

Response to the consultation on our provider handbook

## **NHS GP practices and GP out-of-hours services**

October 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 GP practices and GP out-of-hours 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, national stakeholders such as the General Practitioners Committee of the BMA, the National Association of Primary Care, Royal Colleges including the Royal College of Nursing and the Royal College of GPs, 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 pilot 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 and the population groups, 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 approach – including the 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. For NHS GP practices and GP out-of-hours services this will be by April 2016. We may update prompts 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 Steve Field**

Chief Inspector of General Practice

# 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 relating to our handbook on NHS GP practices and GP out-of-hours 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.

Alongside this consultation, we continued to test, evaluate and develop the new approach through pilot (wave) inspections. These started in January 2014 for out-of-hours services and April 2014 for NHS GP practices.

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

## Incorporating learning from our waves 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 been testing our approach since January 2014. Between January and March we inspected 30 GP out-of-hours services. Between April and September we inspected 336 GP practices and 12 GP out-of-hours services in two waves.

Throughout these inspections we have been gathering feedback from inspection teams and providers to test our approach. We have used this feedback to inform changes to the inspection framework and the inspection process.

## How we engaged and who we heard from

To gather feedback about our consultation we organised 11 events across the country for providers of NHS GP practices and GP out-of-hours services, members of the public and CQC staff (see appendix A for details). These were attended by 253 people.

A self-completion form was also used at some of the later events to capture any additional comments attendees wished to make. We received 22 completed forms and the information in them has been incorporated into the findings from the events.

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

- Five provider consultation events in Birmingham, Newcastle, London, Bury St Edmunds and Preston. Each event was attended by approximately 20 providers. They were hosted by senior members of CQC staff and included presentations followed by table discussions focusing on different aspects of the consultation document.

In addition to these events, the consultation questions were included for discussion on the agenda of the regular meetings of our GP advisory group (29 April) and GP out-of-hours task and finish group (24 April). These meetings included table discussions about specific aspects of the consultation relating to those services.

We received 76 online responses, and 33 written submissions from a range of organisations (see appendix B for a complete list of organisations who responded across all sectors).

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. We 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 parts of the consultation. We analysed and took into account the views of the tweets we received as part of the consultation.

We also asked members of the public to send, using social media, photographs of themselves holding up boards with their own definitions of what good care looks like across the sectors written on them. We analysed the comments we received on the

photographs 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.

We made use of our monthly telephone calls with local Healthwatch representatives.

### **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 NHS GP practices and GP out-of-hours services on Tuesday 27 May.
- 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 (NHS GP practices and GP out-of-hours services) – what we look at and look for on inspections: population groups, key lines of enquiry, and ratings characteristics (what good looks like): three responses.
  - Consultation review 2 (NHS GP practices and GP out-of-hours services) – gathering and using information, ratings, and the Mental Capacity Act and the Deprivation of Liberty Safeguards: one response.

Public community:

- We received 20 responses through the public online community relating to NHS GP practices and GP out-of-hours services. Specific online engagement events during the consultation period included:
  - Review of 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
  - A comment/discussion thread on [‘What does good look like?’](#) ran for the length of the consultation (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 36 people about inspection proposals in primary care services. Where applicable to a particular sector findings from this research 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, relating to all sectors.

## **How we analysed the feedback from the consultation**

We commissioned Quality Health, an independent healthcare consultancy, to support the consultation process. Quality Health 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 we will regulate, inspect and rate NHS GP practices and GP out-of-hours 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 to our approach, which are described throughout the handbook 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. Key lines of enquiry (KLOEs), prompts and ratings characteristics

- We have rationalised some of the KLOEs and prompts to reduce areas of duplication. Our pilot work and feedback from the consultation 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 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 population groups**

- We have clarified and refined the names and definitions for the six population to make it clear what is and is not covered by each, and to describe our approach to inspecting them. For example:
  - The 'mothers, babies children and young people' population group is now titled 'families, children and young people'.

## **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 rating. 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.

## **5. Inspection methodology**

- We will now issue a pre-inspection information request that will provide us with a helpful insight into the practice before we carry out the site visit. It will also ensure that inspection teams are able to make the best use of their time when on the inspection
- GP practices and GP out-of-hours services will be asked to spend half an hour at the start of the inspection telling us about its service and giving its own view of its performance, particularly in relation to the five key questions and six population groups (for GP practices). This should include anything they consider to be outstanding care and practice.

## Section 3: What you told us and our response

### Population groups

#### What we said in our consultation

We set out six key population groups that we will look at when inspecting NHS GP practices to understand the quality of service provided to different groups of people.

The six population groups for NHS GP practices were:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

#### Consultation questions

- Do you agree that these are the right groups for us to look at?
- Do you understand what we mean by these population groups? If not, what is unclear?
- Do you agree that we should rate and report on each of these population groups for GP practices?

## What you said

- Online respondents largely understood the population groups and nearly all people responding through the public online community thought they should be rated and reported on.
- Some online respondents expressed doubts about how relevant or useful population groups were as a basis for inspection, particularly in out-of-hours services.
- Providers were concerned that some of the population groups may not be seen by some practices due to differences in the local population.
- Where people agreed with the groups, the majority agreed with the things to be looked at to judge the quality of care for each group.
- There were concerns about the overlap between groups.
- There was concern from providers that the term 'mother' was open to interpretation. And that fathers and carers were missing from the mothers, babies, children and young people group.
- Providers felt that 'young people' should be in a separate group from mothers, babies and children, as their needs are very different.
- A significant number felt that long-term conditions was the most meaningful group.
- People in vulnerable circumstances was seen as the most problematic term because some of the groups labelled as 'vulnerable' may not consider themselves to be so, and there were questions about which people were included in this group.
- Further groups that people felt were 'missing' included: people with dementia, people receiving end of life care, people with autism, people with a learning disability, students and people with alcohol or substance misuse issues.
- Providers felt that the overriding principle should be on ensuring equitable access for all of those that need to use these services.
- It was felt that the definitions should be more detailed and that it should be clear what is expected of providers in relation to each of these groups.

## Our response

- We are pleased that there was support for the approach of looking at the quality of services in a GP practice through the lens of different population groups. And

we welcome the detailed feedback on the definitions we proposed for each group.

- Since the consultation we have held a number of co-production groups with a range of experts, stakeholder organisations and people who use services to develop the definitions and the inspection framework for these six population groups. This has resulted in a number of changes to the groups and more detailed criteria for inspectors and providers to use. The revised population groups are:
  - Older people
  - People with long-term conditions
  - Families, children and young people
  - Working age people (including those recently retired and students)
  - People whose circumstances may make them vulnerable
  - People experiencing poor mental health (including people with dementia).

Full details on these, including definitions of each group, are included in the revised NHS GP practices and GP out-of-hours provider handbook.

In the handbook we have clarified which people are being considered in the 'people whose circumstances may make them vulnerable' group. Whilst we had some feedback that the use of the word 'vulnerable' was not helpful, we felt that this is the clearest way to describe this group. We have amended the name of this group to make it clearer that it is the circumstances people are in which may make them vulnerable. And we have acknowledged in the detailed definition of this group that these people may not necessarily view themselves as being vulnerable.

# 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 NHS GP practices and GP out-of-hours services is to seek out and listen to the experiences of the public, including people who use services and those close to them. This includes the views of people who are in vulnerable circumstances and 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

- How confident are you that the sources of information we plan to look at will identify risks of poor quality care and good practice?
- Do you agree that the proposed methods of gathering information from the public about their views and experiences are the right ones?
- Will they enable us to gather views from all the people we need to hear from?

## What you said

- Providers were concerned about unevenness of available data across the sector and wanted to see Intelligent Monitoring templates and information about the standard datasets that would be requested.
- There was concern that information from other parts of the health and social care system could effectively distort how GP practices and out-of-hours services are assessed.
- There was also concern about some of the sources of information used to assess GP practices. For example, some sources are more likely to be negative (for example NHS Choices) or based on inconclusive evidence (for example fitness to practise referrals). This view is supported by organisations representing the interests of GPs.

- Providers were worried that practices that adopted a rigorous approach to reporting incidents would be penalised because information would be more visible.
- The majority of those that responded online were either unsure or not at all confident that Intelligent Monitoring would be able to identify good and poor practice in GP practices and out-of-hours services.
- Feedback from events highlighted a range of additional sources of data that could be used, such as: significant events analysis, information from Health and Wellbeing Boards, GP appraisals, did not attend (DNA) rates, removals from the register and prescribing information.
- Just over half of those that responded online agreed or strongly agreed that the ways CQC plans to gather feedback from people who use services and those close to them were the right ones.
- Some providers voiced concerns about the weight given to patient opinion, suggesting that CQC's judgements need to be proportionate and not a reflection of those that complain the loudest.
- Questions were raised about how CQC would weight evidence that provided both positive and negative feedback.
- Suggestions for other methods of reaching those we need to hear from included: running an online focus group prior to the inspection to gain patient views; working with local Healthwatch and local charities; text messaging; and increasing publicity for the reports.
- CQC staff expressed concern about how they would be able to speak with enough patients to make valid judgements.
- Some respondents said that some patient groups would be difficult to get feedback from, for example, those with a learning disability.

## Our response

- We have developed a set of indicators that we will use for Intelligent Monitoring of GP practices. The published handbook describes how we will use information as part of our inspection process. We have tested and engaged with stakeholders to determine the most useful indicators to inform our work and will align our definitions of indicators as far as possible with those used by our partner bodies such as NHS England and Public Health England. The initial indicators will also be published on the NHS Choices website.
- We use the information we collect to give our inspectors some background and context about the areas of care that may need to be followed up, along with local insight and other factors. This information helps us to decide when, where and

what to inspect. This means that we can anticipate, identify and respond more quickly to providers at risk of providing poor quality care. We have used the indicators developed so far to create priority bandings, which we will use to help inform where we prioritise for inspection.

- The indicators may raise questions about the quality and safety of care, but they are not used on their own to make final judgements. These judgements will always be based on a combination of what we find at inspection, Intelligent Monitoring data and local information from the GP practice or out-of-hours provider and other organisations and feedback from people who use services.
- Feedback from inspection teams and inspectors as well as practices after our initial wave (pilot) inspections was clear that, to make the inspection run more smoothly, it would be beneficial for inspectors to have some information to review before they arrive for the inspection visit. We will therefore be asking GP practices to provide some information prior to the inspection. Further details about this are available in the handbook, but this information will include any learning from patient surveys and complaints, and evidence to show that the quality of care and treatment has been monitored. This will not be a change for out-of-hours providers, from whom we already requested information.
- At the start of each inspection we will be asking GP practices and GP out-of-hours providers to tell us their view of their performance, particularly in relation to the five key questions and for GP practices only, the six population groups. We will ask GP practices and out-of-hours services to give us examples of outstanding care and practice. We want providers to be open and share their views with us about where they are providing good care, and what they are doing to improve in those areas they know are not so good.

## 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 question

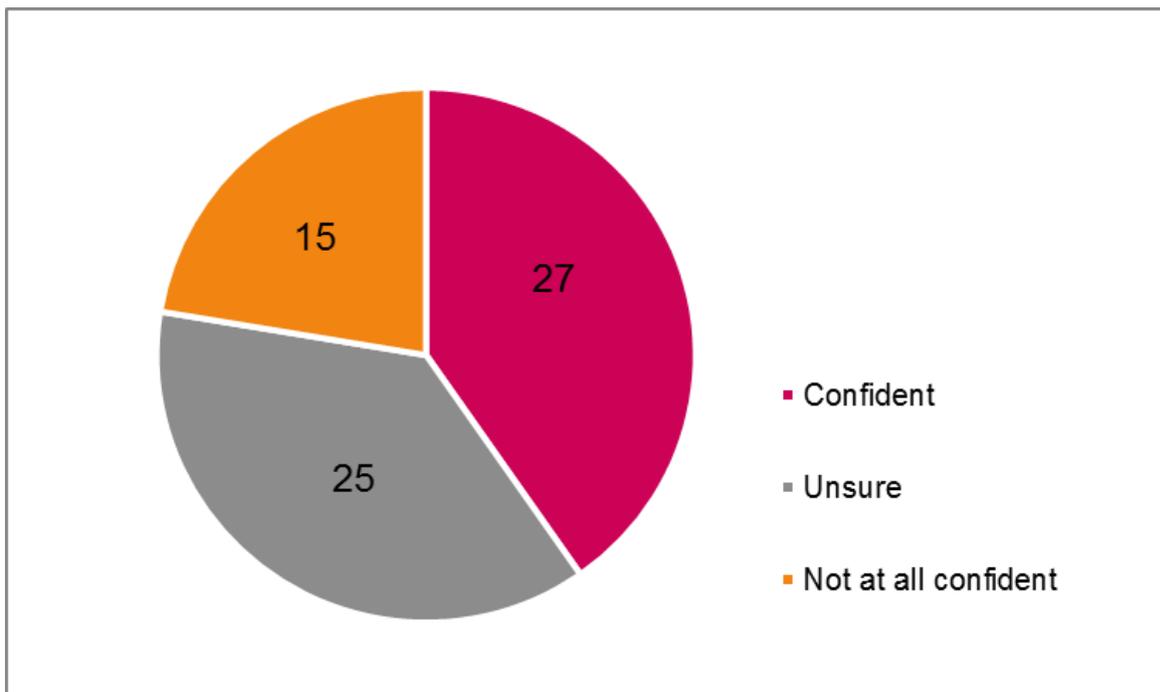
- Do you feel confident that the key lines of enquiry and the list of prompts will help our inspectors judge how safe, effective, caring, responsive and well-led NHS GP practices and GP out-of-hours services are? Is there anything we are missing?
- Do you agree that the key things we have highlighted for each population group are the right things for our inspectors to consider when they are inspecting GP practices?

### What you said

- Some CQC staff were positive about the KLOEs and felt they represented an improvement over the current system.
- Some providers felt that the KLOEs needed to describe best practice and be detailed enough to convincingly represent good standards for each key question and for services overall.
- GP out-of-hours services said the KLOEs needed to be aligned specifically to them.
- Both CQC staff and providers felt there was a lack of detail, and more definitive and explicit prompts and advice were needed. Staff felt there was not sufficient detail to allow confident ratings or to justify them when challenged.
- CQC staff said they needed supportive information and more training for inspectors.

- Only 27 out of 67 people that responded online felt confident that the KLOEs would enable inspectors to judge the overall quality of GP practices and out-of-hours services. A number of amendments were suggested to these by participants at events and by national organisations responding to the consultation.

**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 GP practices and out-of-hours services are?**



- Providers were concerned about how they would demonstrate various elements of the KLOEs.
- There were concerns that some of the KLOEs are impractical.
- Providers also said that KLOEs need to reflect best practice.
- CQC staff wondered how they could judge 'caring' if they were not able to sit in on appointments.

## Our response

- We have reviewed our KLOEs and prompts in response to this feedback and taken the findings from our pilot (wave) inspections into consideration to support the improvement of the KLOEs.

- We have revised our KLOEs and prompts to make it clearer where certain topics sit. As a result, we have moved some of the KLOEs between key questions. For example, issues around obtaining consent for care and treatment was referenced in a number of places: it is now included in effective only.
- 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 more focus on services responding to complex needs, and the role of information sharing. We have also reviewed the language used in our KLOEs to make sure it reflects current practice.
- There is more detail included in our prompts and we have rephrased the prompts as questions for our inspection teams to consider. This makes it clearer, for both our inspection teams and providers, about what we will look at.
- The draft KLOEs included reference to consent issues and the Mental Capacity Act in a number of places. It has proved difficult when reporting to bring together the different elements of this assessment in a way that gives a clear message at provider level. We have therefore brought existing material relating to consent and the Mental Capacity Act together into a single KLOE.
- Previously, the KLOEs covered issues relating to information governance and knowledge management in a number of places, which meant that not enough focus was given in inspections to how well information and records management and systems supported delivery of effective care and treatment. We have included an additional KLOE focusing on the role of information management and systems in supporting effective care delivery to ensure that information can be drawn out in a way that will support CQC's information governance monitoring role, and strengthen our assessments of how well care is co-ordinated between and within providers.
- We have written the KLOEs and prompts so they better apply to both GP practices and GP out-of-hours services. Where there are differences in the prompts, although there are not many, we have made this clearer in the handbook..
- We have provided and continue to provide information and training for inspectors to support them to make judgements against the KLOEs. Much of this is also published for providers on our website. This is intended to provide clarity on our position on key things such as training and competency of chaperones or emergency medicines.

## Characteristics of ratings

### What we said in our consultation

We plan to rate the performance of NHS GP practices and NHS GP out-of-hours services against each of the five key questions and the services overall. Also, for NHS GP practices we will rate services on how they provide care to population groups, as described above. 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 question

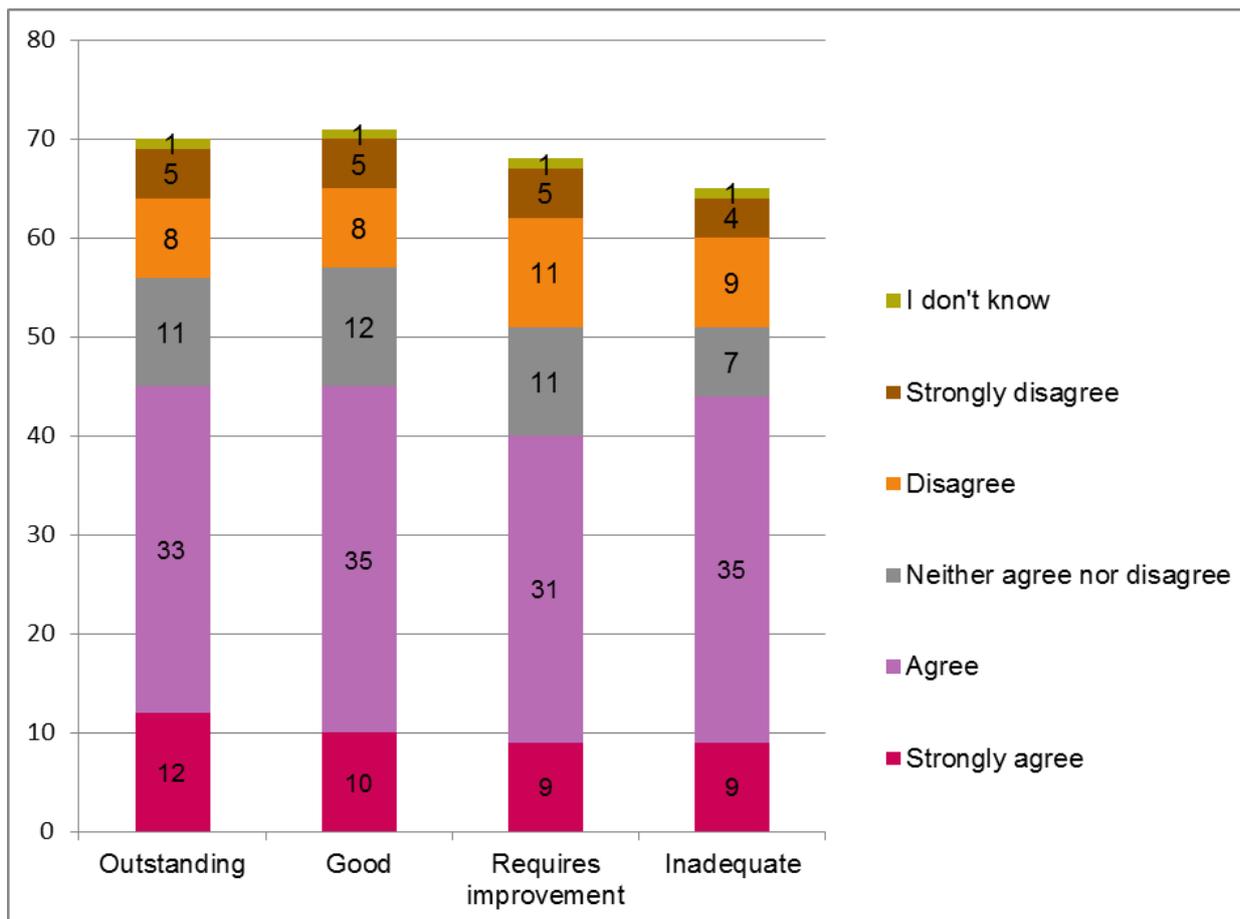
- **Do you agree that the characteristics of outstanding, good, requires improvement and inadequate are what you would expect to see in a NHS GP practice or NHS GP out-of-hours service?**
- **Are there ways in which we could promote learning between providers and services, particularly where we have identified outstanding care?**

### What you said

- The majority of those responding online either agreed or strongly agreed with the characteristics (see chart below).
- CQC staff and providers at events broadly supported our definition of what good looks like in NHS GP practices, although there were some suggestions about the language used.
- Good needs to reflect things such as: person-centred; accessible and conveniently located; treating people equally; treating people with dignity and respect; appropriate numbers of properly trained staff; information on care options; good communication with other services; ability to complain without consequences; acting on the outcome of inspections.

- People were concerned that such requirements were described as good, as these were something they would expect. For example, people were alarmed that appropriately qualified and competent staff was a characteristic of good as they felt this was a basic requirement.
- There was concern that the top end of a rating could differ greatly from the bottom end of a rating.
- There was a feeling that ratings should be based on tougher criteria as it was suggested that it was easy to be inadequate but tough to be outstanding.
- Suggestions for ways of sharing learning included shadowing, encouraging sharing and training, promoting peer review, working with clinical commissioning groups (CCGs), use good practice examples, and publish outstanding processes, systems and policies.

**Online responses: Do you agree that the characteristics of outstanding, good, requires improvement and inadequate are what you would expect to see in a NHS GP practice or NHS GP out-of-hours 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 these characteristics can be applied flexibly, depending on what we find during the inspection.
- We are clearer about the impact on people at different rating levels; for example, the impact on people if a provider is inadequate for safety.

# Applying and reviewing ratings

## What we said in our consultation

To ensure 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. NHS GP practices and NHS GP out-of-hours services 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 question

- Do you agree that the five questions are equally important and should be equally weighted in our aggregation method?
- Do you agree that in general the population groups should be weighted equally?
- Do you agree with our principles for aggregating weightings? Is there anything else that we should include?
- Do you agree that we should use key pieces of information to limit a rating?
- Do you feel confident that the proposed reviews process is sufficiently clear and robust?
- Do you agree with the grounds on which practices and services can challenge their inspection reports and ask for a review of their ratings?

## What you said

- The majority of those that responded online agreed with the ratings principles.
- Both CQC staff and providers felt that it should be tougher to be rated as outstanding, with many stating three out of five overall could be outstanding but others saying five out of five should be necessary.
- Around two-thirds of those responding online thought that all five questions and the population groups were equally important when deciding an overall rating.

- Some organisations felt that patient safety should be given more weight than other key questions.
- Some suggested one rating of inadequate should mean the whole service was inadequate.
- CQC staff and providers were concerned about consistency between inspectors and the equity of inspectors.
- A number of organisations in written submissions opposed the application of overall ratings for GP practices.
- Some online respondents felt the ratings were too subjective.
- CQC staff were concerned that there will be legal challenges and they did not feel confident that the existing structure of KLOEs, prompts and ratings could be defended.
- There were mixed views on whether an overall rating should be the only visible identifier of quality of service.
- There were questions raised about the impact of receiving an inadequate rating. This would vary depending on whether patients had a choice of using the service or not.

## Our response

- We will rate practices in the way proposed in the consultation. This reflects the complexity of general practice by providing a number of ratings at different levels as well as providing an overall rating for a practice. The overall rating is based on the underlying ratings for the five key questions and the six population groups. We have refined our ratings principles to support inspection teams in reaching this overall rating.
- The five questions remain equally weighted to reflect their equal importance.
- The six population groups 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 consulted on a number of ratings principles to support inspection teams to aggregate the ratings for GP practices and GP out-of-hours services. We have also tested these principles in our wave inspections (although we did not formally rate GP practices in our wave inspections).
- 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. 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.
- Consistency is one of the core principles that underpin all our work. This includes consistency of ratings. We have put in place an overall approach for CQC to embed consistency in everything we do. The key elements of this are:
  - A strong and agreed core purpose for CQC.
  - A clear statement of our role in achieving that purpose.
  - Consistent systems and processes to underpin all our work.
  - High-quality and consistent training for our staff.
  - Strong quality assurance processes.
  - Consistent quality control procedures.

Further information on our approach to quality assurance and quality control is included in the handbook.

# 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 NHS GP practices and NHS GP out-of-hours 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

- There were mixed views from the online survey about the best way to encourage compliance with the Mental Capacity Act and Deprivation of Liberty Safeguards.
- From 42 online respondents, 19 thought we should give sufficient weighting in our characteristics of good, 11 thought we should apply limiters and 12 thought we should do this in other ways.

## Our response

- Following feedback from the consultation and from our testing in the wave inspections, we have included a key line of enquiry about consent. This takes into account the requirements of the Mental Capacity Act (MCA) and other legislation, such as the Children Act.
- 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 so they are clear on the requirements of the MCA and what they mean for GP practices.

## Our Human Rights approach

From 9 April to 4 June 2014 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. 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 services users 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 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 for GP practices, and the issue of training for staff.
- The small amount of feedback on our interim regulatory impact assessment agreed with our assessment of costs and benefits, but raised concerns over the size and cost of the new inspection system, including the resource implications of being inspected, especially for smaller practices.

## 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: Consultation engagement events and responses

## Engagement events

### Providers

- **25 April**, Birmingham – 32 providers of GP practices and GP out-of-hours services
- **2 May**, Newcastle – 19 providers of GP practices and GP out-of-hours services
- **13 May**, London – 24 providers of GP practices and GP out-of-hours services
- **14 May**, Bury St. Edmunds – 12 providers of GP practices and GP out-of-hours services
- **16 May**, Preston – 25 providers of GP practices and GP out-of-hours services

### CQC staff

- **13 May**, London – 21 members of CQC staff
- **16 May**, Preston – 5 members of CQC staff

### Public events for service users in all consultation sectors:

- **25th April**, Manchester – 30 participants
- **8th May**, London – 38 participants
- **22nd May**, Birmingham – 35 participants
- **29th May**, Southampton – 12 participants

### Responses received

The total number of responses to the consultation received was:

- **Online** – 76
- **Written submissions** – 33

There is a list of organisations submitting written responses in appendix B.

## Appendix B: Organisations that submitted responses to the consultation across all sectors

### 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 General Practice Education Directors

Director of Postgraduate Education HEE

Gold Standards Framework

LaingBuisson

My Home Life

National Clinical Assessment Service

NHS London Leadership Academy