?

What you said

NHS acute hospitals

- There was general support for the KLOEs from online respondents. However, only a small majority (25 out of 45 people) felt confident that the KLOEs will help inspectors judge the quality of NHS acute hospitals overall.

Online responses: Do you feel confident that the KLOEs and list of prompts will help our inspectors judge how safe, effective, caring, responsive and well-led NHS acute hospitals are?

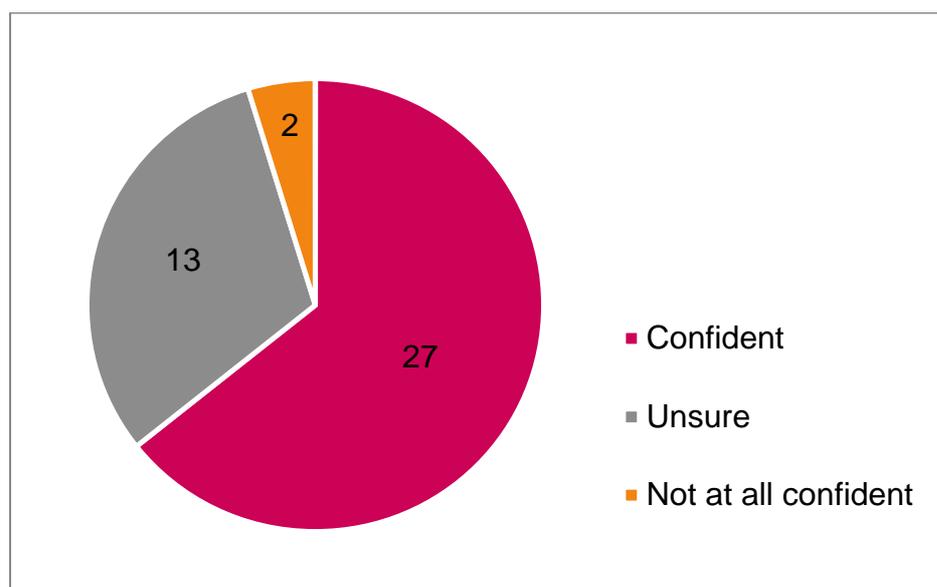


- Overall, feedback from providers at our events was positive. The majority of respondents felt that the KLOEs apply to all the core services, and that they cover most of the important issues for each service.
- While they agreed that the KLOEs would help inspectors to judge a service, they felt that some of the KLOEs did not apply to both inpatient and outpatient services. There was also concern that the KLOEs did not reflect the specific needs or issues of a particular service.
- Some providers were also concerned about how inspectors would make decisions about ratings, as there were different interpretations about what 'effective' care is.
- Training for inspectors was highlighted as a concern by online respondents and providers. People felt that they needed to be well trained to ensure judgements were objective, comparable and robust. Training for Experts by Experience was also a concern to make sure that they were able to judge a hospital fairly.
- Online respondents and providers both agreed that the wording of the KLOEs needed to be reviewed, that the KLOEs needed more detail, for example definitions and clarity about minimum requirements, and that best practice examples should be included.

Community health services

- Overall, the majority (27 out of 42) online respondents were confident that the KLOEs would enable inspectors to judge the quality of community health services. They also felt that the KLOEs provided a framework for a consistent approach by inspectors.

Online responses: Do you feel confident that the KLOEs and list of prompts will help our inspectors judge how safe, effective, caring, responsive and well-led community health services are?



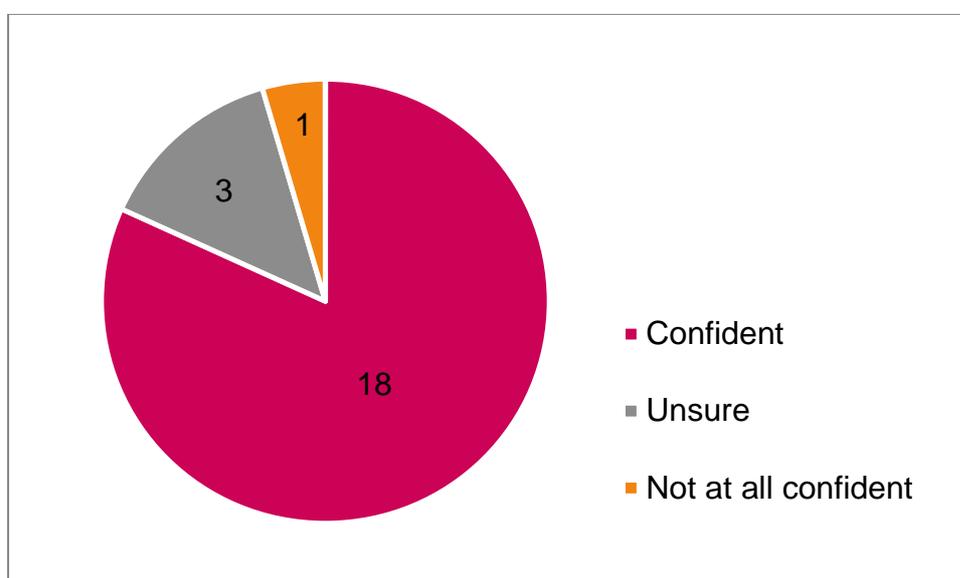
- Some providers said that the KLOEs were good and that they were comprehensive, but that they wanted to see them being used in practice. Others were unsure about the KLOEs and felt that it was just presenting what the inspectors already look at in a different way.
- One group of providers felt that the KLOEs were too broad, and needed to be refined to reflect specific services, for example children's services. Others, however, felt that they focused too much on specific services and did not focus enough on the needs of the people who use services, for example, those with multiple long-term conditions.
- Online responders felt that the KLOEs were comprehensive enough, but understood that they may need to be developed as the breadth of information available changes.
- Some providers were concerned about whether information would be captured appropriately. For example, one of the KLOEs under 'caring' (C1) relating to 'staff attitude' was regarded as a good prompt, but some were concerned that on a short inspection it would not capture the dedication and empathy of staff.
- There were also concerns about the gathering and use of information (such as Intelligent Monitoring data).

- Providers were concerned about whether CQC inspectors would have the correct information and whether they would understand the restraints of local commissioning policies. For example, services that had inherited contracts they did not negotiate and had no control or ability to plan.

Specialist mental health services

- The majority of online respondents thought that the KLOEs would help the inspectors to judge the quality of specialist mental health services overall and by each of the key questions that we ask.

Online responses: Do you feel confident that the KLOEs and list of prompts will help our inspectors judge how safe, effective, caring, responsive and well-led specialist mental health services are?



- People who submitted written responses also welcomed the new, more clearly defined KLOEs. They thought that the prompts were appropriate, with some refinements, and felt that the KLOEs would help ensure clarity and consistency when regulating specialist mental health services.
- In general, providers were supportive of the KLOEs and thought that they were comprehensive. However, some providers thought that the KLOEs and prompts were not detailed enough, and that risk assessments were not shown in the KLOEs. There were also quite a few concerns about the KLOEs relating to the key question on whether services are caring, for example that this question would not be easy to judge as it would depend a lot on the behaviour of the person receiving the care on the day of inspection.
- Some providers made comments on the language used in the KLOEs. For example, under the caring question 'recovery/rehab' should be changed as it is not reflective of the industry.

- People submitting written responses suggested that guidelines on inpatient services should be developed for people with learning disabilities and children and adult mental health services (CAMHS).

Our response

- We have revised our KLOEs and prompts to make it clearer where certain topics sit. As a result, we have moved some of the prompts between key questions.
- We also revised our KLOEs to ensure we had the right level of focus on particular issues. For example, we have included a KLOE on consent, and a KLOE on the role of information. We have also reviewed the language used in our KLOEs to make sure that it reflects current practice.
- We have rephrased the prompts as questions for our inspection teams to consider. This makes it clearer and provides more detail, for both our inspection teams and providers, about what we will look at.
- We recognise that we need to be clearer and give more detail on the areas of the core services that we inspect. To supplement the assessment framework, we will provide service specific guidelines for our inspection teams. These will give more detailed information in terms of how we will inspect, and how the prompts can be supplemented to reflect the particular context of a service. We will publish these guidelines alongside our handbooks as they are developed, and update them to reflect any changes to practice or policy.
- For community health services, we recognise that the prompts and descriptions of good included some specific examples that were not applicable to all core services. For example, they included specific references about end of life care or providing good care to children and young people. We have now removed these references for the community health service assessment framework, which can be applied equally to all core service areas. This additional level of detail will now be included in our service specific guidelines.

Characteristics of ratings

What we said in our consultation

We plan to rate the performance of the hospital/service against each core service, each of the five key questions and the service overall. When we rate services we will use the following four-point scale: outstanding, good, requires improvement or inadequate. We have developed a description of each of the four ratings, for each of the five key questions. These characteristics provide a framework which, together with professional judgement, will guide our inspection teams when they award a rating. We will include new national priorities or policy directions in these characteristics as they emerge.

Not every characteristic has to be present for the corresponding rating to be given.

Consultation questions

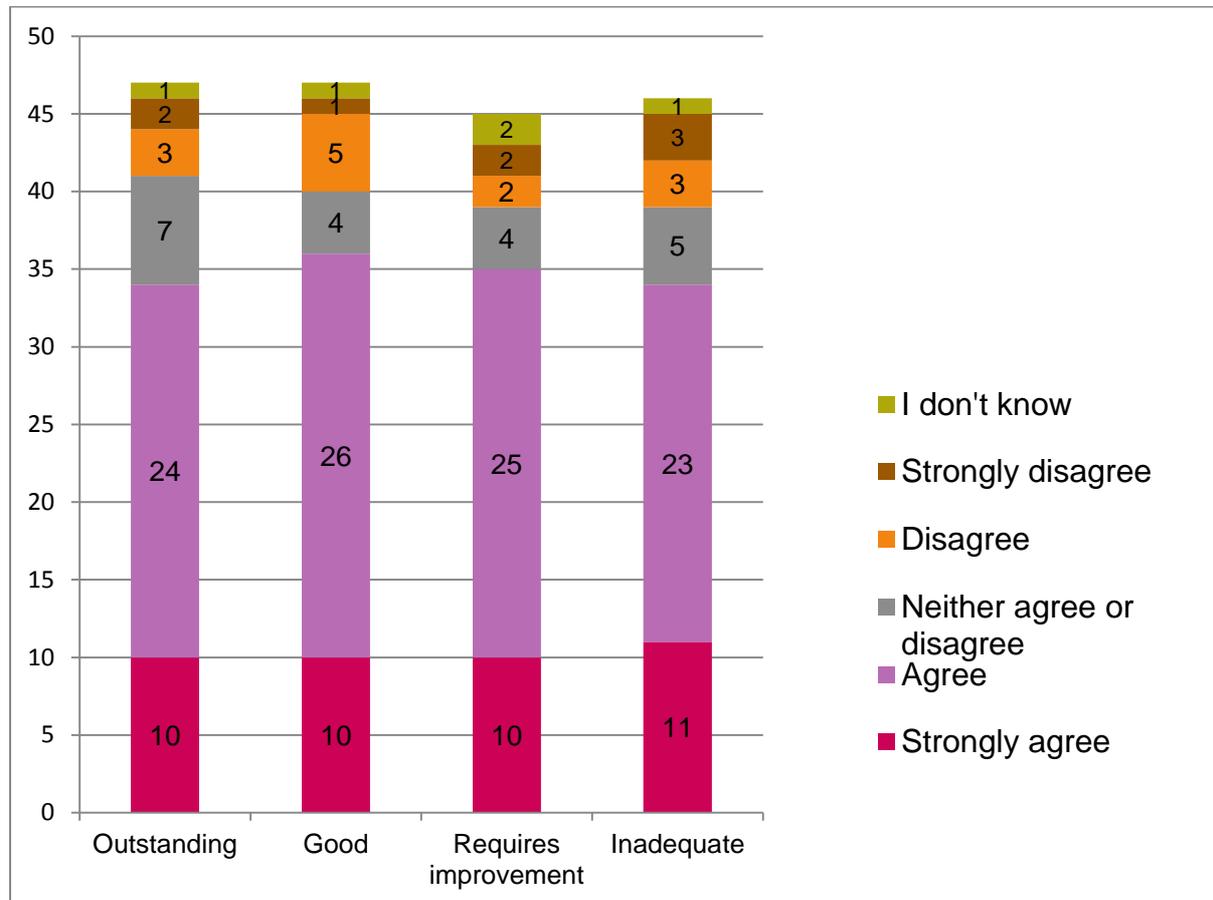
- Do the characteristics of what a service looks like (outstanding, good, requires improvement or inadequate) reflect what you would expect to see?
- What works well, what is missing and what could we improve on?

What you said

NHS acute hospitals

- The vast majority of respondents supported how CQC has defined each rating, although providers at events recommended changes to the language to make it clearer.
- The vast majority of respondents to the online survey either agreed or strongly agreed that the description of each rating reflects what people would see in NHS acute hospitals that are rated as outstanding, good, requires improvement or inadequate.

Online responses: Do the characteristics of what a service looks like (outstanding, good, requires improvement or inadequate) reflect what you would expect to see in an NHS acute hospital?

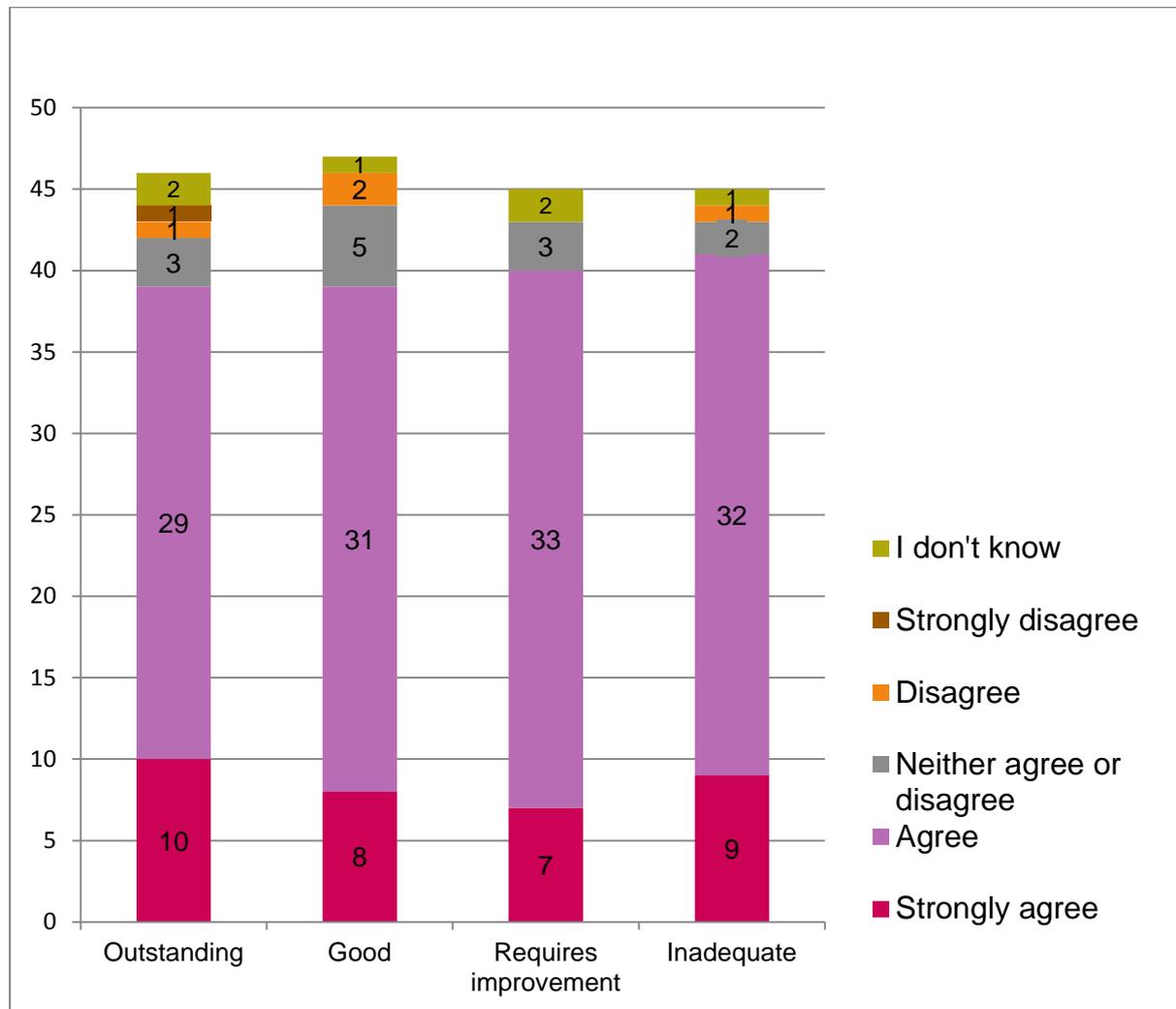


- Although most respondents agreed or strongly agreed that CQC’s descriptions of each rating reflect what people would see in NHS acute hospitals, some felt that CQC needed to place more emphasis on patients themselves and how they feel.

Community health services

- The vast majority of respondents supported how CQC has defined each rating. Providers at events felt that there could be more detail in the well-led question. Also, those that responded online expressed concern that, for a large provider, certain areas of its service may prevent it achieving a higher rating overall.

Online responses: Do the characteristics of what a service looks like (outstanding, good, requires improvement or inadequate) reflect what you would expect to see in a community health service?

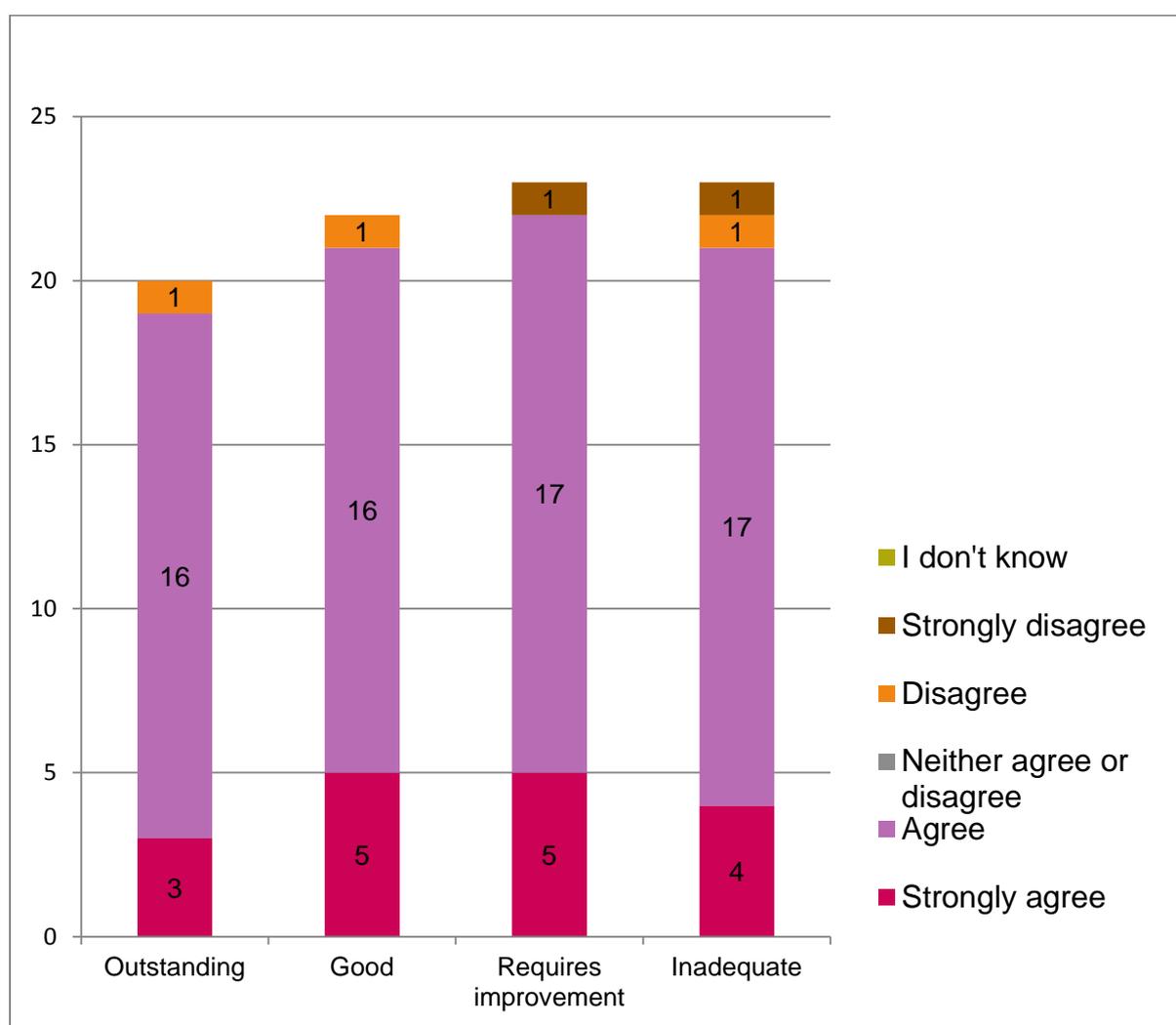


- Qualitative research and feedback from events suggests that the characteristics of good care resonated with the public and people that had experience of different community health services. There were some areas of greater importance or relevance to people than others, but nothing was considered to be missing from these descriptions.
- Some providers queried how inspectors would distinguish between good and outstanding services.
- Buddy systems, local mentoring and a repository of good practice were suggested as popular ways that CQC could promote learning between providers.

Specialist mental health services

- The majority of people that responded online either agreed or strongly agreed that the description of each rating reflects what people would see in specialist mental health services rated as outstanding, good, requires improvement or inadequate. Broadly speaking, those that attended the consultation events echoed this view, although there were some concerns. For example, providers felt that the descriptions of good care were too general and there was some concern that this was not good enough to be a national benchmark for organisations to achieve.

Online responses: Do the characteristics of what a service looks like (outstanding, good, requires improvement or inadequate) reflect what you would expect to see in a specialist mental health service?



Our response

- We have better defined the gap between outstanding and good.
- Some of our characteristics gave specific examples. We have recognised that this was not always helpful when trying to apply the examples on an inspection as this approach could not cover every eventuality. We have worked to make sure that characteristics are not specific examples, so that they can be applied flexibly, depending on what we find during the inspection.
- We are clearer about the impact on people at different ratings levels.
- The characteristics focus more on the experiences of people.
- The characteristics do not explicitly set out national guidance and best practice. Other bodies are better placed than CQC to both identify this and provide the detail and it is not the role of the characteristics to replicate this.

Applying and reviewing ratings

What we said in our consultation

To ensure that we make consistent decisions about ratings we intend to use a set of ratings principles. The principles will normally apply, but will be balanced by the discretion and professional judgement of inspection teams in the light of all of the available evidence. Providers will have the opportunity to request a review of the rating they have been awarded and we have described the proposed process for doing this.

Consultation questions

- Do you agree that the five key questions are equally important and should be weighted equally in our aggregation method?
- Do you agree that in general the core services should be weighted equally, the only exception being where a core service at a trust is particularly small?
- Do you agree with the guidelines for aggregating ratings? Are there any that you disagree with? Is there anything else that we should include?
- Do you feel confident that the proposed reviews process is sufficiently clear and robust?
- Do you agree that providers should be able to apply for a single focused inspection to recognise where improvements have been made?

What you said

NHS acute hospitals

- Staff and providers had mixed views about whether the five key questions should be weighted or not. Well-led and safe were seen as the most important questions by those who said they should be weighted differently. This was also the view of several professionals and some online respondents.
- Almost all responses from the public online community, providers and those responding online agreed that the core services should be rated and reported on separately, and that core services have equal importance and should be weighted equally when deciding an overall rating.

- Many providers felt that to be rated as outstanding overall a service should have to achieve individual outstanding ratings in at least three, if not five, of the key questions.
- The majority of online respondents (27 out of 41) agreed or strongly agreed with the ratings principles. However, many (including professional representatives, NHS bodies and national charities) thought that the guidelines for aggregating ratings were confusing and needed to be made clearer.
- There were also concerns that aggregated provider ratings would not show which services had good ratings and which had poor ratings, and would therefore not be of use to the public. It was suggested that reports should name wards and departments where poor performance was identified.
- One charity also raised concerns that the timescales for submitting comments about factual accuracies was very tight for organisations.
- Overall, 30 out of 42 online respondents agreed or strongly agreed with the grounds on which trusts could challenge their inspection reports and ask for a review of their rating. Thirty-three out of 43 online respondents also felt confident that the reviews process was sufficiently clear and robust.
- There was general agreement from providers that focused inspections were a good idea. However, there was a mixed response from online respondents, with only 22 out of 41 agreeing they would be appropriate, with some arguing they could hide poor care. Online respondents were also concerned about whether CQC had the funding and resources to carry out the focused inspections.
- Online respondents were not confident that CQC has the resources needed to undertake the number of focused inspections that providers may demand, as well as the list of scheduled inspections.

Community health services

- There was mixed opinion among providers about whether ratings of the key questions should be weighted.
- The majority of respondents (33 out of 43) via the public online community supported the proposed ratings principles, and all except one agreed that the five key questions should be equally weighted. However, they were concerned about the limitations that prevent organisations being rated as 'outstanding'.
- Providers told us that we should publish all the ratings for services within a provider and not just the overall rating. This is so that people using the services are able to understand how the services are inspected and rated.
- People were also concerned about how an overall rating would be given when an organisation had multiple sites.
- The majority of online respondents (41 out of 43) agreed with the way in which providers can request a review of their ratings. However, they were concerned about the process for challenging the factual accuracy of ratings reports. They thought there should be an arbitration procedure to avoid prolonged expensive processes and reputational damage.

Specialist mental health services

- In general, online respondents supported the equal weighting of the five questions. However, there was a mixed view from providers about equal weighting of the questions and core services. Some thought that 'safe' should be weighted more strongly than others. Some providers were also concerned about the relative sizes of service areas and their ratings.
- Many providers felt that the ratings should be tougher and, in general, they agreed that lower ratings should take precedence. For example, one rating of inadequate should limit the overall rating to requires improvement.
- Providers also agreed that to be rated outstanding overall, a service should have to achieve individual outstanding ratings in at least three, if not five, of the key questions. They also felt that it was important for better services to be recognised in a provider that had some inadequate services.
- There were concerns about the consistency and fairness of ratings. For example, the experience of the inspectors and their understanding of the services may have an impact on ratings.
- Providers with multiple sites wanted a rating for each site, rather than one overall rating for the group.
- Overall, people agreed that the aggregation of ratings was good and could work well, although there were concerns that good or poor services could be hidden within one overall rating.
- Online respondents were concerned about the timescale for submitting factual accuracy comments for large scale organisations.

Our response

- The five questions remain equally weighted to reflect their equal importance.
- Reflecting feedback across all sectors, we have reviewed the characteristics of outstanding to make sure that there is a clear difference between these and the characteristics of good.
- We have reviewed the suggestions that providers need three or even five key questions rated outstanding in order to be outstanding overall, but our testing to date shows this would mean only a very small number of providers could achieve outstanding. Evidence shows that setting the bar for outstanding at a very high level, which is perceived as unattainable by the majority of providers, is likely to have minimal impact on encouraging improvement. Setting outstanding at this level is also likely to result in more services being rated as good, which makes it harder for the sector to identify and learn from good practice and potentially difficult for the public to identify outstanding care. The number of core services provided by hospitals varies widely, which means that they are not all the same. As a result, we have described our aggregation

principles in bands to make it clearer how they will be applied where there are different numbers of core services.

- Aggregating ratings for NHS trusts and other complex organisations, including those that provide care across a range of sites or provide more than one type of service (for example, acute services and community health services) can be challenging. When aggregating ratings for a provider as whole, the principles we have set out will always guide our aggregation.
- However, we must be also proportionate in our ratings for complex organisations. This is so that we do not unduly penalise a provider because we have concerns in a very small number of areas. As a result, we have more clearly set out the factors that determine when professional judgement should be used to adjust the aggregated ratings, and where there is a very clear and stated rationale for doing so. These include issues about the size of the service, the impact that our concern may have on people, and our confidence about how well the issue will be addressed.
- We will undertake a focused inspection for two reasons: to focus on an area of concern or where certain changes in a provider occur. A focus inspection is not an opportunity to review a rating where there are no concerns.
- Focused inspections will not look at all five key questions. They will focus on the areas indicated by the information that triggers the focused inspection. The reason for the focused inspection determines the scope of the inspection, when to visit, what evidence needs to be gathered, the size of the team and which specialist advisers to involve. Visits may be announced or unannounced depending on the focus of the inspection.
- A focused inspection may result in a change to ratings at the key question or core service level. As a focused inspection is not an inspection of the whole of a provider or service, it will not produce ratings where they do not already exist.

Compliance with the Mental Capacity Act

What we said in our consultation

We inspect and report on how well health and social care services, including specialist mental health services, meet the Code of Practice in the Mental Capacity Act. The code applies when staff are assessing whether people aged 16 and over have the mental capacity to take particular decisions, and when they take decisions on people's behalf – for example where a service works with people who may have cognitive difficulties due to dementia or a learning disability.

Consultation questions

- **How best do you think we can ensure that providers improve the way they conform with both the wider Mental Capacity Act and the Deprivation of Liberty Safeguards?**
 - ~ **Make sure we give sufficient weighting to this in our characteristics of good?**
 - ~ **If providers do not meet the requirements of the MCA and DoLS, apply limiters (meaning a service could not be better than requires improvement) in a proportionate way to ratings at key question level?**
 - ~ **In other ways?**

What you said

NHS acute hospitals, community health services and specialist mental health services

- Online respondents had mixed views about how to encourage compliance with the Mental Capacity Act and Deprivation of Liberty Safeguards. Some agreed that CQC should apply limiters, while others said CQC should give sufficient weighting to this in the description of 'good'.
- Other online suggestions included providing best practice examples, education and support for staff, and providing support and resources to implement this successfully.
- One person at the events suggested creating a website on good practice.

- Respondents to the online survey had mixed views about the best way to encourage compliance with the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Seven of the 20 respondents thought that limiters should be applied, nine thought that sufficient weighting should be given if 'good', and four said something else should be done. Alternative suggestions included giving the same weighting to the MCA and Mental Health Act (MHA) so systematic breaches have the same consequence.
- Some respondents stressed that CQC inspectors need a clear understanding of the MCA process and the different ways this can be used in practice, especially in different care settings. This should be extended to DOLS and mental health interpretation.

Our response

- Following feedback from the consultation we have included a specific key line of enquiry about consent. This takes into account the requirements of the MCA and other relevant legislation.
- This KLOE will have a direct impact on how we rate and judge the key question of 'effectiveness'. As a result, it is not necessary to apply breaches of the MCA as a specific limiter to ratings.
- We are providing MCA training to our inspection teams.

Mental Health Act

We are integrating the way we inspect specialist mental health services and how we carry out some of our monitoring responsibilities under the Mental Health Act. During our comprehensive inspections, our experts will undertake some monitoring in selected locations and review the way providers discharge their duties under the Act overall as part of the well-led question.

The Mental Health Act monitoring activity we carry out on comprehensive inspections will inform our judgements of a provider. We will also carry out additional monitoring visits, which will take place outside of comprehensive inspections. This is to fulfil our statutory responsibilities to meet with people who are subject to the Act and will also provide intelligence to inform our ongoing monitoring of services. Where concerns are identified, this may trigger further inspection or monitoring activity.

Consultation questions

- Do you agree that continued or systematic breaches in the operation of the MHA or adherence to its Code of Practice should be used as described to limit the ratings?
- We are integrating the way we inspect specialist mental health services with how we carry out some of our Mental Health Act (MHA) monitoring responsibilities. Are there any benefits or challenges in our proposals for integrating some of our MHA monitoring activity within our comprehensive inspections of mental health providers under the Health and Social Care Act?
- We are currently testing our methods for reporting on MHA monitoring visits, both as part of our comprehensive inspections and our additional MHA monitoring visits. Which option would be best in relation to reporting on our MHA monitoring?

What you said

NHS acute hospitals, community health services and specialist mental health services

- Nearly all online respondents agreed that CQC should give sufficient weighting in the description of 'good', and limit ratings for non-compliance with the Mental Health Act (MHA). They also that ratings should be limited for continued breaches of the MHA.
- There was support for integrating inspections and MHA visits, with people saying that integrating MHA monitoring will provide a full picture of compliance,

will reduce the burden on CQC inspectors, will reduce confusion caused by the two current inspections, and will help to provide a full picture of the journey through care that people experience.

- However, the challenges of integrating inspections and MHA visits were also highlighted. For example, while the integration of MHA commissioners was seen as positive, it is important to recognise that their expertise is the MHA, and some do not have significant understanding of the Health and Social Care Act. There was also concern that the MHA would not be reviewed independently or frequently enough.
- Opinions from online respondents were fairly evenly split about which option would be best for reporting on MHA monitoring. Eleven respondents felt that publishing reports at hospital or unit level was the best approach, while nine respondents felt that reporting for each core service or care pathway was the best approach.
- Some people submitting written responses were concerned about how the specific and detailed responsibilities laid out in the MHA's Code of Practice will feed into the KLOEs.
- People also wanted further clarity on the reporting functions for current MHA visits. For example, will visits continue to be addressed separately from compliance reports or become part of a more fully integrated approach?

Our response

- We are integrating and aligning our responsibilities for monitoring the MHA with our inspections of specialist mental health services.
- During our comprehensive inspections, our MHA reviewers will monitor MHA activities at selected locations and review how the provider discharges their duties under the MHA overall. The MHA monitoring activity we carry out will always inform our judgements of a provider.
- We will also carry out MHA monitoring visits outside of our comprehensive inspections. This is to fulfil our MHA statutory responsibilities to keep the MHA under review and meet with people who are subject to the Act. It also provides intelligence to inform our ongoing monitoring of the use of the MHA. Further inspection or monitoring activity may be triggered where we find concerns.
- We intend to continue to evaluate and refine our approach to integrating and aligning the MHA with our inspections. This includes the way we report on our inspection and monitoring activity. More changes will be announced in 2015.
- By including a specific KLOE, we have made sure that the requirements of the MHA are taken in to account when we make judgements and award ratings.

Independent mental health providers

What we said in our consultation

We realise that many specialist mental health services are provided by independent sector providers, so we wanted to seek views on ways of inspecting and regulating these services. We asked for views on our approach to information requests for both NHS trusts and independent mental health service providers. As part of our ongoing learning, we will be reviewing how successful our approach to quality summits is in driving improvement. We are currently developing an understanding of the way this approach might be applied to both large and small independent healthcare providers.

For independent sector services with multiple sites that are geographically dispersed, we are considering two options: inspecting all of the provider's services at one point in time to match our approach for NHS providers, or inspecting the provider's sites on a rolling programme over a two to three-year period, with an annual inspection to the provider's headquarters to form a judgement about the leadership of the organisation.

Consultation questions

- **Is the range of information we have listed applicable to independent mental health care providers?**
- **The findings of our inspections will inform the basis of a discussion at a quality summit with commissioners. How can we adapt the approach to quality summits for independent sector providers?**
- **We have set out two options for inspecting independent providers of specialist mental health services that have multiple sites which are geographically dispersed. Which option would be best?**

What you said

NHS acute hospitals, community health services and specialist mental health services

- Nearly all online respondents thought that the range of information listed was applicable to independent providers. Respondents felt that the same standards should apply, no matter what the status of the provider.
- Some online respondents were concerned that the proposed quality summits are not the best way to manage the outcome of inspection, as the onus is on

the provider organisation to call in appropriate partners to discuss key features of the inspection findings.

- Eleven respondents thought that a rolling programme of inspections would be best for providers with multiple sites, and eight thought that inspecting all sites at one time would be best.

Our response

- We will test different models of inspection for independent sector services. We will select an approach for each provider that is suitable for the size and geographical spread of the provider.
- We will continue to test our approach to all independent providers, including the design of the quality summit, and will review our learning from these inspections.

Our Human Rights approach

We consulted on our approach to human rights in our regulation of care services. We received 188 online responses and 11 written submissions from the public, providers, commissioners, CQC staff, health and social care professionals and national stakeholders.

What we said in our consultation

We believe that our human rights-based approach to regulation, inspection and monitoring care services is the best method to ensure that we promote equality and human rights in our work. We have integrated the human rights principles into our key lines of enquiry (KLOEs), ratings descriptors, Intelligent Monitoring, inspection methods, learning and development for inspection teams and into our policies around judgement making and enforcement. Our human rights approach to regulation looks at a set of human rights principles – fairness, respect, equality, dignity, autonomy, right to life and rights for staff – in relation to the five key questions we ask.

Our approach will ensure that we meet our duties under the Human Rights Act 1998 to respect, protect and fulfil people's human rights, and under the Equality Act 2010 to have due regard, when delivering our functions, to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between groups in relation to the 'protected characteristics' of age, disability, gender reassignment, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

Respecting diversity, promoting equality and ensuring human rights will mean that everyone using health and social care services receives good quality care.

Consultation questions

- Do you think our strategy for integrating human rights into the way we inspect, monitor and regulate services is the right approach? Are any changes needed?
- Do you think we have selected the right 'set' of human rights principles?
- Do you think the definitions of each human rights principle is the right one? Are any changes needed?
- Are any changes needed to our human rights topics list?
- Do you have any comments on how we propose to:
 - ~ Identify risks to human rights?
 - ~ Inspect for human rights?
 - ~ Provide learning and development on human rights for our registration and inspection teams?

Are there other ways that we should apply our human rights approach?

- Are our principles for applying our human rights approach the right ones?
- Are there any other ways we can help to encourage improvement in equality and human rights for people who receive care?
- How should we evaluate the success of our human rights approach?
- Would you like to be involved in the development of our human rights approach in the future? How should we involve people who use services, the public, providers and other stakeholders in the development of our human rights approach?
- Do you have any other comments about our human rights approach?

What you said

- The majority of online respondents (92%), as well as responses from written submissions and the broader consultation, agreed that our strategy is the right approach on human rights. However, there were still concerns that it was being viewed as an 'optional extra' and that it should also include factors such as socioeconomic deprivation.

- Other changes suggested included putting the focus on outcomes for people who use services, and making it explicit that our approach includes children and young people as well as adults.
- Nearly all online respondents (94%) agreed that we have selected the right set of human rights principles. In addition to fairness, respect, equality, dignity, and autonomy (FREDA), and right to life and staff rights, some felt that it was also important to add 'Personalisation' and 'Empowerment'.
- Again, 94% of online respondents agreed that the definition of each human rights principle is the right one.
- There was support for our human rights list of topics, but one person suggested that people who use services will need to be proactively supported to make sure they have the 'right to freedom of expression' in creative and person-centred ways.
- Overall, respondents were supportive of how we proposed to identify risks and inspect for human rights, as well as our plans for training and development of our registration and inspection teams. One charity, however, was concerned about how we would monitor human rights related risks and when any risks identified merit further inspection.
- Nearly all online respondents (95%) agreed that our principles for applying our human rights approach were the right ones.
- Half of all online respondents (51%), and a number of organisations submitting written responses, said that they would like to be involved in the development of the human rights approach in the future. Focus groups, surveys, and public meetings were some of the suggestions made for gathering information.

Our response

We have:

- Made some minor changes to the definitions of our human rights principles, based on consultation feedback, and confirmed that 'personalisation' is part of the autonomy principle and that our 'equality' principle includes multiple discrimination or disadvantage.
- Explained the relationship between the human rights approach and work on health inequalities.
- Added more about children's rights.
- Confirmed that we will carry out work to look at 'triggers' for when risks to human rights should prompt a responsive inspection.
- Added a new section about communicating our human rights approach to providers, people who use services and others
- Added more about how we will evaluate our human rights approach, based on consultation feedback. We have also added all the respondents who were

interested in being involved in the development of the approach to a database, so that we can let them know about future opportunities to be involved in this work.

Equality and human rights impact analysis and regulatory impact assessment

We also published an interim regulatory impact assessment and an equality impact analysis for this consultation on our proposed provider handbooks.

What you said

- In general, respondents were supportive of our approach to the equality and human rights impact analysis. Where concerns were raised, these were around: making sure the approach was strong enough to deal with denial by providers; the amount of work involved for GP practices; and the issue of training for staff.
- The small amount of feedback on our interim regulatory impact assessment welcomed our focus on core services and specialist inspections, but expressed interest in CQC's own costs of inspection as well as the costs to providers.

Our response

- We have provided more information in our final regulatory impact assessment about the costs and benefits of our new inspection model.
- We believe, following this consultation, that our human rights-based approach to regulation, inspection and monitoring care services is the best method to ensure that we promote equality and human rights in our work. We have made minor amendments to the human rights approach outlined in the section above.
- We will continue to integrate our human rights principles into our key lines of enquiry (KLOEs), ratings descriptors, Intelligent Monitoring, inspection methods, learning and development for inspection teams and into our policies around judgement making and enforcement.
- Our development of the equality and human rights aspects of enforcing the new fundamental standards will help when providers are 'in denial'. Since we published the initial equality impact assessment in April, we have published our draft guidance for providers on our approach to enforcement, which reinforces our approach to regulating the equality and human rights aspects of the regulations.
- We are developing a programme of learning for CQC staff so that they all have the knowledge and skills to implement our human rights approach in inspection – including gathering evidence, reporting, making judgements about ratings

and about whether providers are meeting the fundamental standards related to equality and human rights.

- Our approach to equality and human rights does not add extra requirements on providers. It uncovers and addresses the equality and human rights aspects that are inherent in our five key questions and the fundamental standards.

Appendix A: Organisations that submitted responses

National charities

Action against Medical Accidents (AvMA)	Marie Curie
Action on Hearing Loss	Mencap
Alzheimer's Society	Mind
Alzheimer's Society - Community Health	National Aids Trust
Alzheimer's Society - NHS Acute Hospital	National Children's Bureau
Autism Alliance	Parkinsons UK
Big Brother Watch	Patients Association
Bliss	Positive Signs
Brap	Public Concern at Work
Carers UK	Scope
Carers UK - Community Health Services	Sense
Carers UK - NHS Acute Hospitals	SIGN Health
Children's Rights Alliance for England	Skills for Care
Diabetes UK	Stonewall
The Disabilities Trust	Relatives and Residents Association
Independent Age	RNIB
The Lesbian and Gay Foundation	RNID
LGB&T Partnership	Together for Short Lives
Macmillan	Women's Health and Equality Consortium

Professional representatives

BMA - NHS Acute Hospitals	Royal College of Paediatrics and Child Health
British Psychological Society	Royal College of Physicians
Foundation Trust Network	Royal College of Physicians - Edinburgh
Medical Defence Union	Royal College of Psychiatrists
Medical Protection Society	Royal College of Radiologists
Royal College of Anaesthetists	Royal College of Surgeons
Royal College of General Practitioners	Royal Pharmaceutical Society
Royal College of Nursing	Society and College of Radiographers
Royal College of Obstetricians and Gynaecologists	

Strategic partners

Association of Directors of Adult Social Services	Local Government Ombudsman
Department of Health	National Institute for Health and Care Excellence
Department of Health Citizen Insight Team	NHS England
Equality and Human Rights Commission	NHS England - Director of Nursing
General Medical Council	Parliamentary and Health Service Ombudsman
Health and Safety Executive	Public Health England
HMIP	UKAS
Local Government Association	

Trade associations

Associated Retirement Community Operators	NHS Clinical Commissioners (NHSCC)
British Medical Association	NHS Confederation
Care England	Registered Care Providers Association
Help for Hospices	Registered Nursing Homes Association
Independent Mental Health Service Alliance	UK Homecare Association
National Care Forum	VODG
Natspec	

Think tanks

Diabetes Think-tank

Health Foundation

Social Care Institute for Excellence

Other organisations

Committee of Directors of Postgraduate Education

Director of Postgraduate Education HEE

Gold Standards Framework

LaingBuisson

My Home Life

National Clinical Assessment Service

NHS London Leadership Academy

Appendix B: Consultation engagement events and responses

Engagement events

- **25 April**, Manchester – 30 members of the public/people who use services
- **8 May**, London – 38 members of the public/people who use services
- **9 May**, London – 40 providers of NHS acute, community health and specialist mental health services
- **13 May**, Preston – 29 providers of NHS acute, community health and specialist mental health services
- **19 May**, Bristol – 23 providers of NHS acute, community health and specialist mental health services
- **22 May**, Birmingham – 18 members of CQC staff
- **22 May**, Birmingham – 35 members of the public/people who use services
- **29 May**, Southampton – 12 members of the public/people who use services
- **4 June**, Nottingham – 36 providers of NHS acute, community health and specialist mental health services

Responses received

The total number of responses to the consultation received on our website was:

- NHS acute hospitals – 49
- Community health – 48
- Specialist mental health – 26

As well as the forms completed online, we received 66 written submissions referring to NHS acute hospitals, 11 referring to community health services and 26 referring to specialist mental health services. There is a list of organisations submitting written responses in appendix A.