

## Consultation 3

# Our next phase of regulation

A more targeted, responsive  
and collaborative approach

Independent healthcare



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# FOREWORD

This is our third consultation on the Next Phase of CQC's regulation. We are now developing a comprehensive overview of the quality of care delivered by providers in the independent healthcare sector, using what we have learned from inspections so far.

Following this consultation, we will continue to develop this view as CQC has been given the power to award ratings to some of these services for the first time from 2018/19. This is important for people who use services, as it will provide more transparency about the quality and safety of services provided by the independent healthcare sector. Going forward, when we have established a baseline of quality for independent healthcare, we want to focus more on understanding how services improve, and will use our insight and regulatory approach to encourage services to provide better quality care.

The independent healthcare sector is changing rapidly to meet demand. Independent healthcare plays an increasingly significant role in England, with many services funded either wholly or partly by the NHS. There is also continuing growth of independent providers delivering elective care in acute, mental health and community sectors, community care for long-term conditions and components of services in NHS trusts. We expect more growth of digitally-enabled diagnostics and imaging provided in the independent sector and we are increasingly seeing more independent primary health care delivered online.

We know it is more of a challenge to measure quality and improvement in the independent healthcare sector than in the NHS, as there is a limited amount of centrally-collected data available to us. But people still need to be assured that they will get high-quality and safe care.

This is why it is so important to regulate independent providers in the same way as we regulate services run by the NHS.

Our strategy for the next five years set out an ambitious vision for CQC to be more targeted, responsive and collaborative in our regulation, so that more people get high-quality care. Using the principles in our strategy, the learning from our inspections and feedback from independent healthcare providers about our regulation, we want to continue the discussion about how we should develop our approach and move into the next phase of our regulatory model.

The landscape of health and social care is changing, so CQC must also adapt and develop our regulatory approach. In doing so, we want to keep the elements that we know people value and improve what people tell us we can do better. We will continue to work with people who use services, care providers, professionals and our local and national partners to co-produce what we do.

We value all feedback about our proposals - thank you for giving us your views.

**Sir David Behan**  
Chief Executive

# INTRODUCTION

CQC's purpose is to make sure health and social care services provide people with safe, effective, compassionate high-quality care and to encourage care services to improve. Our strategy for 2016-2021 set out a vision for a more targeted, responsive and collaborative approach to regulation, and outlined four strategic priorities:

1. Encourage improvement, innovation and sustainability in care.
2. Deliver an intelligence-driven approach to regulation.
3. Promote a single shared view of quality.
4. Improve our efficiency and effectiveness.

In this third consultation for the next phase of our regulation we set out our proposals for developing how we regulate independent healthcare services. We will be able to award a rating to certain types of independent healthcare services from 2018/19, and this consultation includes how we propose to introduce these. The first two consultations on our Next Phase of regulation consulted on:

- consolidating the different sector-specific provider handbooks and assessment frameworks for health and for adult social care services
- our approach to regulating NHS trusts, primary medical services and adult social care, and registering services for people with a learning disability
- our approach to regulating new models of care and large or complex providers
- our approach to encouraging improvements in the quality of care in local areas using our unique knowledge and capability
- how we carry out our role in relation to the fit and proper persons requirement for directors.

The proposals in this consultation represent an evolution of our approach, rather than introducing new methods. It builds on our knowledge of independent healthcare services and our specialist expertise, and will enable a more targeted, responsive and collaborative approach, in line with our strategy.

## **What we mean by independent healthcare services**

This consultation refers to services that can be described as 'independent healthcare'. There is no agreed definition of independent healthcare, but in the context of CQC's regulation, we mean:

**“Health care that is provided by organisations that are not NHS trusts or NHS GP services, such as private corporations or companies, charities, social enterprises, voluntary and faith-based organisations and individual providers of care.”**

There is a wide and diverse range of independent healthcare services, and providers often deliver more than one type of service. Figure 1 shows the types of independent healthcare provider included in this consultation. These organisations provide care that is paid for in a number of ways, including self-funded by patients or through private medical insurance arrangements, or directly commissioned by clinical commissioning groups.

Although these organisations are classified as ‘independent’, many of them provide services that are funded either wholly or partly by the NHS. This includes, for example:

- community interest companies providing NHS community healthcare for an area
- independent acute hospitals providing surgical procedures for NHS patients as well as private patients
- independent ambulance providers responding on behalf of NHS ambulance trusts to 999 calls
- independent substance misuse services working alongside the NHS in a substance misuse hub.

For this reason, where possible, we regulate them in the same way as a similar service provided directly by the NHS.

As well as the different types of services and funding arrangements, there is variation in the size and shape of the market, the degree of system oversight, and the availability and comparability of data.

In our inspections of independent healthcare services so far, we have also found variation in the quality of care provided – both within and between the different types of service. For example, the majority of hospices have been rated as good or outstanding. But we have also identified emerging concerns in some services, such as primary health care delivered online, independent ambulance services, and substance misuse services offering detoxification or assisted withdrawal.

## **Proposals in this consultation**

We are now asking for views on our proposals to evolve our approach to regulating independent healthcare services to bring it into line with other types of healthcare services. We believe that we should take a consistent approach and regulate all services as far as possible in the same way, irrespective of the type of organisation they are or how they are funded. Therefore, we have adopted the principle that any developments we make in our regulation of independent healthcare services will follow the approach taken in other sectors.

Our proposals include:

- Introducing a rating for independent healthcare services that we have not previously had the powers to rate in a way that is consistent with our approach to rating all other services.
- Assessing services at the provider level and regulating new and complex types of provider.
- Working collaboratively with partners and providers to develop robust data collections to enable us to effectively monitor the quality of services.
- Moving towards more unannounced and short notice inspections.
- In independent acute hospitals, making changes to how we define some core services.
- Publishing a shorter, more accessible and user-friendly inspection report.

The proposals are informed by what we have learned from inspecting most of these services during the last three years. We also draw on feedback from the public, people using services, providers and other stakeholders. In developing our proposals, we have considered the feedback from respondents in independent healthcare to our first two consultations, and feedback from independent doctors to our 2015 consultation on regulating these providers. Using this, and by engaging with providers of independent healthcare, we know that we can improve the way we regulate. This consultation sets out how we propose to make these improvements.

We ask specific questions on our proposed approach throughout this consultation document, and provide a full list at the end. All questions are also on the online webform: [www.cqc.org.uk/nextphase](http://www.cqc.org.uk/nextphase).

## Types of service included in this consultation

Figure 1 lists the types of independent healthcare services that CQC regulates, and whether we propose to rate them or develop our regulatory approach to them.

<b>Figure 1: Proposals to rate and evolve regulatory approach in this consultation</b>		
<b>Type of independent healthcare service</b>	<b>Proposals to rate?</b>	<b>Proposals to evolve regulatory approach?</b>
Independent acute hospitals (excluding cosmetic surgery-only hospitals)	Already rated	Yes
Independent acute hospitals (cosmetic surgery only)	Yes	Yes

Single specialty services: long-term conditions (neuro-rehabilitation)	Already rated	Yes
Single specialty acute services: termination of pregnancy, dialysis, refractive eye surgery, diagnostic imaging, endoscopy	Yes	Yes
Community services	Yes – rating <b>all</b> providers for the first time (previously only rated some)	Yes
Mental health services	Already rated	Yes
Substance misuse services	Yes	Yes
Ambulance services	Yes	Yes
Non-hospital acute independent doctors	Yes	Yes
Independent doctors and clinics providing primary care services, including online	Yes	No – already consulted on to bring into line with inspection approach for NHS GP practices
Hospices	Already rated – but assessed and rated for the first time using the assessment framework for healthcare services	Yes
Single speciality services: laboratory, hyperbaric, fertility; blood and transplant services	No plans to rate	Yes

### **Independent doctors and clinics providing primary care services, including online**

We have previously consulted on our approach to monitoring and inspecting independent doctors and clinics that provide primary care services, including those provided online. Therefore for these services, we are only asking for feedback about our proposals to rate them, now that the legislation enables us to do so.

## **Independent doctors providing non-hospital acute services**

In developing our approach to regulating independent doctors providing non-hospital acute services, we are considering how we may regulate them in a similar way to independent doctors providing primary care services. This is because they provide services in a similar way, often providing consultations and minor treatment in clinics and consultation rooms.

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

These services are not included in this consultation if they are delivered by independent healthcare providers. This is because we consulted on our approach to regulating and inspecting them in June 2017, and we published our approach in October 2017.

## **How to respond**

CQC welcomes your views on how we propose to monitor, inspect, rate and report on the quality of independent healthcare services.

We are grateful for your feedback to this consultation and will use your responses, and the feedback from engagement events, to shape our final approach. This will enable us to be responsive to risk and improvement, and to be more efficient and effective by working directly with our partners to increase alignment and reduce duplication.

Please let us know if all or part of your response is confidential or if you wish to remain anonymous, so that we do not include this in our published summary of responses. We will do our best to meet all requests for confidentiality, but because CQC is a public body subject to freedom of information legislation, we cannot guarantee that we will not be obliged to release your response (including, potentially, your identity) or part of it, even if you say it is confidential.

The easiest way to respond is by using the online webform:

[www.cqc.org.uk/nextphase](http://www.cqc.org.uk/nextphase).

If you have difficulty in accessing the consultation, please email [nextphase@cqc.org.uk](mailto:nextphase@cqc.org.uk).

The deadline for your response is: **3pm on 23 March 2018**.



# REGULATING INDEPENDENT HEALTHCARE PROVIDERS

In this section, we describe how we propose to develop our approach to regulating independent healthcare services in the context of a changing landscape of care and in line with the direction set out in our five-year strategy.

We describe how we will register, monitor, inspect, rate and take action to encourage improvement in independent healthcare services. This represents an evolution of our approach to date, and reflects what we have learned from regulating independent healthcare over the last few years as well as our learning from regulating other types of health and social care services.

## 1.1 Registering

In our June 2017 consultation, we set out our proposals to develop our approach to registration and our register of all providers. Using the feedback, we are now working to:

- improve our register so that it clearly tells the public about who owns care providers, what services they provide and to whom, where to find these services, and any relationships and links between providers
- clarify who is required to register with us so that we can hold to account all those who are accountable for quality and make sure they improve quality across their services
- improve our understanding of large and complex organisations so that we can take a more targeted and responsive approach to regulation.

We will require all legal entities to be registered with CQC if they meet our revised criteria as a provider of a regulated activity. We will implement this requirement in a phased way across different types of provider, with the first registrations of this nature in 2018/19. We will publish the schedule for these changes once we have completed detailed impact assessments.

We are committed to ensuring that people are protected when they receive care, and that CQC's quality ratings and inspection reports are meaningful to the public. For this reason, we will continue to inspect at a location level, where services are provided.

## 1.2 Monitoring

We want CQC's monitoring function to play a greater role in how we regulate independent healthcare services. We are currently developing our new CQC Insight model for specific types of independent healthcare services. Across the sector as a whole, this will be further supported by strengthening our processes for managing our relationship with providers and collecting information from them, which will enable us to monitor potential changes in the quality of care more swiftly. We will use this intelligence to target our regulatory activity and encourage improvement.

### CQC Insight

We are developing a new model for using data and information to monitor services that we regulate, called 'CQC Insight'. This will identify potential changes to quality – either improvement or deterioration – since the previous inspection, and will highlight critical data that inspectors need to follow up with the provider. We will use the tool to inform our decisions about when and what to inspect, as well as to support our findings and ratings when we report.

In independent health care, the availability of information varies across different types of services and for some services there is very little data available of sufficient quality and coverage. This means we are currently unable to develop a CQC Insight product to support our monitoring of them.

Where data is available, we will phase the introduction of our CQC Insight tools. We have tested tools to support how we monitor services for people with a learning disability and substance misuse services, and we will roll out CQC Insight for independent acute hospitals and providers of mental health services from early 2018/19. We will expand the data content for these services over the course of 2018/19, and create CQC Insight tools for others where the available data is of sufficient quality, depth, and coverage to allow us to monitor them effectively.

We will continue to work in partnership with others (for example, the Private Healthcare Information Network) to improve how we share information and ensure that data helps us to prioritise our resources where risks to people are greatest. Where appropriate, we will work collaboratively with partners and providers to develop robust data collections to enable effective monitoring.

# Relationship management

## With providers

Maintaining a good working relationship with providers is essential to effective regulation and to achieve a single shared view of quality. Rather than focusing all our activity around an inspection, we will maintain regular contact throughout the year with independent healthcare providers at each registered location, and with some providers at a corporate level.

Regular, open and consistent communication through meetings and other contact will enable us to share information in a more timely and manageable way, and will help to develop an effective working relationship with the provider, built on trust and mutual professional respect. As part of this, we will ask for information about any organisational developments and strategic plans, and will be able to update providers on our methods and regulatory approach.

We will ensure that any information we gather during relationship management meetings will actively contribute to our monitoring and regulatory risk management process, and will encourage improvement. When information indicates issues of concern, we will continue to respond immediately and, when appropriate, escalate these issues through our enforcement process. We will seek assurances from providers on how they are addressing issues and will monitor the impact.

## Complex providers that deliver different types of services

We will identify a single CQC relationship-holder who will work alongside named leads for each type of service to coordinate our regulatory activity for that provider. We will also align the way we collect information from these providers and combine our monitoring information to inform a single regulatory plan.

## With local and national organisations

It is also essential to strengthen our relationships with local and national organisations to support more effective regulation of independent healthcare services. This will reduce duplication and improve how we share information about the quality of services.

For independent healthcare services, this includes local organisations such as:

- NHS Commissioners, where the independent healthcare provider provides NHS services
- local authority commissioners (those that commission health visiting and school nursing or substance misuse services from independent healthcare providers)
- NHS Improvement.

National organisations include:

- insurers (as the main funders of care paid for privately, insurance companies collect data on the quality of care of providers they commission from, and data on experiences from claimants using those services)
- the Competition and Markets Authority
- the Private Healthcare Information Network
- accreditation bodies
- the Independent Sector Complaints Adjudication Service
- Public Health England
- professional regulators (the General Medical Council, the Nursing and Midwifery Council, the Health and Care Professions Council).

We will also engage with the public and the groups and organisations that represent them, such as:

- Healthwatch
- local, regional and national specialist voluntary, community and social enterprise organisations.

### **CONSULTATION QUESTIONS: Monitoring the quality of services**

We propose to strengthen how we manage our relationships with providers of independent health care and with local and national organisations.

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

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

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

To support how we monitor the quality of independent healthcare services, we propose to routinely work with local and national organisations to exchange information about services.

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

## Regular provider information collections

We are currently introducing provider information collections for providers of adult social care and primary medical services to support how we monitor them between inspections.

In line with this approach in other sectors, we are proposing to develop a routine provider information collection to support our monitoring of independent healthcare providers. This will be particularly valuable where not enough data is available nationally for some types of service to feed into a CQC Insight product (for example, independent ambulance services). We will pilot any proposed information collections before implementing them. .

In doing this, we will not ask providers for data that is already available from other sources, such as Hospital Episode Statistics data, the Mental Health Services Data Set or from national audits. We will only ask for information that supports CQC’s monitoring, inspection and rating activity.

The timescales for introducing a provider information collection for independent healthcare are still to be confirmed, but it is likely to be from 2019/20.

In addition to a provider information collection, we will continue to request some specific information before an inspection (see section on maximum [inspection frequencies](#)).

We aim to keep these provider information requests to a minimum, although we anticipate that we may need some additional information after an inspection, to follow up our observations and findings. We plan to move to a single online submission process for this.

Current approach to monitoring	New approach to monitoring
<ul style="list-style-type: none"> <li>• Some regular engagement meetings with larger providers, but most engagement focused around inspection.</li> <li>• Provider information requests before an inspection only.</li> </ul>	<ul style="list-style-type: none"> <li>• Strengthened relationship management with providers and local and national organisations.</li> <li>• CQC Insight for some services, initially for independent acute hospitals and mental health services.</li> <li>• A regular monitoring collection for some independent healthcare services, following piloting.</li> </ul>

## **CONSULTATION QUESTIONS: Monitoring the quality of services**

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

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

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

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

We propose to collect information regularly from independent healthcare providers to help us to monitor the quality of services in between inspections.

### **Q3a. Do you agree that this is the right approach?**

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

### **Q3b. What impact do you think this proposal will have?**

## **1.3 Inspecting**

CQC is moving to a more targeted and tailored approach to inspection for all sectors that we regulate. To be more proportionate, targeted and responsive, we need a better balance between monitoring the quality of care and carrying out on-site inspections.

However, because we have not yet completed the 'first round' of inspections for all independent healthcare services, and we have not yet rated them all, we are planning to introduce this in a phased way.

## **Assessment framework for healthcare services**

Following feedback from our first consultation in December 2016, we replaced 13 sector-specific assessment frameworks and their corresponding key lines of enquiry (KLOEs) and prompts with only two assessment frameworks: one for healthcare services and one for adult social care services. This was to reduce complexity for providers and create greater consistency in inspections.

We are not proposing any further changes to the assessment framework in this consultation, but are using this opportunity to clarify how and when we will start to implement it for providers of independent healthcare services.

We will start to use the [assessment framework for healthcare services](#) when inspecting all providers of independent healthcare **from April 2018**. This includes inspections after April 2018 to follow up concerns found in previous inspections. We know that many independent healthcare providers deliver a number of different types of service, and so having one assessment framework for all healthcare services will simplify and streamline our regulation and inspection of these services. This will be supported by supplementary sector-specific prompts, where appropriate.

## Types of inspection

To be more proportionate, targeted and responsive, we need a better balance between monitoring the quality of care and carrying out inspections. We will continue to inspect all five key questions in full in many of our inspections (are they safe, effective, caring, responsive and well-led?). For some services, our inspections will focus on particular core services or key questions where information suggests that risk is greatest or that quality is improving over time.

When inspecting newly-registered providers or locations we will carry out a comprehensive inspection of all five key questions across all services that we usually inspect.

These routine inspections may be supplemented by inspections that focus on specific risks or concerns identified through monitoring activity or from an earlier inspection, or from information shared with us such as from a whistleblower or safeguarding information. These inspections may not address all five key questions, or all of the services that we usually inspect.

For complex providers that deliver different types of health and care services, we will coordinate our inspection activity with inspectors from our primary medical, hospitals and adult social care inspectorates within a defined period, except for any focused inspections we carry out in response to concerns about quality in individual services.

### Inspecting hospices

We will also carry out an initial comprehensive inspection of all hospices from April 2018. This is because CQC's Hospitals directorate will inspect hospices using the new assessment framework for healthcare services, rather than the previous adult social care inspection approach. This will ensure that we are treating these services fairly and consistently and that we provide a rating for all hospices using the assessment framework for healthcare.

# Planning inspections

## Using intelligence to plan inspections

Once we have awarded initial ratings, our inspections will become more targeted based on the intelligence that we hold. Where a number of different services are provided at or from a location, we may potentially only focus on a particular aspect, depending on what our monitoring information indicates in terms of quality and risk. To plan our inspection approach and activity for each location, we will review the information that we hold about it and the quality of its services. We may do this for some larger providers that deliver a number of services from one or more locations through an internal regulatory planning meeting.

## Announcing inspections

We propose that the majority of inspections of independent healthcare providers will be unannounced or carried out at short notice, which is in line with our approach across most other sectors that we regulate. The exception to this is for some small providers or services where, for practical reasons, we need to give notice in order to carry out an effective inspection. We also aim to be more flexible around notice periods for inspection. For example, inspectors may give a longer notice period where we are focusing on a specific theme or inspecting a local area or a complex provider. We may also carry out short notice or unannounced inspections where we have concerns.

### **CONSULTATION QUESTIONS: Planning inspections**

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

#### **Q4a. Do you agree that this is the right approach?**

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

#### **Q4b. What impact do you think this proposal will have?**

## Frequency of inspections

If we have concerns about a service, we will inspect more frequently than if we are assured that it is maintaining a good quality of care.

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



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

We will continue to test and confirm the maximum intervals as we implement these developments. This is particularly the case for those types of independent healthcare service that we have not yet inspected, such as diagnostics and acute non-hospital independent doctors, and the types of independent healthcare services that we have inspected but not yet rated. We will review these maximum intervals as we understand more about risk across the different types of independent healthcare service following inspections and ratings.

We will continue to follow up concerns or breaches of regulations on inspections where appropriate.

Please note that the inspection frequencies stated here do not apply to independent doctors or clinics providing primary care services, including services provided online. For these services, we use the inspection frequencies set out in our [guidance for primary care providers](#).

## Assessing the well-led key question

We always consider the leadership, culture and governance of all health and care services under the well-led key question, and we give a rating for this question at both a core service level (where applicable) and the location level. We will continue to always consider this in our inspections of independent healthcare services. This is because as well as a wide and diverse range of services, including some complex and specialist services, independent healthcare providers take many different organisational forms and sizes, ranging from large corporate organisations with a number of locations, to small clinics run by one or two clinicians.

As well as assessing the well-led key question in individual services and locations, in the longer term we plan to develop and introduce an assessment of how well a provider supports and enables the delivery of good or outstanding quality care at all its locations, all of the time. If we find issues at the location level, we will assess quality at the provider level, as we believe that we can more effectively encourage improvement by intervening at a higher level.

We will develop a process and test this with a small number of providers across all health and care sectors from January 2018. We will develop and test the approach throughout 2018/19 through co-production, which involves working with providers, people who use services and commissioners in adult social care, primary care and community health services, as well as independent health care.

This type of assessment may become a standard part of our approach if it proves to be effective in encouraging improvement, reducing duplication, and supporting greater consistency.

## Core services

We assess different 'core services' for independent acute hospitals, community health care services, mental health services, ambulance services. For each type of independent healthcare service, its core services are the ones that are most commonly provided. They are typically services that people use the most, or in some cases, the ones that may carry the greatest risk.

We will not always inspect every ward, department or part of a core service in a single inspection. To help us select and prioritise the specific areas to visit, we may either:

- select a random sample of some wards or parts of the service
- select others according to various factors about risk, quality and the context of the services.

Note: we do not use core services in our inspections of acute single specialty services or non-hospital independent doctors or independent doctors and clinics providing primary care services, including online.

Our experience from comprehensive inspections so far suggests that the core services we have inspected in the sub-sectors of independent acute hospitals, community, mental health and ambulance services are largely the right ones for many independent healthcare services. As a result, the majority of core services that we will inspect in these services will remain the same. However, we do recognise that the definition of these core services is not always flexible enough for some types of independent healthcare services. Therefore, we are proposing some specific changes to what we define as a core service in the following sub-sectors.

### Independent acute hospitals

#### Outpatients and diagnostic imaging

We are proposing to separate the existing core service of outpatients and diagnostic imaging, to create two distinct core services. This is because it better reflects the way these services are organised and managed in independent acute hospitals. While diagnostic imaging services are often co-located with outpatient departments, they are usually managed separately and have their own distinct organisational structures.

We propose that outpatients and diagnostic imaging become separate core services and that we inspect them routinely in independent acute hospitals. This is different to our inspection approach in NHS acute trusts, where diagnostic imaging has become an additional core service and we do not inspect it routinely. We are proposing this different approach because, unlike in the NHS, there is less data available about diagnostic imaging in independent healthcare settings to enable us to confidently and accurately assess the level of risk to determine when to inspect a service.

Previously, our inspections resulted in a single rating for outpatient departments. This proposed change will result in two ratings – one for each core service – following our next scheduled inspection of an acute hospital.

### **CONSULTATION QUESTION: Core services**

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

#### **Q5a. Do you agree that this is the right approach?**

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

#### **Q5b. What impact do you think this proposal will have on a provider overall and in relation to its ratings?**

## **Inpatients**

We are proposing to create a single core service of inpatients. This will combine our existing separate core services of medical care and surgery. This will apply to those independent acute hospitals that do not have separate governance or organisational arrangements for their medical and surgical services. Most independent acute hospitals admit very few medical patients; these patients are often cared for in the same wards as surgical patients and are usually looked after by the same ward staff or team. Our view is that creating a single inpatient core service will better reflect the way that these services are organised and managed.

In independent acute hospitals that do have separate organisational and governance arrangements for their medical and surgical services – for example, separate medical wards and nursing teams – we propose to continue to inspect these hospitals using the existing separate core services of medical care and surgery.

It is important to note that, where provided in an independent acute hospital, we will continue to inspect, rate and report on the individual core services of:

- urgent and emergency care
- critical care
- termination of pregnancy
- services for children and young people
- end of life care
- outpatients
- diagnostic imaging
- maternity.

Our proposals to change our approach to outpatients, diagnostic imaging and inpatients will not affect acute single speciality services or independent doctors, as we will also continue to inspect, rate and report on these as individual services.

In response to the national cancer strategy, we are developing a programme to improve the quality of services for people diagnosed with cancer. As part of this, we are reviewing and strengthening the content of all our inspection frameworks that relates to cancer services, and improving our guidance and training for inspectors in this area. This work is still in at an early stage, but it is likely to look at the changes that we may need to make to our inspections of independent healthcare services and when to introduce them.

### **CONSULTATION QUESTIONS: Core services**

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

**Q6a. Do you agree that this is the right approach?**

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

**Q6b. What impact do you think these proposals will have on a provider overall and in relation to its ratings?**

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

**Q7a. Do you agree that this is the right approach?**

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

**Q7b. What impact do you think these proposals will have on a provider overall and in relation to its ratings?**

## Independent community healthcare

We propose to introduce a ‘**community single specialty**’ service for some independent community healthcare services. We believe this may be a more effective way of inspecting some services, particularly those that deliver a single service that may reflect more than one core service. For example, this could be a community stoma care service or a community intravenous service for both children and adults.

We also propose to introduce a community single specialty service for services that deliver only a small part of a core service, for example, a standalone school nursing service. We would continue to use the existing core services for all large independent community healthcare providers (in line with our approach to NHS trusts) and we would also use these where they fit well for smaller services.

### **CONSULTATION QUESTIONS: Core services**

Some independent community healthcare providers may only deliver a single service, or may deliver only a small part of a community service. For these providers, we propose to introduce the ‘community single specialty’ service.

#### **Q8a. Do you agree that this is the right approach?**

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

#### **Q8b. What impact do you think this proposal will have on a provider overall and in relation to ratings?**

## Effective use of accreditation schemes

As with our approach in NHS hospitals, we are keen to make better use of relevant accreditation schemes across appropriate services. We propose to reflect participation in accreditation schemes in the well-led key question at provider level, as evidence of a commitment to quality improvement and assurance. The achievement of accreditation under a specific scheme would be reflected in the effective key question of the relevant service.

Where an accreditation scheme itself meets key quality standards and has a good level of uptake among providers, we propose to move towards using accreditation under that scheme to reduce, or over time, in some areas potentially replace, CQC inspection of the accredited service.

This is intended to support our overall aim to adopt a more targeted and proportionate approach to regulation, avoid duplication and reduce requirements on providers, where appropriate.

Current approach to inspection	New approach to inspection
<ul style="list-style-type: none"> <li>• All providers inspected at least once during our first programme of inspections.</li> <li>• Core services in acute independent hospitals always include medical care and surgery as one core service, and outpatients and diagnostic imaging as one core service.</li> <li>• Core services in community health care always include adult's services and children's services.</li> </ul>	<ul style="list-style-type: none"> <li>• Once inspected and rated, move towards maximum inspection intervals determined by location ratings and monitoring information.</li> <li>• Moving towards more focused inspections.</li> <li>• Some changes to core services for independent acute hospitals and community services to better reflect how these services are organised.</li> <li>• Focus on the well-led key question in all inspections.</li> </ul>

## Inspection reports

For all health and care providers, we will introduce a more succinct report, which will be more accessible and user-friendly and will provide the information that the public and people who use services want. We will also continue to explore how we can better present information for large organisations that provide community, mental health and ambulance services across a large geographical area.

For some types of independent healthcare services, we plan to publish a separate appendix of all the evidence that supports our findings and ratings alongside the inspection report. This will help to structure the evidence and help our inspectors to gather the evidence they need to reach a robust judgement.

### CONSULTATION QUESTIONS: Inspection

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

#### Q9a. Do you agree that this is the right approach?

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

#### Q9b. Please explain why you agree or disagree with this proposal.

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

#### Q10a. Do you agree that this is the right approach?

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

#### Q10b. What impact do you think this proposal will have?

## 1.4 Rating

CQC has previously had powers to rate only certain types of independent healthcare services, including acute and mental health hospital services, specified acute single specialities, and hospice services. Legislation has not previously applied to all types of independent services, which has meant that some providers have been inspected, but not rated. The Department of Health has amended the performance assessment regulations to enable us to rate most other independent healthcare services and we now have the powers to rate almost all independent healthcare providers from 2018/19. Figure 2 shows those services that we will rate using our new powers, and Figure 3 shows those that will continue not to be rated.

We will start to rate services as part of this next phase of regulation when we have the legal powers to do so and have considered and incorporated feedback from this consultation. The timescales for introducing ratings across all types of independent healthcare services will be confirmed when we publish our response to this consultation. We will also publish guidance for providers to confirm our approach.

Once we have given a rating to a service, the provider is [legally required to display this](#).

### Figure 2: Independent healthcare services that we will rate for the first time

- Independent acute providers of cosmetic surgery only.
- Single specialty services including: termination of pregnancy services, dialysis, refractive eye surgery, diagnostic imaging and endoscopy services.
- Independent community services.
- Independent substance misuse services – residential and community.
- Independent ambulance services.
- Non-hospital acute independent doctors.
- Independent doctors and clinics providing primary care services, including online.

### Figure 3: Services that will continue to be excluded from ratings following the changes to the regulations

- Primary dental care.
- Some minor cosmetic surgery services.
- National screening programmes.
- Health and justice services.

- Hyperbaric chambers.
- Blood and transplant services.
- Services licenced by the Human Fertilisation and Embryology Authority (HFEA).
- Independent pathology laboratories.
- Independent podiatry services.
- Children’s homes undertaking regulated activities.

These services continue to be excluded from ratings because either:

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

In 2017, the Department of Health consulted on amending the performance assessment regulations to enable CQC to rate most independent healthcare services. The [response to that consultation](#) sets out more detail about those services that continue to be excluded from ratings.

We propose to rate independent healthcare providers in the same way that we rate other services. This includes awarding a rating for the five key questions: are services safe, effective, caring, responsive and well-led, and then aggregating these up to an overall rating at service and/or location level. Where an independent healthcare provider delivers a number of core services we will also aggregate the ratings for these core services to an overall location level rating.

We propose to rate at these levels on our four-point scale: outstanding, good, requires improvement and inadequate.

We decide all ratings using a combination of aggregating the ratings for the key questions and the professional judgement of inspection teams. We propose to use the same set of [ratings principles](#) to help us to determine the final ratings that we use for all other services, which are published on our website.

Ratings will be based on our assessment of the evidence we gather against the key lines of enquiry in the [assessment framework for healthcare services](#). Inspectors will refer to the corresponding ratings characteristics for the key lines of enquiry and use their professional judgement to decide on a rating.



Sometimes, we won't be able to award a rating. This could be because:

- the service is new
- we don't have enough evidence
- the service has recently been reconfigured, such as being taken over by a new provider.

In these cases, we will use the term 'inspected but not rated' when we publish an inspection report. We may also suspend a rating at any level. For example, we may have identified significant concerns which, after reviewing but before a full assessment, lead us to re-consider our previous rating. In this case, we would suspend our rating and then investigate the concerns.

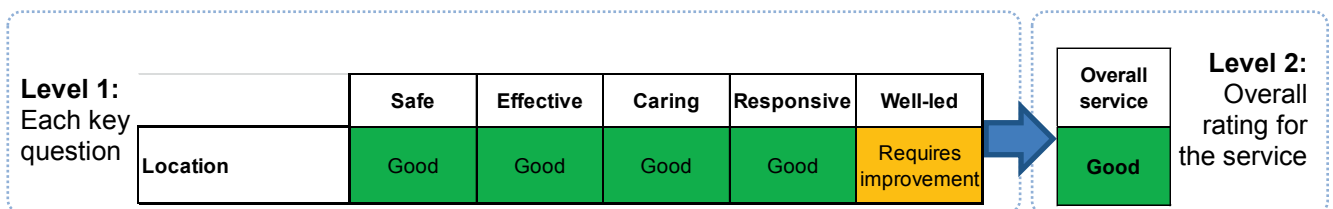
We will rate at different levels according to the type of provider and the number of core services they provide (where relevant). For all types of independent healthcare services we will rate at the following levels:

**Level 1:** A rating for each of the key questions for the service.

**Level 2:** An overall rating for the service. This will be an aggregated rating informed by our findings at level 1.

Rating example 1 shows how the two levels work together for a single specialty service:

### Rating example 1



Rating example 2 shows how the four levels work together for a provider that delivers more than one core service. For example, for each independent acute hospital location, we would rate the quality of care at four levels:

**Level 1:** A rating for every core service inspected against every key question.

**Level 2:** An aggregated rating for each core service.

**Level 3:** An aggregated rating for each key question, except for providers with one location (hospital). For these providers, the rating for well-led will be determined by the assessment of the well-led key question.

**Level 4:** An aggregated overall rating for the location as a whole.

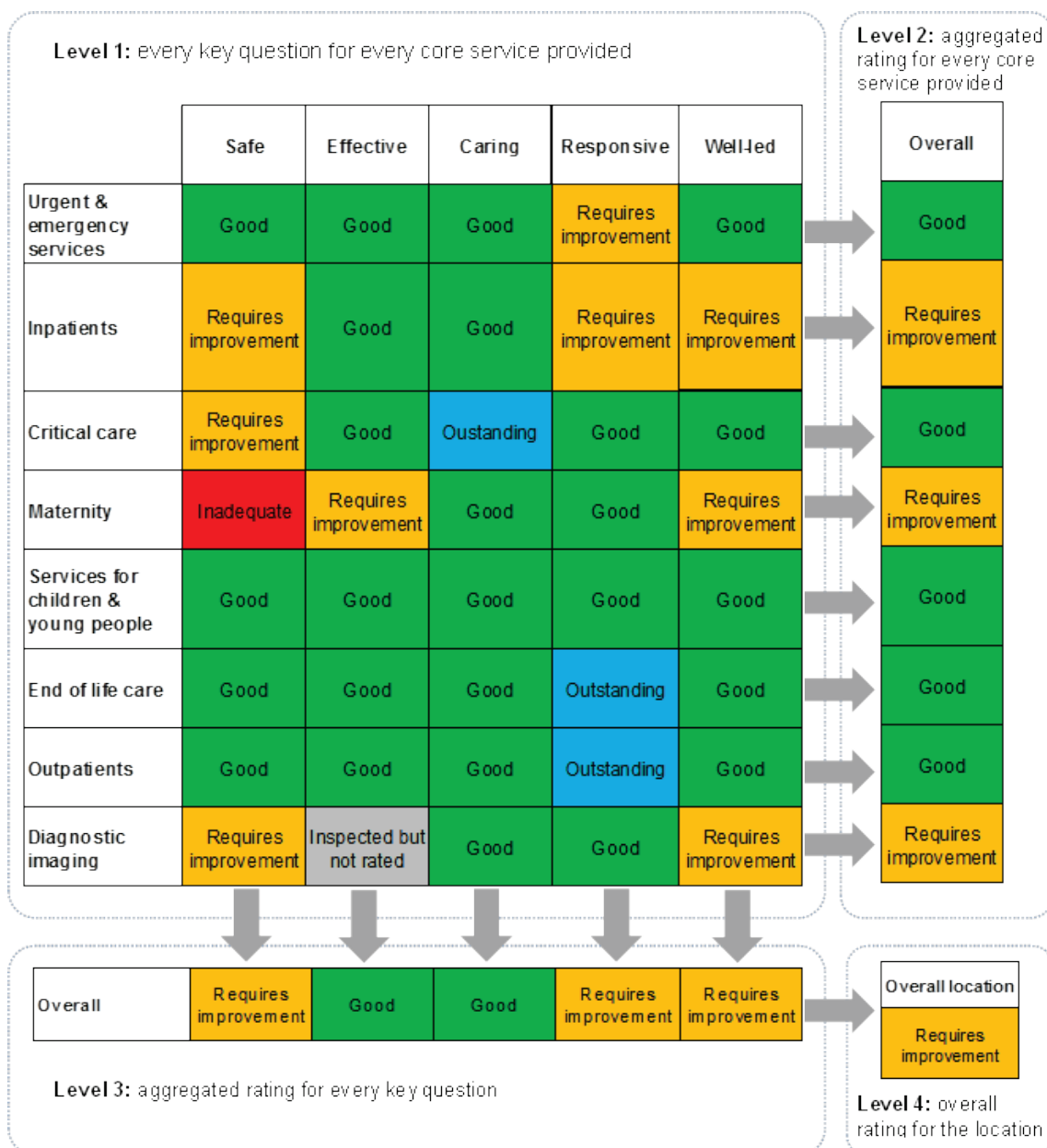
**Please note:** for NHS trusts, we also rate performance at the following two levels to reflect the additional aggregation:

**Level 5:** Each of the key questions. This is informed by our findings at level 3 for each location in the NHS trust, and information on the five key questions that is available at trust level only. For a single site NHS trust this is equivalent to level 3.

**Level 6:** The NHS trust as a whole. For a single site NHS trust this is equivalent to level 4.

We do not propose to rate at these two additional levels for independent healthcare providers.

## Rating example 2



Mental health, ambulance and community health services are frequently delivered from multiple locations. For some larger providers such as community interest companies (CICs) that provide a range of NHS-funded services to a local population, the levels of ratings for these providers are likely to be:

**Level 1:** A rating for every core service against every key question

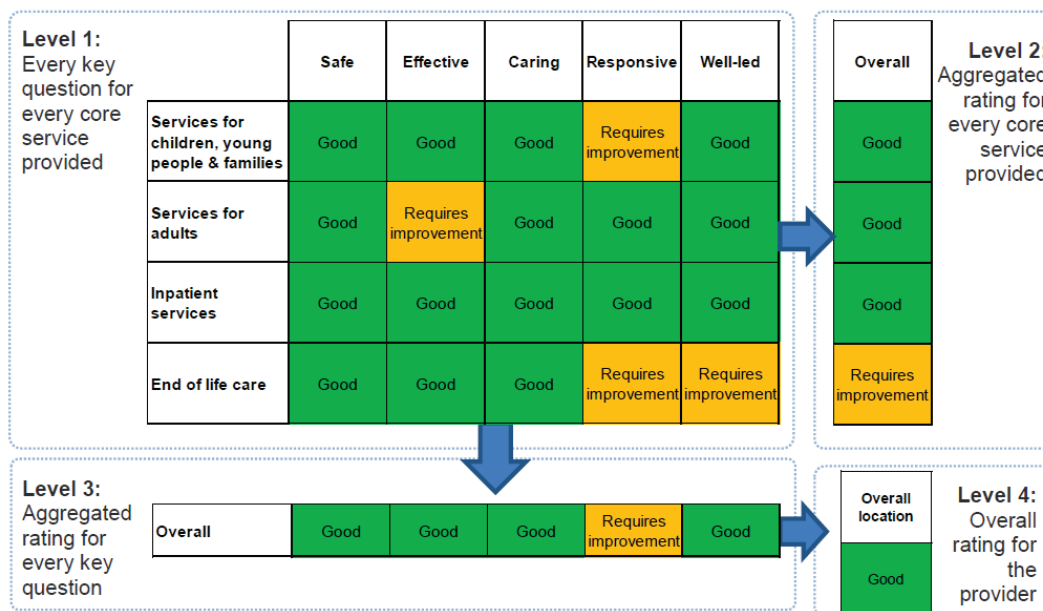
**Level 2:** An aggregated rating for each core service

**Level 3:** An aggregated rating for each key question

**Level 4:** An aggregated rating for the provider

Rating example 3 shows how the levels work together for a large provider such as a community interest company (CIC) that provides community health services.

### Rating example 3



## Services that we have already rated

Where we carry out a focused inspection of a service that we have already rated, we propose that its aggregated ratings will be a combination of previously allocated and new ratings from recent on-site inspection activity. Providers will then be required to display an updated ratings grid to show this. Focused inspections that look at a specific concern may result in a change to a rating for a core service or location-level rating.

## Services we have not yet rated

For services that we have not previously been able to rate we intend to carry out a comprehensive inspection considering all five key questions and core services, where relevant, in order to award an initial first rating.

Once we have given a rating to a service, the provider is [legally required to display this](#).

Current approach to rating independent healthcare services	New approach to rating independent healthcare services
<ul style="list-style-type: none"> <li>Currently only able to rate some independent healthcare services (independent acute, mental health hospital location and hospice services)</li> </ul>	<ul style="list-style-type: none"> <li>We will rate the independent healthcare services in the same way that we rate other services, including rating five key questions; core services where applicable and location-level ratings on a four-point scale (outstanding, good, requires improvement and inadequate); we use principles to aggregate our ratings up from the lowest level.</li> </ul>

### CONSULTATION QUESTIONS: Ratings

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

**Q11a. Award a rating for CQC's five key questions (are services safe, effective, caring, responsive and well-led?) and aggregate these up to an overall rating at service and/or location level.**

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

**Q11b. What impact do you think this proposal will have?**

**Q12a. Rate at the service and/or location level on our four-point scale of: outstanding, good, requires improvement and inadequate.**

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

**Q12b. What impact do you think this proposal will have?**

**Q13a. Aggregate ratings using our published ratings principles.**

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

**Q13b. What impact do you think this proposal will have?**

## Services that repeatedly require improvement

When a service is rated as requires improvement, our regulatory response will take into account whether it has breached any regulations, its track record on quality and its plans to improve.

In some circumstances, for example where services are unable to demonstrate that they have the leadership or governance processes in place to assure and improve quality, this may represent a breach of Regulation 17 (good governance). We will always consider this when a provider has received an overall rating of requires improvement more than once, and we may ask for a written report that sets out how it will assess, monitor and improve the quality and safety of its services. This action plan will need to be agreed with the provider's commissioners where they exist and where appropriate. If the provider is rated as requires improvement for a third time, we will hold a formal management review meeting to consider the next steps and the potential use of our enforcement powers.

These proposals will work alongside our current approach to using [special measures in independent healthcare](#).

We will also look at quality across all of a provider's services and, where more than half are rated as requires improvement or inadequate, we will hold a management review meeting to decide the best course of action. Our [enforcement policy](#) provides details of the actions we may take.

To encourage providers to improve, we will promote examples of good practice and improvement, and available sources of support. We will also monitor services more closely to identify any changes or deterioration in quality, so that we can respond more quickly if necessary.

# TIMETABLE FOR IMPLEMENTATION

We propose to implement the developments set out in this consultation over time. Our published response to this consultation and guidance for providers will confirm more detailed timeframes for implementing these proposals. Once we have carried out a first inspection and rated all independent healthcare services, we want to introduce a more responsive, intelligence-driven approach to regulation, with improved monitoring and inspection activity focused where risk is greatest or where quality is improving.

<b>26 January – 23 March 2018</b>	<ul style="list-style-type: none"> <li>• Consult on proposed changes to our regulation of independent healthcare services.</li> </ul>
<b>April 2018</b>	<ul style="list-style-type: none"> <li>• Start to introduce CQC Insight for some independent healthcare services, including engaging and testing with providers on the content.</li> <li>• Start to use the assessment framework for healthcare services for all independent healthcare providers.</li> </ul>
<b>June/July 2018</b>	<ul style="list-style-type: none"> <li>• Publish our response to this consultation and our updated guidance for providers (date TBC).</li> <li>• Start to rate independent healthcare services with our new powers to rate.</li> </ul>
<b>October 2018</b>	<ul style="list-style-type: none"> <li>• Launch CQC Insight for independent healthcare providers.</li> </ul>
<b>April 2018 – March 2019</b>	<ul style="list-style-type: none"> <li>• Develop and test provider-level assessment alongside live testing of registration changes.</li> </ul>
<b>April 2019 – March 2021</b>	<ul style="list-style-type: none"> <li>• Phased implementation of provider-level assessments, subject to registration changes for some providers.</li> </ul>

## **CONSULTATION QUESTION: Overall**

**11a. Do you have any other comments on our proposed approach to regulating independent healthcare services?**

# CONSULTATION QUESTIONS

## MONITORING THE QUALITY OF SERVICES

We propose to strengthen how we manage our relationships with providers of independent health care and with local and national organisations.

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

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

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

To support how we monitor the quality of independent healthcare services, we propose to routinely work with local and national organisations to exchange information about services.

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

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

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

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

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

We propose to collect information regularly from independent healthcare providers to help us to monitor the quality of services in between inspections.

### **Q3a. Do you agree that this is the right approach?**

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

### **Q3b. What impact do you think this proposal will have?**

## PLANNING INSPECTIONS

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

### **Q4a. Do you agree that this is the right approach?**

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

### **Q4b. What impact do you think this proposal will have?**

## **CORE SERVICES**

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

### **Q5a. Do you agree that this is the right approach?**

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

### **Q5b. What impact do you think this proposal will have?**

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

### **Q6a. Do you agree that this is the right approach?**

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

### **Q6b. What impact do you think these proposals will have on a provider overall and in relation to its ratings?**

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

### **Q7a. Do you agree that this is the right approach?**

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

### **Q7b. What impact do you think these proposals will have on a provider overall and in relation to its ratings?**

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

### **Q8a. Do you agree that this is the right approach?**

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

### **Q8b. What impact do you think this proposal will have on a provider overall and in relation to ratings?**

## **INSPECTION**

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



**Q9a. Do you agree that this is the right approach?**

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

**Q9b. Please explain why you agree or disagree with this proposal.**

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

**Q10a. Do you agree that this is the right approach?**

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

**Q10b. What impact do you think this proposal will have?**

## **RATINGS**

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

**Q11a. Award a rating for CQC's five key questions (are services safe, effective, caring, responsive and well-led?) and aggregate these up to an overall rating at service and/or location level.**

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

**Q11b. What impact do you think this proposal will have?**

**Q12a. Rate at the service and/or location level on our four-point scale of: outstanding, good, requires improvement and inadequate.**

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

**Q12b. What impact do you think this proposal will have?**

**Q13a. Aggregate ratings using our published ratings principles.**

(Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree)

**Q13b. What impact do you think this proposal will have?**

## **OVERALL APPROACH**

**Q14. Do you have any other comments on our proposed approach to regulating independent healthcare services?**

# How to respond to this consultation

Please respond by 3pm on 23 March 2018.

## Online

Use our online form at: [www.cqc.org.uk/nextphase](http://www.cqc.org.uk/nextphase)

## By email

Email your response to: [nextphase@cqc.org.uk](mailto:nextphase@cqc.org.uk)

## By post

Send your response to:

Freepost RTTE-JTBT-ZTHH  
Next Phase Consultation  
3rd Floor Yellow Zone  
Care Quality Commission  
151 Buckingham Palace Road  
LONDON  
SW1W 9SZ

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