CareQuality Commission

CQC's strategy 2016 to 2021

Shaping the future: consultation document

January 2016

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

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

Our role

- We register care providers.
- We monitor, inspect and rate services.
- We take action to protect people who use services.
- We speak with our independent voice, publishing regional and national views of the major quality issues in health and social care.

Our values

- Excellence – being a high-performing organisation.
- Caring – treating everyone with dignity and respect.
- Integrity – doing the right thing.
- Teamwork – learning from each other to be the best we can.

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Foreword

Over the past three years we have radically changed the way we work, resulting in greater confidence in us as an organisation and in our findings. In our next phase we need to build on our current regulatory approach and improve its efficiency and effectiveness. At the same time, we need to adapt to the changes in the health and care sectors we regulate. We have to achieve all of this with fewer resources.

We know from our inspection findings, and from what you have told us so far, that our approach has been effective in identifying and sharing examples of really good care, and in driving improvement in services while protecting people from very poor quality care.

However, we can't stand still. The landscape is changing and new models of care are emerging. At this time of once-in-a-generation change, it is more important than ever that people know there is a strong, independent regulator on their side.

Independent quality regulation provides transparency so people know how good the services are that they use. We know there are large variations in quality between services: while a great deal are good, a small minority have been rated inadequate and a more substantial proportion require improvement. Regulation must protect people from poor care while at the same time encourage sustainable improvements that are led from within organisations that deliver care.

Our vision sets out to achieve a health and care system where people trust and use the judgements we make about the quality of care; where people have confidence that good and poor care will be identified and action taken where necessary so they are protected; where organisations that deliver care are encouraged to improve quality; and where organisations are encouraged to use resources as efficiently as possible to deliver high-quality care.

This document sets out how we propose to deliver this vision, by becoming a more efficient and effective regulator so that we stay relevant and sustainable for the future.

The public and organisations that deliver care have told us that the way we regulate health and adult social care has improved over the last three years. However, we know there is more to do.

Many of you have already given us your views, which have shaped the proposals we have set out – thank you. We want to keep listening. Please give us your views on the questions that we ask throughout this document. We will reflect on your feedback and use it to develop our final strategy, to be published in May 2016.

Peter Wyman, Chair
David Behan, Chief Executive

Our proposed strategy – at a glance

Purpose

CQC makes sure that services are safe, effective, compassionate and high-quality and we encourage services to improve.

Context

The way that services regulated by CQC are used and delivered is changing.

CQC must deliver its purpose with fewer resources.

Ambition

To become a more efficient and effective regulator so that we stay relevant and sustainable for the future.

Our vision for quality regulation in 2021

- People trust and use expert, independent judgements about the quality of care.
- People have confidence that good and poor care will be identified and action taken where necessary so they are protected.
- Organisations that deliver care are encouraged to improve quality.
- Organisations are encouraged to use resources as efficiently as possible to deliver high-quality care.

Achieving our vision

As well as making continuous improvements to our core operating model, CQC will focus on six themes:

- Theme 1: Improving our use of data and information
- Theme 2: Implementing a single shared view of quality
- Theme 3: Targeting and tailoring our inspection activity
- Theme 4: Developing a more flexible approach to registration
- Theme 5: Assessing how well hospitals use resources
- Theme 6: Developing methods to assess quality for populations and across local areas.

Implementing our vision over five years

- We will build on our existing approach and co-produce changes with our partners.
- We will plan and carry out our work more effectively and efficiently so that our expenditure matches our future budget.
- We will support our staff and develop the right processes, capabilities and behaviours to deliver our purpose.
- We will continuously monitor our impact so that we offer good value for money.

Introduction

We are currently developing the Care Quality Commission (CQC) strategy for the next five years. This is the third in a series of documents in which we have asked for your help to develop our approach to quality regulation of health and social care services. It builds on the conversation we began in March 2015 with our first *Shaping the future* document, and continued with *Building on strong foundations* in October when we asked for your feedback to inform this consultation. This document reflects your views and reactions and sets out for final consultation our proposals for how CQC will operate over the five years from May 2016.

We begin by setting out our vision for regulating health and adult social care quality. We set out the difference that we believe quality regulation can make to people who use services and organisations that deliver care. We then explain how we will achieve this vision and the areas we intend to focus on. We finish by setting out how we intend to deliver this over five years and with fewer resources. We have also published our *Draft equality and human rights impact analysis* which will be finalised in line with the strategy.

We would like to hear your views on our proposals so that we can shape the final strategy. This is really important as it makes sure we consider what matters most to you as we develop and finalise our plans.

How you have helped us so far

We have listened to the views of the public, providers, professionals, CQC staff, commissioners of care services and other stakeholders. We have also made sure to listen closely to people in communities who often don't have their voices heard.

Thank you to all of you who have provided feedback so far. Specifically, we have:

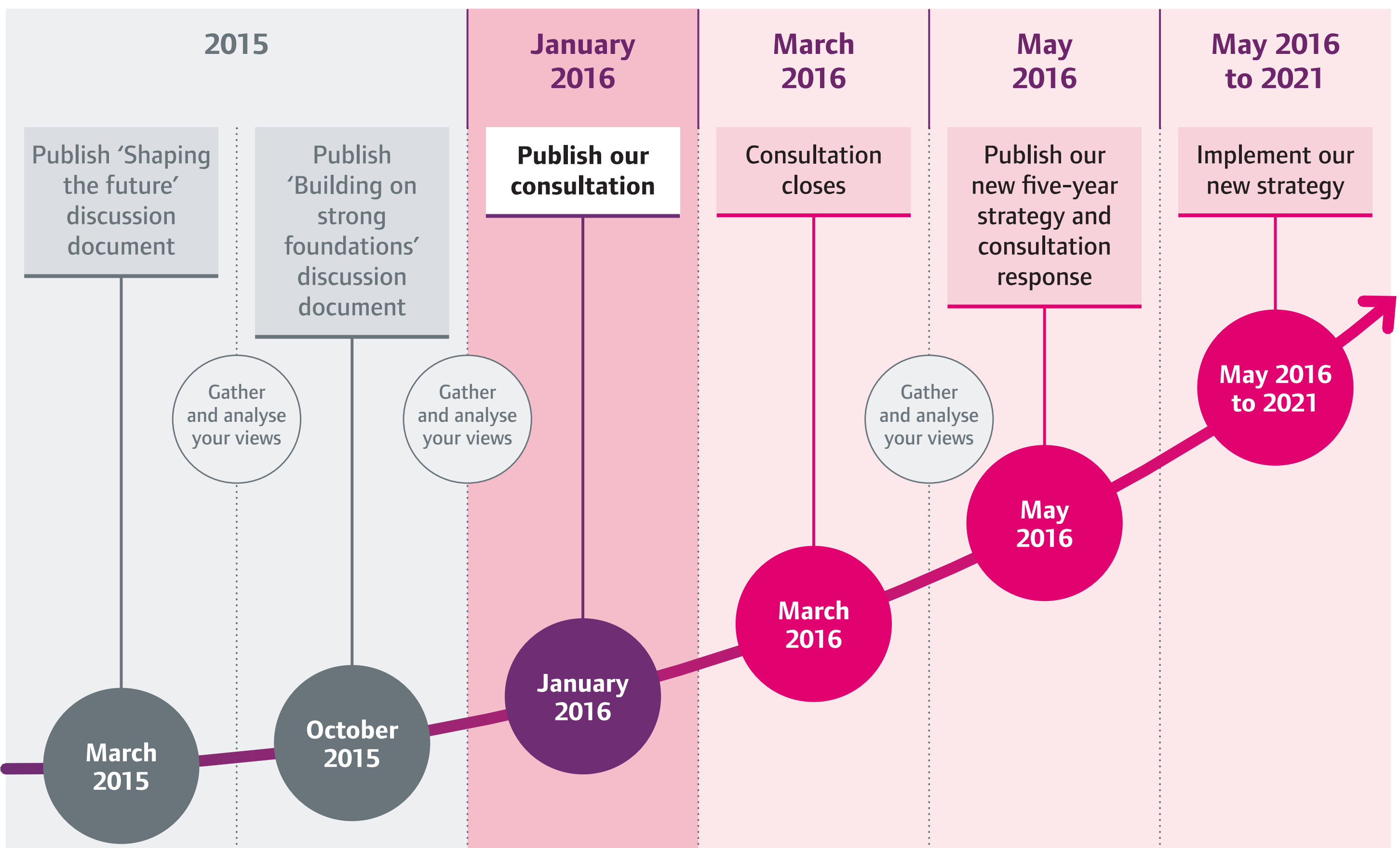
- Received 800 responses to online surveys, and 30 stakeholder letters.
- Held 10 co-production workshops.
- Conducted advisory meetings with statutory and voluntary sector groups.
- Held focus groups and meetings with hard-to-reach communities.

- Held online community discussions.
- Had regular meetings with stakeholders.
- Involved more than 1,200 CQC staff.

These conversations have helped shape the ideas in this document, ensuring that we build on what is good about the way we work, improve where we need to, and develop to make sure our approach and our operating model are fit for the future.

Throughout the document there are 'You have said so far' boxes, which set out the main themes from the responses we received to *Building on strong foundations*.

We would now like to gather your views on the questions in this document. You can respond either through our online form: www.cqc.org.uk/2016strategyconsultation or by email: strategyconsultation@cqc.org.uk. We will formally respond to your feedback on these questions when we publish our strategy in May 2016.



Our vision for quality regulation

Quality regulation of health and adult social care services can and does make a real and positive difference to the lives of people who use services and to the organisations and professionals who deliver these services.

CQC's purpose is, and will continue to be, to make sure that health and social care services deliver safe, effective, compassionate, high-quality care and to encourage services to improve.

Our role in achieving this purpose is to register, monitor, inspect and rate services to make sure they meet fundamental standards of quality and safety; to take action to protect people who use services; and to use our independent voice to help bring about improvements in care. We ask the same five questions about every service we inspect to give a complete view of the quality of care provided: Is it safe? Is it effective? Is it caring? Is it responsive? Is it well-led?

We have a vision for what quality regulation should achieve – a health and care system where:

- People trust and use expert, independent judgements about the quality of care.
- People have confidence that good and poor care will be identified and action taken where necessary so they are protected.
- Organisations that deliver care are encouraged to improve quality.
- Organisations are encouraged to use resources as efficiently as possible to deliver high-quality care.

Over the next five years, the way that services are used and delivered is going to change. The NHS *Five Year Forward View* describes three challenges facing the heath and care system: the health and wellbeing gap, the care and quality gap, and the funding and efficiency gap. The Government's Spending Review in November 2015 provided increased funding for the NHS up to 2019/20, but greater efficiency savings than ever before are still required. The review gave local authorities the power to levy an increase in council tax, on the condition this is used to fund social care, and provided additional funding through the Better Care Fund. However, the current pressures on the adult social care sector will continue as more people need care and costs increase, for example as the national minimum wage rises. The health and care system has begun to respond with new

models of integrated care and stronger local partnerships, most recently reflected in the NHS planning guidance for 2016/17 to 2020/21.

At a time when health and social care services face this unprecedented change, it is more important than ever that people know the regulator is strong, independent, and on the side of people who use services.

We know that there is more we have to do to improve how we work. The Public Accounts Committee in December 2015 noted that we have made substantial progress in strengthening the way that we monitor, inspect and rate health and adult social care services. The committee also made clear that there are areas where we need to improve, such as how quickly we publish reports following inspection. We have been working hard to improve our performance and this will continue to be a top priority for us.

It is our ambition to become a more efficient and effective regulator so that we stay relevant and sustainable for the future. In common with other organisations, we will deliver our purpose in 2019/20 with fewer resources. This means we need to develop new ways of working to stay relevant as the services we regulate change, and to stay sustainable by delivering our purpose more efficiently. In this strategy, we seek to balance improving what we do now with a gradual introduction of new ways of working.

We now describe our vision in more detail. When we publish our final strategy, we will set out how we will measure whether we have achieved this vision.

People trust and use expert, independent judgements about the quality of care

Regulation is used in many industries to address imbalances in the information that people who use services have, compared to the people who provide services.

Our new, comprehensive approach to inspection started in early 2014 and so we are now beginning to develop a systematic picture of the quality of care. We give a quality rating to most of the providers and services we inspect. Ratings help people to make informed choices and ensure transparency in terms of the quality of services. Of people using our inspection reports to make decisions about care services, 86% of those who responded to our survey said they found our ratings somewhat or very useful. Our ratings enable examples of excellence and services delivering high-quality care to be highlighted and celebrated, as well as supporting providers and oversight bodies to recognise areas for improvement.

We know we have more to do to improve how we work, for example the timeliness of our published reports, and we will continue to work hard to achieve this. Our ambition for quality regulation is to ensure that information online and in other formats is extensively used by the public, and is available to them in a way and at a time that meets their individual needs. We intend that CQC's information is recognised as an exemplar among organisations providing information about care services.

The NHS *Five Year Forward View* proposes developing new models of integrated care and building stronger local partnerships between the different organisations providing care. The NHS planning guidance for 2016/17 to 2020/21 sets an objective that at least half of the population will be covered by the New Care Models programme by 2020. This will be supported by

greater devolution of powers and budgets to local communities to plan and organise health and care services, and a renewed commitment in the Government's Spending Review to locally integrated services.

Over the next five years, the way that services are used and delivered will therefore change. Assessments of quality need to reflect this. We know from our inspections that a person's experience of care is shaped not only by how an individual service performs but also by how services work together. When care is badly coordinated, the result is poor access to care or poor quality care. Equally, good coordination leads to better outcomes. And as more data about the outcomes of care becomes available, assessments of quality will need to take this into account in judging how effective the care delivered has been.

Quality regulation should tell people more about how well services like hospitals and care homes work together to provide high-quality care and what outcomes this delivers for people who use services. This would include where care is provided in new ways, for example through new technologies.

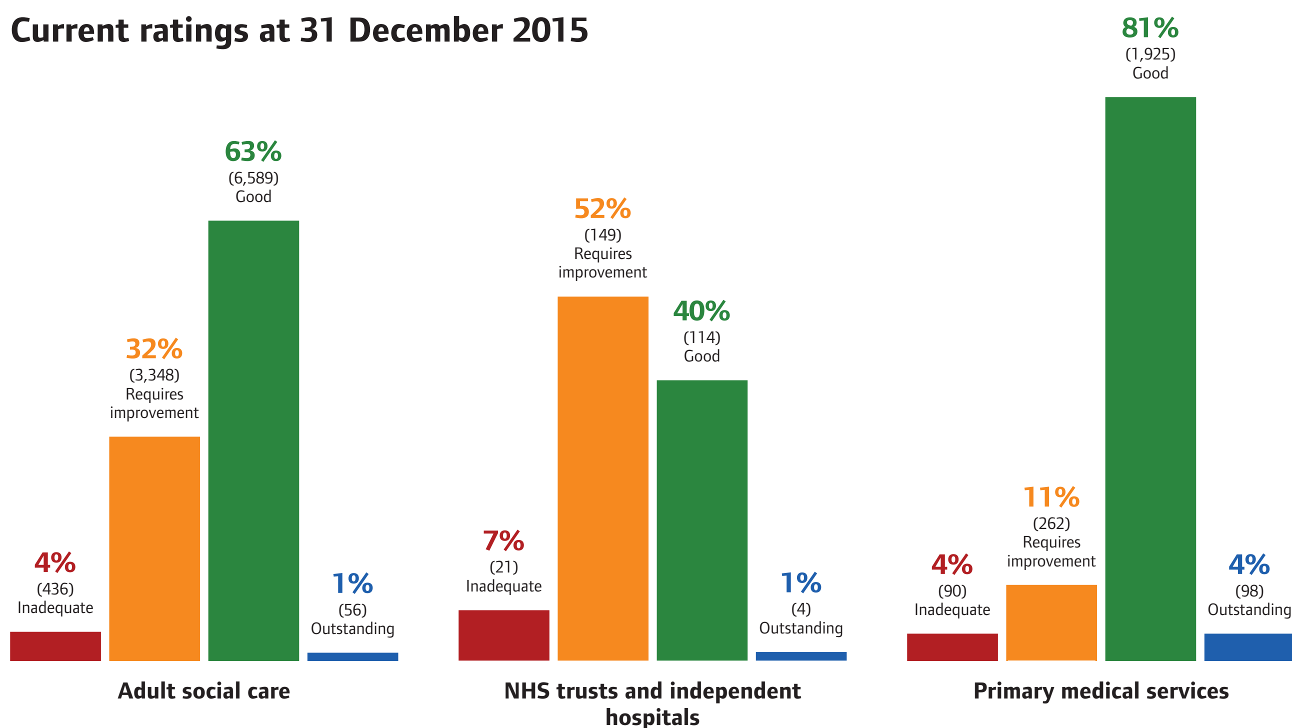
People have confidence that good and poor care will be identified and action taken where necessary so they are protected

Providing the public with confidence that the services they use are safe is a fundamental role for regulation in many sectors, including the food industry, the airline industry, and the health and care sector. CQC has a legal remit to protect and promote the health, safety and welfare of people who use health and social care services.

There is significant variation in quality across health and social care services in England, as detailed in our *State of Care* report 2014/15.

Many of the services we have rated so far deliver good or outstanding care, but a substantial proportion received a rating of requires improvement. Four per cent of services we have rated so far have been rated inadequate. In 2014/15 we carried out 1,179 enforcement actions.

Current ratings at 31 December 2015



Source: CQC ratings data

Given this level of variation, there continues to be a need for independent quality regulation so people know how good the services are that they use, know that they will be protected from poor care, and know that good care will be actively encouraged. Regulation must ensure that people's basic human rights – such as dignity, respect, equality, fairness and choice and control over the care they receive – are always considered, and that there is not a widening gap in the quality of care for different groups of people.

To make sure that poor care is identified, it is really important that people are able to tell us about their experiences of care, including staff who work in services. We are determined to listen and act on people's views and experiences to help us improve the overall quality of care in England and prevent poor care and abuse happening to others in the future. We want more Experts by Experience and members of the public involved in our work to help us speak to more people using services and those close to them.

The public have told us they are increasingly confident in our new and more rigorous approach to inspection. We are not complacent, however. We are working to continue to improve what we do and how we do it, including how quickly we respond and take action when concerns are raised with us about the quality and safety of care. Only by demonstrating how we act to tackle poor care will public confidence continue to improve.

Organisations that deliver care are encouraged to improve quality

Regulation is not only there to give people information about the quality of their services and to protect people from the risk of poor care. It should also encourage improvements in the quality of care. As part of our legal remit, we encourage improvement in the services we regulate.

Care providers tell us that quality regulation has a role to play in encouraging improvement. Of the providers we surveyed, 63% (of 2,803 providers) felt that outcomes for the people who use their service have been or will be improved as a result of CQC's inspection, and 64% (of 2,689) said the inspection helped them to identify areas for improvement. Whether they had been inspected or not, 71% (of 3,667) found inspection reports useful.

The primary responsibility for delivering good care lies with the organisations that provide care. Sustainable change should be led from inside organisations, drawing on learning from each other rather than solely through regulation. However regulation plays a crucial role in encouraging improvement – through the sharing of information in a transparent way, using inspection activity and reports to help providers to identify and tackle problems, and sharing good practice within and across sectors.

In a challenging environment it is even more important that regulators work closely with others – people who use services, professionals and staff, commissioners, funders and providers of care – to improve quality. The oversight system must be as efficient as possible and that means removing duplication between national bodies including CQC, NHS England, NHS Improvement, the National Institute for Health and Care Excellence, and professional regulators.

Organisations are encouraged to use resources as efficiently as possible to deliver high-quality care

Over the next five years, improving quality will mean finding ways to deliver better care for the same or fewer resources. The health and social care system needs to be transparent about whether resources are used effectively and efficiently, so that services remain sustainable into the future.

Our focus has always been – and always will be – on quality and getting the assessment of this right. However, we have a legal requirement to encourage the efficient and effective use of resources by services we regulate. Over the next five years – a time of ongoing financial constraint – it is right for the quality regulator to focus on understanding what improves quality, including how resources are used.

Our *State of Care* 2014/15 report showed that from our evidence so far, money is not the only answer to delivering high-quality care. We found three areas that play a critical part in quality improvement. These are good, strong leadership with a shared view of quality; careful staff planning, training and development; and working together across the sector, including better data collection and safeguarding work.

CQC, as the quality regulator, has a contribution to make, alongside other partners, to shine a light on how resources can be used as well as possible to ensure quality across the entire health and social care sector.

What our vision means for you

The public

Our commitment to the public is to be transparent about what we find, to act when we find poor care, and to be open and honest as we hold providers to account. Our judgements must be credible, so that people have confidence in us when we say a service provides good quality care. Listening to the views and experiences of people who use services is essential to help us improve our judgements and ratings.

We will keep reviewing how we can be more effective and efficient so that taxpayers get good value for money. For example we will use increasingly relevant data and information to make good decisions about where, when and what we inspect. We will also work with other oversight bodies to share information.

Looking to the future, we want to provide a more complete picture about how it feels to receive care across services and we will look to the public to help tell us about any changes in their local areas.

Providers

Our commitment to providers of health and care services is that we work together to develop and deliver our approach. We will be professional, consistent, transparent and fair. We will ask providers, as well as the public, whether they think we are doing this. We will work with providers to implement a single shared view of quality – to help them make the improvements needed and to reduce duplication across the health and social care system. We want to support providers to improve, while always maintaining the independence of our judgements and acting on the side of people who use services.

Tell us what you think

1a Do you agree with **the vision** we have set out for regulation of the quality of health and adult social care services in 2021? (see pages 6-11)

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

1b What do you agree with, or not agree with, about the vision?

....

Achieving our vision

Our core role of regulating the quality of individual health and social care services, protecting people from poor care and publishing our findings is at the heart of our vision for 2021. This will remain our top priority and we will always make sure these services provide people with safe, effective, compassionate, high-quality care and encourage them to improve. However, we also need to find new ways of working so that we can continue to deliver our purpose as the health and social care sector changes. This section sets out our current model of regulation, and then explains how we propose to develop this model and our ways of working to achieve our vision.

This is a five-year strategy and we have set out an ambitious vision of where we want to get to. It will take time, and we will not achieve all of our proposed developments in the first years. The final part of this document sets out more detail on how we will bring in changes over time, and how we will reduce our expenditure by becoming more efficient and effective.

You have said so far

You have told us that you support our **approach to regulation** and we should continue delivering our purpose. You have also said that you believe we should focus on areas such as **working better with our partners**, our inspections and ensuring we stay on the side of the public and people who use care.

You also said that we should continue to inspect and take **enforcement action** when we find poor care, as this is a central role for CQC and the most effective way to continue increasing confidence in our work.

You also emphasised that funding reductions could undermine the quality of services, with a few of you expressing concern that local authorities risk sacrificing quality in favour of policies designed to make financial savings. In light of this, you also emphasised the importance of CQC adapting to this changing landscape.

Our current model of regulation

In 2013 we introduced fundamental changes to our model of regulation. We know we still have work to do to deliver this approach consistently and to a high standard. Over the next five years we will continue to focus on the aspects of our model that people have said make the greatest difference – taking action swiftly when we find poor care and publishing independent expert ratings of quality. We know from our inspection findings and what you have told us that our approach has been effective in driving improvement in services and protecting people using services from poor quality care. Our approach has also helped us to identify and share examples of good practice.

Our core operating model will stay the same and we will ensure we continually improve how we deliver our four main functions:

- We **register** those who apply to CQC to provide health and adult social care services. This is a legal requirement to assess and register new providers of services, and existing providers that make changes to the services they offer.
- We use feedback, including people's views and experiences, and data to **monitor** services, and then carry out expert **inspections**, making a judgement of each service and for many services giving an overall **rating** and a rating against each of the five key questions. We ask every service: Is it safe? Is it effective? Is it caring? Is it responsive? Is it well-led?
- Where we find poor care we ask providers to improve and we can **enforce** this if necessary. We have enforcement powers including the ability to suspend, de-register or prosecute a service providing poor care to make sure those in leadership positions and responsible for poor care are held to account.
- We provide an **independent voice** on the state of health and adult social care in England on issues that matter to the public, providers and other stakeholders. We help share learning on good practice to encourage continuous improvement. We use our evidence to produce thematic reports (on particular groups of people who use services such as people having a mental health crisis), statutory reports (for example, our *State of Care* report), events, articles and other publications.

We will make continuous improvements to the supporting systems and processes we use so that we consistently deliver the standards of excellence we demand of others. We will look at evidence from surveys of providers, the public and inspection teams, as well as other performance measures, to understand the impact of our work.

We will complete comprehensive inspections of all services that we rate by the end of our 2016/17 financial year. This will provide a powerful baseline understanding of the quality of health and adult social care services in England for the first time. These inspections will continue to make up most of our activities in 2016/17, the first year of our new strategy.

CQC's core functions

Register	Monitor, inspect and rate	Enforce	Independent voice

Developing our model of regulation

Although maintaining and embedding our current model of regulation remains our top priority over the next five years, we must also develop new ways of working so that we respond to changes in the health and social care sector, and continuously improve. To do this, we are proposing six themes for developing our model of regulation which together will help us to achieve our vision:

- Theme 1: Improving our use of data and information
- Theme 2: Implementing a single shared view of quality
- Theme 3: Targeting and tailoring our inspection activity
- Theme 4: Developing a more flexible approach to registration
- Theme 5: Assessing how well hospitals use resources
- Theme 6: Developing methods to assess quality for populations and across local areas.

In this section we describe these themes and explain in practical terms what any changes will mean for the public and for organisations that provide services.

Our vision and themes apply to all the sectors we regulate. However there will be differences in how we apply changes to each sector, just as our current model varies from hospitals to adult social care, for example. We will co-produce any changes with people who use services and organisations that deliver care, as well as other stakeholders including health and care system partners. We will set out detailed plans at the level of each sector where appropriate.

THEME 1: Improving our use of data and information

We have a unique understanding of the quality of health and care services from the information we collect when we inspect hospitals, care homes, GP practices, community care services and other types of care. We get this information from people who use services, from providers and from our partners. We now want to make better use of this information – so that we focus our efforts where the risk of poor care is greatest and on those services that need to improve. In some sectors, this will mean we inspect good and outstanding services less often.

CQC is aspiring to become 'intelligence driven'. This means we will strengthen the way we use data and information to underpin our decision making. We will build on our experience in this area and continue to find innovative ways to gather and use information. We know that when good information is used properly, it can help people to feel in control of their decisions, encourage services to improve and ultimately change lives. This means balancing our use of numerical data and non-numerical data by continuing to improve our analysis of qualitative information, such as people's experiences of

care. Together, this will enable us to better identify risks of poor care and target our inspection activity.

You have said so far

Many of you said that **using smarter monitoring and insight from data** is an appropriate approach and would produce useful information. You said it could allow for trends and issues with performance to be identified.

"A broad dataset could be invaluable in identifying underlying trends in care quality and anticipating where services are at risk of providing poor care."

Where there were concerns it was with the accuracy and reliability of data. Comments included a concern that too much reliance on data would miss the big picture of care and also that data could be skewed.

"It is not just about the figure – it is important to look behind the story."

Many of you believed that this approach could allow commissioning bodies, membership organisations and other regulators to operate more effectively.

"As a sector regulator CQC is uniquely positioned to use its considerable intelligence and analytics capabilities to highlight variations in performance, and this information should be made available and promoted to providers, commissioners, and the public to encourage improvement."

There were mixed responses in terms of the perceived burden on providers, with some who thought that this would reduce the burden and others who thought it would increase it – particularly mental health providers, due to the complexity of quality measurement in this sector.

For CQC to be intelligence driven, it is really important that people tell us about their experiences of care and that we share this information better with our partners (such as local authorities in relation to safeguarding concerns). We want to know about poor care, abuse and neglect as soon as they happen. We also welcome information about good care. This information helps us to improve the overall quality of care in England and helps us to prevent poor care and abuse happening to others in the future.

More information can help us to develop better insights into the quality of care and this helps us decide what, when, and where to inspect, including if we need to carry out an urgent inspection. We are investing in tools that will enhance our ability to interrogate large datasets and derive greater insight from information.

In order to hear from more people using services and their family or advocates, we will also expand our Experts by Experience programme and involve more members of the public in our work than ever before. We will continue to support people to tell us about the care they have received.

We also recognise the importance of listening to feedback from staff who work in services. We have just established the National Freedom to Speak Up Guardian, who will help to create a culture of openness in the NHS so that the concerns of staff are valued, encouraged, listened to and acted on. This role will be located in CQC but will remain independent.

We will develop a new model for how we obtain and use our data and information, which we are calling 'CQC Insight'. This will build on the strengths and learning from our current Intelligent Monitoring system that has provided us with a richer understanding of the relationship between individual data items and the actual quality of care we observe on our inspections. CQC Insight will highlight the critical data that inspectors and analysts need

to follow up directly with the provider. It will increase the range of data based on the views of people and their families about their experiences of care. This will enhance our ability to be intelligence driven in our approach where there is traditionally little numerical data about the quality of care, such as social care delivered in people's own homes. It will build on the way we currently obtain information and it will help us to better protect people who use services. It will guide our inspection activity to help us prioritise our resources where the risks to the public are greatest.

The model will have a set of indicators in line with the five key questions we use when we inspect services. We will highlight good performance and trigger actions when concerns are raised. We are investing in new technologies to better capture and analyse this data, to get a clearer understanding of the performance of services and the risk of poor care.

We will continue to partner with others (for example the National Information Board) to better share information and ensure that data available nationally, including outcomes data, will help us to predict risk and understand how effective services are. We will also use digital technologies to improve the quality and scope of the data we have. This is an area where we are working to develop our plans, and we would welcome any specific input on how we can make best use of new technologies in our work.

Tell us what you think

2a Do you agree with our proposal to make **greater use of data and information** to better guide us in how we identify risk, and how we register and inspect services? (see pages 14-16)

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

2b What do you agree with, or not agree with, about greater use of data and information?

....

THEME 2: Implementing a single shared view of quality

People who use services, care providers and other oversight bodies have welcomed the inspection framework we have developed to assess quality based around the five questions we ask about every service – Is it safe? Is it effective? Is it caring? Is it responsive? Is it well-led? – and the key lines of enquiry that underpin these. Over the next five years, we want to build on and improve this framework by working with others to implement it as a single shared view of quality across health and social care. This will support organisations that provide care to understand their own quality and identify necessary improvements, and it will reduce duplication and make the oversight system more efficient.

There are two parts to this proposal:

- Developing a shared framework for measuring quality of care against CQC's five key questions and key lines of enquiry that is then used in common by providers and oversight bodies.
- Using this framework, enabling providers to tell CQC more about how they are delivering high-quality care and where they are making improvements.

We would ultimately like to see all national and local oversight bodies (such as NHS Improvement, NHS England, commissioning groups, local authorities and professional regulators), as well as providers themselves, use this framework to understand and report on provider quality. People have welcomed the transparency that CQC's inspections and reports have brought to understanding the quality of care – the benefits would be even greater if everyone in the system looked at quality in the same way. This is not an ambition that CQC can deliver alone and we will work closely with our partners to implement a single view.

You have said so far

The majority of you commented on what we described as **'co-regulation'** in *Building on strong foundations*. Many of you said that it was an appropriate approach and would be very helpful to providers, while a few of you indicated that you do not like the idea.

Those of you who responded positively said that providers would feel empowered and confident to help deliver excellent services.

"It would give me more confidence that the provider was committed to quality."

Nearly half of you had concerns, including issues relating to providers' ability to monitor their own quality effectively and about CQC's relationship with providers becoming "too cosy". Your comments included a concern around the ability of providers to be self-critical and for CQC to remain independent.

"At this point there is insufficient detail on the level of information a provider would submit, how onerous and what timescales would need to be worked to that would meet the requirements. Potentially this could be an extra burden on providers from an administrative perspective."

You made suggestions for closer alignment and collaboration with other oversight bodies, working with partners such as NHS England, NHS Improvement, local authorities and clinical commissioning groups.

"This should involve agreeing and making explicit the roles and responsibilities of other stakeholders in the system in relation to driving improvement, such as NHS Improvement."

You also said that we should avoid duplicating roles that are held by other sector bodies.

"The newly established National Quality Board also offers an opportunity for all national partners to develop a single shared view of 'quality' in the NHS, which could be a helpful underpinning to quality regulation."

Our inspections show that providers that demonstrate high-quality performance tend to have strong leadership at all levels, have systems in place to measure their own quality, and recognise where improvements are required. We want to encourage all providers to do this, because we recognise that, ultimately, it is providers themselves and not the regulator that make improvements to the care people receive.

We know that several providers, for example Frimley Park Hospital and the Priory Group, already align their internal quality monitoring and improvement plans with CQC's framework. We would seek to build on what works well to encourage all providers to use our single framework to monitor their own quality and to share this with CQC. This would enable providers to explain in their own words how they are delivering high-quality care that meets the needs of those who use their services.

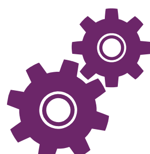
Making use of what a provider tells us would only be one part of our approach to inspection. It would never be the only information used by CQC to assess their quality or rate a service. We would continue to inspect services to see for ourselves the quality of care being delivered, including carrying out unannounced inspections in response to concerns about quality. We would continue to use all of our regulatory and enforcement powers when appropriate.

We would check this information against what we know and what others, including the public, are telling us about that provider. We could use this information alongside our inspection information to help us determine where we inspect and what we look at when we inspect. It would also make it easier for commissioners, regulators and the public to access and use shared information about quality, giving providers time to focus on improving quality of care at the frontline.

How CQC defines quality – the five key questions

Are services...

Safe?



Effective?

Caring?

Responsive?

Well-led?

In order to make a real impact at both a local and national level and develop a truly shared view of quality, we need to work with NHS England, NHS Improvement, professional regulators and representatives from bodies such as the Royal College of GPs, as well as the National Quality Board. We will also work with representatives from across the adult social care sector including organisations such as the Social Care Institute for Excellence and the Association of Directors of Adult Social Services.

This is a change that cannot happen quickly and we will make sure it is developed at the right pace. It is important that providers, the public, care professionals and organisations across health and social care have the opportunity to join this conversation.

Tell us what you think

3a Do you agree with our proposal for implementing a **single shared view of quality?** (see pages 17-19)

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

3b What do you agree with, or not agree with, about a single shared view of quality?

....

THEME 3: Targeting and tailoring our inspection activity

Most of the resources we have to deliver our purpose are devoted to inspection activity. One of the main developments from our last strategy was to introduce a new approach to inspection that was sector specific, and included specialists and people with practical experience of using services (Experts by Experience).

We now have learning from these new inspections in all sectors. Firstly, we need to continue improving the underlying processes we use such as reporting and evidence collection. We also need to reflect on the information we now have about the quality of care in England in all sectors and use this to focus on what we want to achieve from inspections in the future and therefore how our approach might change.

You have said so far

Over half of you commented on our question about **more responsive and tailored inspections**. Many of you said that it was an appropriate approach and it would be effective and valuable as it would lead to more efficient use of CQC resources and improve what providers think of us.

"Realistically, in the current financial climate, it's hard to see how full implementation of a programme of comprehensive inspections can be sustainable. Moving to more responsive and tailored inspections therefore seems a practical necessity."

A few of you had serious concerns with this proposal, including a risk that providers' performance might not be consistent over time and comprehensive inspections to assure quality were still needed. Your comments included a concern that an outstanding service could rapidly deteriorate and a proactive inspection regime would be needed to pick this up.

We know there are some changes we need to carry out across all our inspection activity, including:

- Continuously improving the processes that underpin our operating model such as the reporting process, and recording and use of evidence.
- Linking our information to better assess and report on care pathways where people move between services in different care sectors – for example a person with diabetes who receives care from a GP practice, an acute hospital and district nurses, and who may live in a care home.
- Developing how we regulate a provider at a corporate level in a way that reflects their role in leadership and oversight of quality of care. For instance a major care home provider that operates care homes in more than 20 locations, or an independent healthcare provider that operates hospitals across 10 locations.
- Looking at how we register and inspect services that are innovative and offer unique combinations of services, including some that are new models of care or use new technologies.

Our future activities will be also driven by our inspection findings in particular care sectors.

For **NHS trusts** this will mean focusing follow-up activity on those services that have ratings of either requires improvement or inadequate, and reporting at the level of localities for services such as community health trusts and mental health trusts.

For **independent healthcare**, we will focus on increasing our engagement with providers at the corporate level to test their oversight of quality of care at individual locations.

For **general practice**, we will continue to develop the way we inspect to take account of changes to the way the sector is organised and delivered – for example through new models of care or federated practices. We will work with the professions and partners such as NHS England and the General Medical Council to improve the way we work together, reducing the burden on practices and using a single view of quality. This approach will enable us to continue to rate general practice as well as focusing on the role that practices play in the wider health and social care system.

For **dentists** we have been working with our partners in the system through the Regulation of Dental Services Programme Board and are committed to ensuring that we are making the most effective and efficient use of our inspections.

For the joint inspections we carry out in relation to **children's services** and **health and justice** we will ensure our methodologies continue to be tailored to the needs of these sectors.

For **adult social care**, we will continue to develop our model to reflect the diverse range of services and changing public expectations of care, including how we gather evidence effectively on services provided in people's homes. We will seek to establish better intelligence to help spot potential rapid deteriorations in care quality so we can target inspections effectively. We will review our approach to corporate providers and other providers with multiple locations, reflecting their role in leadership and oversight of the quality of care delivered locally. We will also work with partners in the system to reduce the burden from duplication in data collection and to develop a shared view of quality.

These proposals are likely to reduce the frequency with which we inspect services and the size of inspection teams overall. This will help us to target our resources where risk is greatest and improvement is needed.

We want to be very clear that these proposals would not compromise the core aspects of our role that matter most to people. The following principles will guide us:

- We will continue to perform the full range of our statutory duties in all the providers and services we regulate.
- We will continue to carry out responsive inspections triggered by information that identifies risk or concerns about quality, especially where people's basic human rights could be impacted.
- We will not make a judgement on quality (including awarding a rating) without evidence from inspection.
- We will not make a decision on how often we inspect a provider, location or service based solely on the information received by a provider.

Based on our experience of introducing change, we will develop these proposals carefully to allow co-production and testing of new methods with the public, providers and system partners, and training of CQC staff.

Tell us what you think

4a Do you agree with our proposal for **targeting and tailoring our inspection activity**, including reducing the frequency of some inspections so we target our resources on the greatest risk? (see pages 19-21)

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

4b What do you agree with, or not agree with, about targeting and tailoring our inspection activity?

....

THEME 4: Developing a more flexible approach to registration

Organisations applying to provide a new health or care service are legally obliged to register with CQC. When they register they must satisfy us that they will meet all required standards. We want to develop our approach to registration so we can be more flexible in registering different types of providers. This means we will be able to adapt and respond to new and innovative models of care, while still continuing to reject providers of services that could put people at risk.

You have said so far

A majority of you commented on our question on **risk-based registration** (targeting providers that present a greater risk, and applying a higher degree of scrutiny at registration).

Many of you have said that this is an appropriate approach and would be very helpful to providers. You said it would be a good way to maintain an overview of what is happening in services and would demonstrate trust in providers when they have shown they are providing good care.

"Overall this would have a positive impact on the trust as it will bring more flexibility for innovation and for large providers taking on new areas of care."

However nearly half of you have expressed serious concerns with this approach, including how robust our risk assessments are and the implementation of this approach more widely. You said that existing sources of assurance can be imperfect and CQC's risk assessment mechanisms may not be strong enough.

"We are very concerned that this could result in services falling through the net. We also feel that this could result in overdue attention on potentially negative areas, instead of demonstrating excellence."

When a new service registers with us, regardless of how they are set up, we always need to answer some fundamental questions, for example: Who owns the service? Where is it delivered? What type of setting is the care delivered in? What particular people or population groups does the service support? We will make sure that we talk early to providers to understand these answers clearly, particularly for providers of new models of care where the service may be organised in an innovative way.

We will target our resources so we continue to protect people from services that are unsafe or poor quality by preventing these services from registering, and closing down unregistered services that are providing care illegally. As

a result we will have more flexibility to work differently with providers that require a less intensive registration process because they present less risk – for example, providers that are simply changing an administrative or head office location, or applications from providers with strong track records and evident expertise. For this type of registration we will be able to use our inspection and monitoring processes to provide ongoing assurance rather than at registration, therefore reducing unnecessary duplication and administrative cost. This will ensure a more positive registration experience for all providers.

We will make sure services are registered at the right level, for example at the corporate level when it is a provider operating services from a number of different locations. This will mean we can hold their leadership to account and ensure that leaders at all levels understand their responsibilities for quality of care, and that we can engage with them on identified areas for improvement using the single shared view of quality that we are proposing.

Tell us what you think

5a Do you agree with our proposal for a more **flexible approach to registration?** (see pages 22-23)

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

5b What do you agree with, or not agree with, about a more flexible approach to registration?

....

THEME 5: Assessing how well hospitals use resources

In July 2015 the Secretary of State gave CQC a new role in assessing NHS trusts' use of resources. This means we will begin to check that hospitals are making decisions and using their resources – such as staff, equipment and facilities – in the most economical and efficient way to ensure services are sustainable and offer value for money. We set out our initial thinking on how to undertake this work in *Delivering cost effective care in the NHS* published in October 2015.

We will consider what you have told us so far in developing our proposals for assessing the use of resources in NHS trusts, which we will publish for consultation later in 2016. We understand the need to align our approach with other organisations, and to avoid creating unnecessary new burdens on providers. We are working closely with providers and others, including the review of NHS productivity being led by Lord Carter, to explore how ambitious the scope of our assessments should be and to make sure our role joins up closely with NHS Improvement. We are working to ensure that we have common metrics for assessing providers on their use of

resources, and will look to share information as much as possible to avoid duplication.

You have said so far

Nearly half of you said that assessing the **use of resources in NHS trusts** would be appropriate and necessary and that this could help improve the way NHS trusts work. You said it would encourage trusts to be aware of their duty to ensure resources are not wasted and money is well spent.

However, many of you said that this would double up with work other organisations already do and is outside of CQC's remit. You also said that this could confuse the public. Some of you had doubts about whether this would be effective in improving care for people who use services and would be driven by money and not be patient centred.

"Typically quality management is seen as separate to finances: it is not clear whether the evidence base really supports this as a worthwhile extension of CQC's remit."

Many of you thought this should be a low priority for CQC and that making our model more efficient and effective should be our top priority.

The demands on the NHS from an ageing population with more complex needs will continue to grow. Meeting these demands and delivering good quality care on a sustainable basis requires all providers to take seriously the need to work together to reduce waste, increase patient flow and avoid delays, and to ensure the management and leadership of services is sufficiently focused on these goals.

Our focus will therefore be on how operational performance is structured and delivered to support economical and efficient care, rather than on financial management and controls, or on the financial position in isolation. The assessments will share information on the performance of providers so that use of resources is considered as an essential component of good quality service delivery. We will also shine a light on good practice so that others can learn and improve.

We will base this approach on the process we already use for quality ratings, including data monitoring, providers completing an information request, an inspection, a rating, and follow-up activity.

We want the assessment of use of resources to be an incentive for providers to achieve a rating of good or outstanding. We also want to make sure the right support is given to providers found to be inadequate. We will pilot our assessment from April 2016. We will then evaluate and refine our approach ready to start a full roll-out in NHS acute trusts early in 2017.

Initially we will only be carrying out provider-level assessments of how well NHS acute trusts use their resources. Across all sectors, however, we will continue to analyse the data we hold to understand the relationship between resources and quality. We will use our *State of Care* report and other opportunities to highlight what we find.

We are not asking a specific question in this document on assessing use of resources in NHS trusts as we are consulting on this later in 2016. However in advance of this, if you want to share your views, do send them by email: hospitalsconsultation@cqc.org.uk

THEME 6: Developing methods to assess quality for populations and across local areas

CQC's current provider-based approach to inspection will continue to be necessary. However there is more that we can do to encourage improvements in people's experiences of care by looking at how organisations work together to coordinate care to better meet people's needs.

The way that services are used and delivered will change over the next five years and we will work closely with people, providers and our partners in the health and social care system to make sure that our operating model remains fit for the future. The *Five Year Forward View* and the NHS planning guidance for 2016/17 to 2020/21 set a clear direction for the move towards more place-based activity, including local areas working together to set out their plans for improvement in local 'Sustainability and Transformation Plans'. We will develop our approach with our stakeholders, and pilot our proposals, so that we can be confident about the value they bring to people as the way that services are delivered continues to change.

You have said so far

The majority of you commented on our question about care services for **specific populations and in specific local areas**. Nearly half of you made positive comments and agreed that assessing care for populations and places would generate useful information and support integrated care services.

"The CQC…should consider the impact on the delivery of new models [of] care and how the CQC's inspection methodology can adapt to respond to them."

"Many people have complex conditions and care from several difference sources. Looking at an individual's care across those sources would be very useful."

Many of you questioned CQC's ability to establish a robust process for assessing care for particular population groups or places and felt this was not within CQC's remit. You also had doubts about how the information generated would help providers improve the quality of care.

"Inspecting in this way would be costly and results would be of questionable value, particularly given the challenges of attributing area-level issues to individual agencies with responsibility or the capacity to create improvements."

Many of you thought that changing CQC's focus in this way should not be a priority as it would mean allocating resources from other activities.

Firstly, we will make sure that we are able to register, monitor, inspect and rate new models of care, including those that span traditional sectors or organisational divides. This will be consistent with our commitment to protect and provide useful information for people who use services, and to encourage improvement.

Secondly, we will strengthen how we inspect and report on how well providers are working with their partners to provide high-quality care. We will develop and test approaches to assessing how well services are meeting the needs of particular population groups (such as older people), and people with mental health needs or a learning disability. To do this, we will support our staff to work together across our hospitals, primary medical services and adult social care teams, and to share their information about the quality of care within a local area.

As we complete our baseline assessment of the quality of all health and adult social care services, we will also start to present our ratings and findings in more accessible ways. This will provide the public and our partners with a clearer picture of the quality of care in their local area and how it compares with other areas. We will consider what other information we could provide at a local level that could be useful to people, providers and oversight bodies, and how we could coordinate this activity with NHS England's work to rate the performance of clinical commissioning groups.

Sharing learning with others

Our plans to look at the quality of care for populations and places put us at the forefront of assessing care quality across multiple providers. Alongside CQC, healthcare regulators in Scotland and the Netherlands are also developing new approaches that take a more person-centred view. We will share our learning with these other organisations and also learn from them as we develop our approach.

Thirdly, in addition to our core functions of registration, inspection and enforcement, we can also carry out reviews and investigations to assess and encourage improvement in relation to specific themes or pathways of care. Earlier this year we published our *Right here, right now* report that considered how general practice, A&E departments, mental health teams and the police work together to support people experiencing a mental health crisis. We will be publishing further thematic reports over the next few months and into 2016/17 on topics including integrated care for older people, end of life care, and diabetes care in the community. We will continue to focus on a small number of national priority themes.

Finally, in 2016, we will publish the results of two pilots that looked at whether CQC could add value by undertaking a more comprehensive assessment of the quality of care in a local area. These reports will look at factors that influence quality, such as system leadership, commissioning and workforce issues. Subject to the results of the pilots, we want to explore more ways that we could assess the quality of care received by people in a local area or by specific population groups by undertaking further reviews or investigations.

Some of these proposals will be new areas of work for us. In a period when our budget is being reduced, we need to be clear about what approaches would bring most value to people using services. We will continue to develop and test these proposals in partnership with you.

Tell us what you think

6a Do you agree with our proposal for **assessing quality for populations and across local areas?** (see pages 25-27)

- ☐ Strongly agree
- ☐ Agree
- ☐ Disagree
- ☐ Strongly disagree

6b What do you agree with, or not agree with, about assessing quality for populations and across local areas?

....

Implementing our vision over five years

This is a five-year strategy and we have set out an ambitious vision of where we want to get to. It will take time. Our strategy must help us to deliver our purpose more effectively, with fewer resources, and in a way that responds to the changing health and social care landscape. Our priority initially will be to continue to improve how we carry out our core role of regulating individual health and social care services and publishing our findings. Alongside this we will be developing the six themes in this document. The following principles will guide us over the next five years:

- We will build on our existing regulatory approach and co-produce changes with our partners.
- We will plan and carry out our work more effectively and efficiently so that our expenditure matches our future budget.
- We will support our staff and develop the right processes, capabilities and behaviours to deliver our core purpose.
- We will continuously monitor our impact so we offer good value for money.

You have said so far

A few of you commented about **how we prioritise our resources**, in particular the potential limitations imposed by CQC's financial situation and its staffing level. Many of you said that we need to find ways to become more cost-effective, while making sure our assessments continue to be rigorous and consistent.

Our focus in the first two years – building on our approach

In 2016/17 and 2017/18 we will build on the strong foundations we already have in place and focus on:

- Evolving our inspection model and completing comprehensive inspections across all services that we rate.
- Developing our intelligence so we can better assess quality of care and understand risk.
- Working with partners to develop a single shared view of quality of care.
- Starting to roll out an assessment of the use of resources in NHS trusts.
- Making improvements to our registration function.
- Registering and inspecting new care models as they develop.
- Continuing to test methods for assessing quality for specific populations and across local areas.
- Improving the efficiency of our supporting systems and processes, including using digital technologies.
- Developing and phasing in the other changes we will make to our model over the five years.

In common with our work so far, we will co-produce any changes with the public, organisations that provide care and our partners like NHS England.

Delivering our vision with reduced resources – being more efficient and effective

We will deliver the vision set out in this strategy with fewer resources than we have currently. The Government's Spending Review has defined the policy and financial context for public services in England until the end of the financial year 2019/20. The Department of Health has been asked by HM Treasury to deliver an overall 25% reduction in spending and CQC will need to contribute to this reduction. We will therefore need to deliver our purpose in 2019/20 with fewer resources. We expect this to mean a reduction from our budget of £249 million in 2015/16 to a budget of £217 million in 2019/20.

Our budget is made up of a combination of grant-in-aid from Central Government budgets and income from fees paid by providers. Like all public bodies with fee-setting powers, CQC is expected by the Government to increasingly recover the chargeable costs of the services we provide through fees. This means that over the next five years, the majority of our funding would come from fees, and this will influence our relationship with providers. We have been consulting separately on our fees for 2016/17 and beyond, and plan to publish our response to this in March 2016. We will ensure that we remain accountable to providers and the public for how we use our income, and demonstrate that our judgements are independent and we are fair, efficient, effective and proportionate. In this context, we estimate that the current budget for CQC is approximately 0.16% of the overall spending on health and adult social care in England and we estimate it will reduce to 0.15% by 2021.

We have introduced fundamental changes to our model of regulation over the past three years, but many of the supporting systems and processes we use are not yet efficient enough.

How we will use technologies to improve our efficiency and effectiveness

We want to make the best possible use of developing technologies so that our interactions with others are efficient and professional, and internally our use of information and records is efficient and effective. We provide some examples below:

CQC provider portal

CQC's provider portal allows registered care providers to send us statutory notifications of serious events and apply for registration changes online. The system is quick, efficient and saves providers and CQC valuable time. Forms submitted using the portal are around twice as likely to be correct when compared with post or email submissions. In November 2015 we upgraded the portal to allow prospective providers to register, replacing our previous paper system. We plan to continue developing the portal and encouraging more new providers to register online. This will significantly reduce the number of forms we reject for missing information.

CQC website developments

In Autumn 2015, we carried out a review of our public website, staff intranet and provider portal. We spoke to the main users of each channel and found out what they needed and how their experience could be improved. On the basis of that review we plan to improve the quality of the content we publish, and focus on improving the features that best meet the needs of our audiences as we develop and redesign our digital services from 2016 onwards.

National resource planning tool

We are improving the way we schedule inspections to implement best practice in resource planning and productivity. We are currently developing a web-based tool to support the management of our internal and external resources, helping teams to work together more effectively and reducing administration. The tool will bring together all the key people (inspectors, analysts, specialist advisors and Experts by Experience) involved in our inspection activity to better match our supply with demand. After a period of testing the tool will go live during 2016.

IT infrastructure

We will modernise our IT infrastructure to take advantage of the agility and cost savings that this offers. Staff will be provided with up-to-date and flexible tools to support easier access to our systems, as well as enabling our staff working in different locations to collaborate effectively.

Data analysis tools

We are planning to secure more sophisticated tools to help us better analyse and visualise the data and information we hold about providers. This will make us more efficient in processing and analysing large volumes of numerical data, and more effective in communicating our analyses. It will also enable us to automate the analysis of qualitative data, including people's comments on their experiences of care, rather than relying on manual coding and processing. This development will happen alongside our continuing work with different and new techniques to make better use of the large datasets we hold.

We believe we can make significant savings over the next five years by improving these systems and processes, including greater use of new technologies to help us to identify and reduce waste and duplication, and to standardise core activities (see box on page 30).

We will develop clear plans for how the proposals described in this document will shift how we use our resources by 2021. We expect to see a reduction in our expenditure on inspections and registration as we improve our use of intelligence, and our underlying systems and processes. As we develop our approach, we will set out the new expenditure we will need, for example for assessing how well NHS trusts use their resources. Many of our plans for looking at quality for populations and places will not require additional expenditure, but some will. The extent to which we can develop and implement these activities will depend on our ability to make savings elsewhere.

Managing change and developing our staff

We will deliver this strategy successfully if we work together to make changes. To meet the challenges of becoming more efficient and effective, as well as more responsive and flexible, we will look at our processes, capabilities and behaviours. We will also look at the areas for improvement we have identified in our staff surveys to further improve morale and staff engagement.

- Our processes are the structures and systems that will support our proposed changes. We need to identify the greatest opportunities for improvement and invest in the best digital and other systems. We also need to look at our governance processes to help manage change and risk effectively.
- Our capabilities are the skills and competencies that will enable us to work differently and innovatively. As the health and social care sector changes and we address new challenges, we need to make sure we have the right capabilities to deliver our vision, especially in leading and managing change in a way which is supportive and involves all staff.
- Our behaviours will help us to work effectively to deliver change. Our CQC values of excellence (being a high performing organisation), caring (treating everyone with dignity and respect), integrity (doing the right thing) and teamwork (learning from each other to be the best we can be) are an important foundation for everything we do now and in the future.

Evaluating our impact

Understanding the impact we have on others, both in terms of the benefits we bring and the costs we incur, is essential so that we are accountable to our stakeholders and can use this information to identify areas for improvement. We are therefore developing an approach to assessing the impact of CQC's operating model.

This has included developing our surveys of providers, the public and inspection teams to better capture our impact. We are working with Ipsos MORI to undertake case studies with providers to explore in detail the administrative costs incurred as well as the cost and benefits of changes providers make as a result of CQC activity. In addition, we are exploring what changes in ratings and analysis of external indicators of quality of care can tell us about the impact of CQC.

The range of available evidence will allow us to measure whether we have successfully delivered our vision and help us to understand the impact of our future strategy. It will be brought together, with information about CQC's own costs, in an annual assessment of our impact and value for money, with the first assessment due to be published in 2016.

Equality and human rights

As part of the changes to the CQC operating model over the past three years, we developed a human rights approach to regulation which ensures that equality and human rights are embedded in the way we regulate services. The *Draft equality and human rights impact analysis* that accompanies this consultation summarises, for each of the main proposed changes, the opportunities for improving equality and human rights, and the risks. It also includes the ways that we propose to maximise these opportunities and mitigate risks, taking into account comments made in *Building on strong foundations*.

Tell us what you think

7 What impact do you think our proposals will have on **equality and human rights?** (see our *Draft equality and human rights impact analysis* at: www.cqc.org.uk/2016strategyconsultation)

....

What happens next

We will look at the comments you send us and use these to finalise and publish our new strategy in May 2016. We will also publish a consultation response document which will set out your views and our response.

Tell us what you think

8 Are there any **other points** that you want to make about any of the proposals in this document?

....

How to respond

You can respond through our online form: www.cqc.org.uk/2016strategyconsultation or by email: strategyconsultation@cqc.org.uk.

You can also tweet us your thoughts at #cqcstrategy

Please reply by 14 March 2016.

Thank you for taking the time to contribute to the development of our future work. Your feedback and comments are important to getting this right.

Summary of consultation questions

1a Do you agree with **the vision** we have set out for regulation of the quality of health and adult social care services in 2021? (see pages 6-11)

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

1b What do you agree with, or not agree with, about the vision?

....

2a Do you agree with our proposal to **make greater use of data and information** to better guide us in how we identify risk, and how we register and inspect services? (see pages 14-16)

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

2b What do you agree with, or not agree with, about greater use of data and information?

....

3a Do you agree with our proposal for implementing a **single shared view of quality?** (see pages 17-19)

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

3b What do you agree with, or not agree with, about a single shared view of quality?

....

4a Do you agree with our proposal for **targeting and tailoring our inspection activity**, including reducing the frequency of some inspections so we target our resources on the greatest risk? (see pages 19-21)

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

4b What do you agree with, or not agree with, about targeting and tailoring our inspection activity?

....

5a Do you agree with our proposal for a more **flexible approach to registration?** (see pages 22-23)

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

5b What do you agree with, or not agree with, about a more flexible approach to registration?

....

6a Do you agree with our proposal for **assessing quality for populations and across local areas?** (see pages 25-27)

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

6b What do you agree with, or not agree with, about assessing quality for populations and across local areas?

....

7 What impact do you think our proposals will have on **equality and human rights?** (see our *Draft equality and human rights impact analysis* at: www.cqc.org.uk/2016strategyconsultation)

....

8 Are there **any other points** that you want to make about any of the proposals in this document?

....

Care Quality Commission

How to contact us

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