Care Quality Commission

A new start

Responses to our consultation on changes to the way CQC regulates, inspects and monitors care services

October 2013





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

Our purpose:

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

Our role:

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

Our principles:

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

Contents

Foreword from our Chief Executive and Chair 2

Introduction 5

Section 1: Who we engaged with and how 6

Section 2: Summary of what people told us 8

Section 3: An overview of how we will inspect and regulate all care services – what people told us 10

- What we asked in this section 11
- Asking the right questions about the quality and safety of care 12
- A better system for organisations applying to provide care services 13
- Intelligent monitoring of information and evidence about the quality and safety of care 14
- Simple, clear standards to help us judge the quality and safety of services 15
- Expert inspection teams, led by Chief Inspectors of Hospitals, Adult Social Care and General Practice 17
- Ratings to make clear the quality of care and to help people choose between services 19

Section 4: How we will inspect and regulate NHS and independent acute hospitals – what people told us 20

- What we asked in this section 20
- Intelligent monitoring of NHS acute hospitals 21
- Changes to how we inspect NHS acute and independent hospitals 22
- Ratings for NHS acute and independent hospitals 23

Section 5: Changes to CQC's regulations 26

- Questions we asked in this section 26
- Regulatory Impact Assessment and Equality and Human Rights Impact Assessment 27

Annex 1: 20 most popular fundamentals of care identified by the public 28

Annex 2: Timeline for change 29

How to contact us 30

Foreword from our Chief Executive and Chair

▶ During the past six months we have started to put in place root and branch changes to the way we regulate health and social care services and significant improvements to how we organise ourselves. These changes support the new vision and direction we set out earlier this year in our strategy for 2013 to 2016, *Raising Standards, Putting people first* and our recent consultation, *A New Start*. They will enable us to deliver our purpose – making sure health and social care services provide people with safe, effective, compassionate, high-quality care and encouraging services to improve.

▶ The key changes include the introduction of Chief Inspectors; expert inspection teams; clear standards of care; better use of information to help us decide when, where and what to inspect; ratings to help people choose care; a focus on highlighting good practice; a commitment to listen better to the views and experiences of people who use services; and a determination to build a high-performing organisation that is well-run and well-led.

▶ We know there are some topics where people are keen for more clarity and further detail and some areas of concern to resolve. We are committed to working with the public, providers, stakeholders and our staff to do this. We know there is further work to do around areas such as the definitions of the five key questions for each sector and our thinking on the fundamentals of care. Our aim is to clarify and simplify our proposals in these areas so the public are clear about the quality of care they can expect whenever or wherever they receive care.

▶ Alongside our consultation, we have already started to deliver significant changes to the way we work and to our structure:

- Our three Chief Inspectors are all now in post. Professor Sir Mike Richards is our new Chief Inspector of Hospitals; Andrea Sutcliffe is our Chief Inspector of Adult Social Care, and Professor Steve Field is our Chief Inspector of General Practice. I am delighted with these appointments and with the energy, passion and commitment they are bringing to the organisation.
- In July this year we began a radical overhaul of how we regulate and inspect acute hospitals. We have introduced new hospital inspection teams, headed by a senior clinician or executive working alongside our senior inspectors. The teams are significantly bigger and include professional and clinical staff and other experts, including trained members of the public who we call Experts by Experience. We have begun the first wave of a programme of inspections of acute hospitals, covering every site that delivers acute services and eight key service areas: A&E; maternity; paediatrics; acute medical and surgical pathways; critical care; end of life care; and outpatients.
- Our teams hold public listening events before each inspection and proactively seek the views of people who use services and national and local partners, including local Healthwatch.
- Over the coming months they will hold meetings with local partners to share the results of the inspections with them and decide what action needs to be taken. The first such meetings and the reports from these inspections will be published in November this year. These reports will provide the public with better information about the quality of care in

their local hospital and we will ask the public to tell us what they think of them.

- We are already making better use of information and evidence to direct our resources to where it is most needed. Our analysts have developed the way we monitor hospital intelligence to give our inspectors a clear picture of the areas of care that need to be followed up within an NHS acute trust. Together with local intelligence monitoring and other factors, this information helps us to decide when, where and what to inspect. This means that we can anticipate, identify and respond more quickly to acute hospitals that are failing, or at risk of failing.
- We will develop intelligence monitoring for different types of care services as we change the way we regulate and inspect them, and we will publish the analysis of our intelligence monitoring at regular intervals.
- Between now and April 2014 we are testing, evaluating and refining the way we inspect and regulate NHS acute and mental health trusts, and we will be consulting on the detailed guidance that will underpin this later in the year. We will also decide whether hospitals are to be rated as 'outstanding', 'good', 'requires improvement' or 'inadequate'. If a hospital requires improvement, or is inadequate, we will expect it to improve. Where there are failures in care, we will work with Monitor, NHS England, and the NHS Trust Development Authority to make sure that a clear programme is put in place to deal with the failure and hold people to account.
- The changes to the way we inspect NHS hospitals will be finalised in April 2014 when new Regulations will be introduced to underpin them. We will have inspected all NHS acute trusts using this new approach by December 2015.
- Alongside this, by October 2014, we will introduce changes to all the other services that we regulate. The pattern and phases of change will be similar for all sectors, although the timings may differ by a few months. Over the next few weeks, each Chief Inspector will set out their priorities for the programme of work ahead. Together with their teams, they will each co-produce, engage and then consult on the changes they are proposing. Between January 2014 and October 2014, they will begin a programme of inspections to test and refine their approach, publish intelligence monitoring on the services that they regulate and issue the first ratings of services. The changes will be finalised by October 2014, when new Regulations will be introduced to underpin them. You can see a more detailed timeline in Annex 2.
- Our Chief Inspector of Adult Social Care, Andrea Sutcliffe, has already set out CQC's early thinking on our priorities for adult social care in *A Fresh Start for Adult Social Care*. It is an introduction to the sorts of things we want to discuss and how we will do that with the public, people who use services and their carers, providers, our staff, and organisations with an interest in our work.
- Understanding the experiences of people who use adult social care services is paramount. They are often in very vulnerable circumstances and, for many people, their care affects every part of their lives. Many are older people coping with several health conditions; many are also affected by dementia and cannot speak up for themselves. The importance of being treated with dignity, compassion and respect is paramount. Andrea will also lead the development of an important new role for CQC – that of monitoring the finances of some providers of adult social care services and making sure the interests of people who use services are paramount in the event of a provider going out of business.
- Later this year our Chief Inspector of General Practice, Professor Steve Field, will be setting out CQC's thinking on the programme of work

to introduce changes to the way we inspect and regulate GP and dental practices. In the same month, Professor Sir Mike Richards will also publish more detailed proposals on changes to the way we inspect other types of mental health services, including how we will integrate our regulatory work with our monitoring of people's rights under the Mental Health Act.

- The Secretary of State is granting CQC greater independence in the Care Bill currently before Parliament. We will no longer need to ask for approval from the Secretary of State for Health for a range of operational decisions, for example to carry out an investigation into a hospital or care home.
- Patients and the public must have confidence that our judgements are independent. This move will further assure people using services that this is the case and that they can rely on our information to make informed choices about their care and the care of their loved ones.
- The Care Bill also underpins some of our most important changes, for example it gives us the power to publish ratings of care services, to hold individuals to account for failures in care, and to require care services to be open with the people who use them where there are failings in care.
- Internally, the rest of our executive team is almost in place. Paul Bate has joined us as Executive Director of Strategy and Intelligence and Hillary Reynolds as Executive Director of Change. Our new Board is in place, including the reappointment of Kay Sheldon, a tireless champion of the interests of people who use services.
- James Titcombe, who tragically lost his baby son in a preventable death several years ago at Morecambe Bay Hospital Trust, has also joined us to make sure we focus on people, safety and quality. James has campaigned for some years to improve health services and will be a great asset to our organisation.

▶ The aim of all of this work is to improve the lives of people who use care services by improving the quality and safety of their care. We approach this work with humility, recognising that while regulation and inspection have an important role to play, it is the role of care professionals, clinicians, providers and commissioners to work continually to improve the lives of the people in their care. We will work closely with them, but we will never forget that our primary reponsibility is to the patient, the person using a care service and the consumer, and not to the hospital, the organisation, or the system.

David Behan
Chief Executive

David Prior
Chair

Introduction

In June this year we published our consultation, *A new start*, which proposed radical changes to the way we inspect and regulate care services.

A new start sets out the principles of how we will inspect all services, and more detailed proposals for how we will inspect NHS trusts and foundation trusts and independent acute hospitals. It also described some changes to Regulations proposed by the Department of Health that will underpin the changes. This document analyses what people told us during our consultation and our response to their views.

The consultation was part of an intense period of engagement and consultation on the changes we are making that began last year. In future, the engagement will be led by our new Chief Inspectors of Hospitals, Adult Social Care and General Practice. They will each set out their priorities; co-produce detailed proposals with the public, providers, our staff, and organisations with an interest in our work; test new approaches to inspection, ratings and better use of information and evidence; and formally consult on and finalise the changes.

Our Chief Inspector of Hospitals has already begun this work; our Chief Inspector of Adult Social Care and Chief Inspector of General Practice are about to embark on it.

Section 1

Who we engaged with and how

Our consultation ran between 17 June and 12 August 2013. We received 725 formal responses online, by social media, by post and by telephone.

We also carried out a programme of proactive communication and engagement during the consultation period, engaging with 2,900 people overall. They included members of the public, people who use services, carers, our staff, organisations that provide care, care professionals, voluntary organisations, and organisations with an interest in our work. The programme included regional events held around England for providers and people who use services, including events hosted by the Department of Health; focus groups, one to one discussions and interviews with members of the public; regional events specifically for staff; and online discussions. The breakdown of who we reached through the different methods is:

- 142 members of the public in 16 focus groups and 20 interviews (about the five key questions, fundamentals and expected standards).
- 260 members of the general public on our online community.
- 331 members of the public and 492 providers at 36 CQC regional events.
- 1,400 members of staff at 40 CQC regional events.
- 42 members of the public through our advisory group.
- 60 stakeholders through our five stakeholder advisory groups.
- 58 Experts by Experience at an Acting Together conference.
- 57 local Healthwatch representatives discussed fundamentals standards.
- 74 people from groups whose voices are seldom heard at focus groups.
- Five events hosted by the Department of Health with public and providers.

We also carried out web surveys and shared information through our online communities. We reached:

- 4,521 people through a web survey
- 4,500 providers through our online community.

How we analysed the feedback

Our analysis identified where there was strong support, differences of opinion, issues relating to the differences, and key themes. To identify these we used a range of criteria which included:

- Positive and negative responses by all audiences. (Where 75% of online responses or more supported our proposals we identified this as 'strong support'; where 50 - 75% of our online responses supported them we identified this as 'mixed views'; where less than 50% supported them we have identified this as 'opposed to' our proposals).
- Positive and negative responses by stakeholders, public, acute providers, adult social care providers, primary medical service providers, mental health providers and CQC staff.
- The frequency of themes and issues identified by all groups.
- Need for coherence and consistency in our proposals.
- Need and opportunity to work with strategic partners, stakeholders and others.
- Importance of building credibility with stakeholders providers and public.
- Potential gaps in our expertise or resource.

We also took into consideration the approach we used to gather people's views. For example, the public focus groups and one-to-one interviews were more in-depth and rigorous than other methods, so the outputs from these were treated with more significance than the outputs from other methods.

All the figures in this report are based on online responses.

Section 2

Summary of what people told us

There was strong support for the following:

- The overall changes we are making to how we will inspect and regulate all care services.
- Regulating different services in different ways, based on what has the most impact on improving the quality of people's care.
- 'The five key questions we will ask.
- Larger, expert inspection teams.
- More use of people with experience of care, such as Experts by Experience, in our inspection teams.
- Intelligent monitoring of NHS acute hospitals, how we will organise 'indicators' to direct our regulatory activity and the sources for the first set of 'indicators'.
- Publication of our methodology for doing this and the results of our analysis.
- Rating a service and hospital and inspecting a core of services to award a hospital rating.
- The introduction of a statutory 'duty of candour' to make sure those who provide care services tell people about any problems that have affected the quality of care.

There were mixed views on the following:

- Whether or not fundamentals of care are expressed in a way that makes it clear whether they have been broken.
- Whether or not they feel the fundamentals of care are relevant to all groups of people and settings.
- Whether CQC should seek to be the single authoritative assessment of quality and safety.
- Rating a trust.
- Whether or not the rating labels and scale for ratings are clear and fair.
- Inspection judgement being the most important factor in a rating.

There was opposition to the following:

- The need for both fundamentals of care and expected standards.
- Inspection frequency of 3 to 5 years for trusts rated outstanding and 2 to 3 years for trusts rated good.

People requested clarification of, or made suggestions for changes to, the detail of the following:

- **The five key questions we will ask all services.**
- **The fundamentals of care.**
- **Relationship between the five questions, standards and regulations.**
- **The role and value of people's experiences, concerns and complaints in inspections, intelligent monitoring and ratings.**
- **Our proposals for mental health.**
- **The information we will use and how we will weight it in our intelligence monitoring.**
- **Our approach to ratings, what information we will take account of, how we will decide a rating, what we will rate and how will we quality assure our decisions.**
- **How we will publish ratings and any supporting information.**
- **Our role in the assessment of commissioning.**

People also raised the following general issues:

- **Ensuring our approach is person-centred.**
- **Recognising the valuable role of carers.**
- **Ensuring we look across care pathways.**
- **Our resources and capacity to deliver the changes.**

The rest of this document sets out in more detail what people told us in relation to the specific consultation questions we asked. We have also included a summary of what people told us in relation to each section of the consultation document.

Section 3

An overview of how we will inspect and regulate all care services – what people told us

This section describes what people told us about the general principles that will guide the way we inspect and regulate all services – our operating model.

The principles apply to: the way we register those that apply to provide care services; the standards that those services have to meet; how we use data, evidence and information to monitor services; the expert inspections we carry out; the information we provide to the public on our judgements about care quality, including a rating to help people compare services; the action we take to require improvements and, where necessary, the action we take to make sure those responsible for poor care are held accountable for it.

The consultation also included some joint proposals between CQC and the Department of Health on changes to regulations that underpin our work.

Figure 1: Overview of our future operating model

What we asked in this section

In this section we asked the following questions:

General

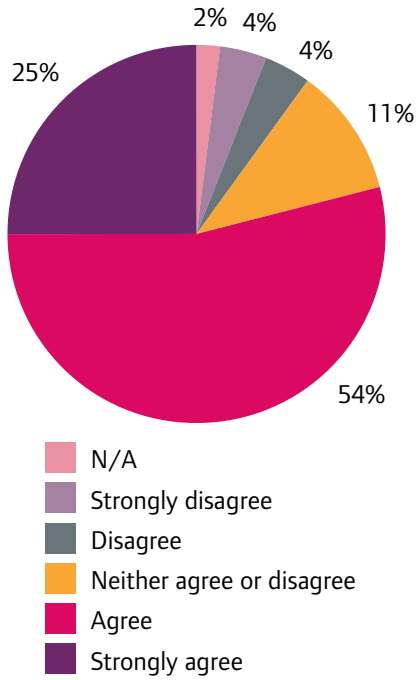
1. **What do you think about the overall changes we are making to how we regulate?**
2. **What do you like about them? Do you have any concerns?**

Fundamentals of care

3. **Do you think any of the areas in the draft fundamentals of care above should not be included?**
4. **Do you think there are additional areas that should be fundamentals of care?**
5. **Are the fundamentals of care expressed in a way that makes it clear whether they have been broken?**
6. **Do the draft fundamentals of care feel relevant to all groups of people and setting?**

What people told us and our response

What people told us about the overall changes we are making to how we regulate



There was strong support for the general principles of how we will inspect and regulate all care services. The principles included:

- Asking the right questions about the quality and safety of care.
- A better system for organisations applying to provide care services.
- Intelligent monitoring of information and evidence about the quality and safety of care.
- Expert inspection teams, led by Chief Inspectors of Hospitals, Adult Social Care and General Practice.
- Better information for the public.
- Ratings to make clear the quality of care and to help people choose between services.
- Investigations and reviews of particular aspects of care.

Providers of care services, organisations with an interest in our work, our staff, and people who use services cautioned us against simply transferring the approach we use to regulate and inspect NHS acute hospitals over to other sectors. They said we should develop a tailored approach to inspecting

and regulating each sector and some types of services within a sector. Some representative groups wanted more detail about how we will address the needs of specific communities.

Our response

We agree that we should tailor our approach to different sectors and different types of services. Our Chief Inspectors will work with providers, the public, our staff and organisations with an interest in our work to do this. We will be taking into account the needs of specific communities in our more detailed guidance that we will be publishing later in 2013 and in 2014 for each of the sectors that we regulate.

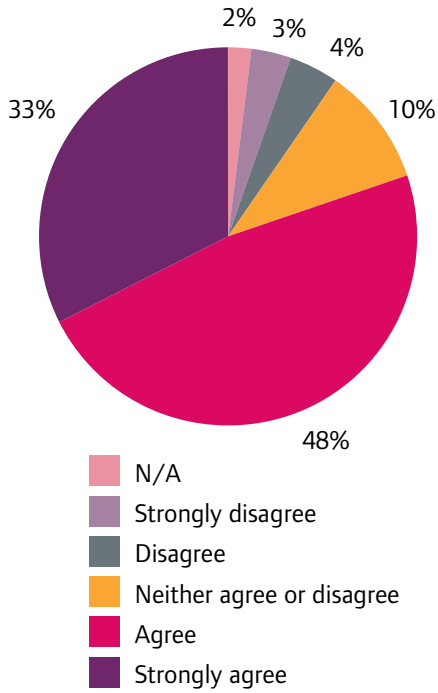
Asking the right questions about the quality and safety of care

To make sure we get to the heart of people's experiences of care, we said that we will ask the following five questions of every service:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

What people told us

What people told us about the definitions of our five questions



There was strong support for the introduction of the five key questions. All groups felt that fewer, simpler questions than we use at present would make our inspection process and our reports much simpler and easier to understand.

The public and people who use services identified strongly with the questions 'Is it safe?' and 'Is it caring?'. However, they said the definitions of 'safe' and 'caring' needed to be clearer and that they should be different for different types of care.

There was concern, for example, that the question 'Is the service safe?' could discourage providers from taking positive risks, particularly those who provide services to people with mental health issues and learning disabilities. People felt the that definition of this question needed to put people's needs and well-being ahead of being too risk averse.

The public thought the question 'Is it effective?' applied more to medical care than to adult social care. They interpreted the question "Is it responsive?" as meaning "Is it responsive to their needs as an individual?"

Providers and organisations with an interest in our work identified with the question 'Is the service well-led?' in relation to corporate, large and medium sized providers, but felt it did not work for small adult social care providers such as shared lives schemes. The public focus groups understood that we would be interested in this question, but said that it was of less interest to them.

There was also criticism that the questions were not person-centred enough. People felt the questions were paternalistic and read as if they were being 'done to' someone rather than involving them. People suggested replacing 'Is the service responsive?' with 'Is the service putting the patient at the centre of their care?".

Our response

We are taking into account helpful suggestions we received in relation to the definitions of the five key questions.

We will work with the public, people who use services and their family carers, providers, and key stakeholders to define them. We will develop guidance about what they mean for different sectors and different types of services. Our guidance will describe what good care looks like in relation to each of the five questions; the standard of care people should be able to expect; and what inadequate may look like. Many of the comments we received were relevant to our proposals on the fundamentals of care and expected standards.

We agree we need to clarify that our approach is person-centred. We will make sure this is reflected in our guidance for each sector so there is a clear understanding that people who use services and their family carers need to be at the centre of what we do and what this should look like for different services.

In relation to asking these questions of NHS acute hospitals, we will learn from the inspections of acute hospitals that we are currently carrying out using our new approach. We will clarify and refine this approach during the next few months.

A better system for organisations applying to provide care services

We said that we would introduce a better system for providers applying to register with us to provide care. Our proposals included making sure named directors or leaders of organisations commit to delivering safe, effective, compassionate care and personally holding them to account for that commitment.

What people told us

Very few people commented on this section. Those who **did** comment supported our proposal that we would hold named directors or leaders of organisations to account for poor quality care as well as managers who deliver the care on a day to day basis. Our staff also supported our proposal for a more rigorous test of services that apply to be registered with us and checks to provide further assurance of a provider's ability to offer safe, high-quality care.

Our response

When a provider applies to us to provide care services, our registration process will gather the information we need to answer the five key questions – is it likely to be safe, effective, caring, responsive and well-led? This will include information about the suitability of members of Boards or equivalent bodies of organisations, and the fitness of proposed care providers who are individuals, members of partnerships and managers. We will assess the suitability of proposed premises, policies, procedures, equipment and staffing arrangements; and the likely effectiveness of quality management and improvement systems. We will then make a judgement about whether the proposed service will deliver fundamentals of care in a personalised, inclusive and respectful way.

Intelligent monitoring of information and evidence about the quality and safety of care

We said that we will rethink and redesign the way we use information and evidence to direct our regulatory activity and be clearer about the national 'indicators' that are most important in monitoring the quality of care.

What people told us

We did not ask a specific consultation question about this. However, all groups - providers, organisations with an interest in our work, staff, the public and people who use services - generally supported our proposals. Providers and stakeholders said we needed to make sure we had an effective process for gathering and maintaining information from whistleblowers due to its sensitive nature.

Adult social care providers recommended using internal quality assurance information as a source of information, as this would encourage providers to make sure they have effective quality assurance systems in place.

The public wanted more clarity on how people's experience of using services and complaints will be used and for this to be emphasised in how we monitor information and in how we judge services.

Our response

Information from whistleblowers is one of the key data sources that we are using in our intelligent monitoring of information and evidence. We used information from whistleblowers to guide which NHS acute hospitals we selected for our first wave of new style inspections in July 2013.

We will publish our analysis of intelligent monitoring of all NHS acute and specialist trusts in October 2013 and will continue to refine and learn about the best use of this type of information.

Internal quality assurance information has traditionally been a difficult source of information for us to use because providers have different approaches to this. As we develop the way we use intelligent monitoring in relation to adult social care services, we will work with the sector to explore options for using quality assurance information.

In relation to how we will use people's experiences of care and complaints, we are currently using Patient Opinion, NHS Choices; CQC Your Experience forms; the Friends and Family Test and the National Inpatient Survey in our intelligence monitoring. In future we will establish a regular flow of information from local Healthwatch and a clearer route for local views from other sources.

We want people to tell us about their experiences of care. Whether it is a concern, an observation, a positive report about a service or an issue they have raised as a formal complaint. The information is extremely valuable to us as people who use a service are best placed to know whether they are receiving safe, compassionate and high-quality care.

The information may lead us to make further enquiries, including contacting the provider of the service if people say we can. We may use the information to help us decide what to look at when we inspect, or to bring forward an inspection. We may also look in detail at specific cases and use them to inform the judgements we make about care services. Wherever possible we will let people know what action we have taken as a result and we will report publicly on all the information we have received from people and what we have done in response.

However, it's important to say that we aren't able to settle formal complaints on behalf of individuals. It is the duty of the provider to do this and, where necessary, the relevant ombudsman or professional regulator. The only exceptions to this are formal complaints made by people whose rights are restricted under the Mental Health Act (or their representatives) about the way staff have used their powers under the Act.

Where people want to make a formal complaint to a provider or to the ombudsman, we will support

them by providing information that helps them to understand how to do this.

We will also maintain and improve our focus on the views and experiences of people who use services in our inspections and throughout our work.

Simple, clear standards to help us judge the quality and safety of services

We reflected on the findings and suggestions made by Robert Francis in his report into Mid Staffordshire NHS Foundation Trust, particularly in relation to us having clear and simple standards against which care can be judged. We said we would look at three levels of standards: the fundamentals of care, expected standards and high-quality care. We said the fundamentals of care would represent the basic requirements that should be the core of any service and that there would be immediate, serious consequences for services where care falls below these levels. To start a public discussion of what the fundamentals of care should be, we suggested the following to stimulate debate:

I will be cared for in a clean environment.

I will be protected from abuse and discrimination.

I will be protected from harm during my care and treatment.

I will be given pain relief or other prescribed medication when I need it.

When I am discharged my on-going care will have been organised properly first.

I will be helped to use the toilet and to wash when I need it.

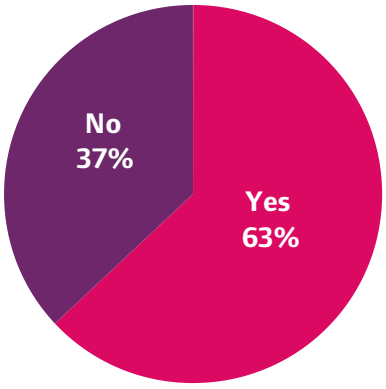
I will be given enough food and drink and helped to eat and drink if I need it.

If I complain about my care, I will be listened to and not victimised as a result.

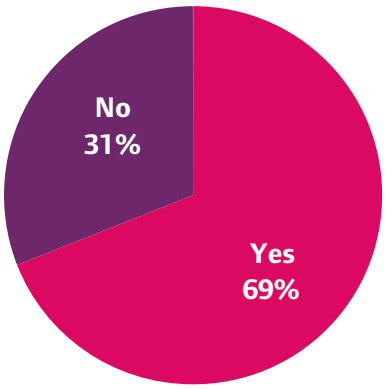
I will not be held against my will, coerced or denied consent or the proper legal authority.

What people told us

People's views on whether the fundamentals of care are expressed in a way that makes it clear whether they have been broken



People's views on whether the fundamentals of care feel relevant to all groups of people and settings



There was strong support for all of the fundamentals of care suggested in the consultation, but all groups questioned the need for separate fundamental and expected standards and were confused about the difference between the two. They felt the public would not understand the difference.

However, when members of the public at focus groups, were given sufficient time to discuss it, they did understand the difference between them and were able to describe the fundamentals of care. The type of care service and people's different needs were clear factors in determining whether something was an expected or a fundamental of care. For example in adult social care, more aspects of care were considered to be fundamentals of care rather than expected standards.

Many additional fundamentals of care were suggested. The public focus groups identified 20 fundamentals of care, with hygiene, negligence and staff/training qualifications being the areas of care most frequently mentioned. You can find these in Annex 1.

The most common additional fundamentals of care suggested by all respondents were:

- Being treated with dignity and respect, including an emphasis on equality, diversity and human rights.
- Involvement in care planning.
- Involvement of friends, family and carers in decisions/planning of care.
- Being listened to.
- Communication in a way people understand.
- Appropriate levels of qualified staff.

All groups also recommended amending the phrasing of some of the suggested fundamentals of care because they felt the wording was ambiguous. For example, people felt that phrases such as 'clean environment' and 'when I need it' were not specific enough and open to interpretation.

All groups also felt that the relevance of the wording varied depending on the care setting. For example, the relevance of a clean environment was different for care provided at home compared to a surgical unit in an acute hospital.

There was also a concern from organisations with an interest in our work that by having two levels of standards this would result in providers focusing on the fundamentals of care at the expense of expected standards because of the threat of prosecution for breach of a fundamental of care.

The public were very much in favour of us clearly identifying the point at which we would be able to exercise a range of more serious sanctions.

There were mixed views from all groups about whether the fundamentals of care we suggested were written in a way that clearly described when they were not being provided. Some responses supported the simplistic wording and the clarity they provided, while others felt they did not give enough detail to describe when they were not being provided.

All groups felt that the fundamentals of care we suggested were predominantly focused on episodic care delivered in an acute setting. However, people generally agreed that some were relevant to all types of care, for example 'I will be protected from harm during my care and treatment'.

All groups suggested developing guidance to describe when a fundamental was breached for each sector, whilst organisations with an interest in our work suggested reducing the number of generic fundamentals of care and developing additional, sector specific ones.

The public and people who use services in particular noted that carers were not mentioned in the fundamentals of care. People felt we needed to emphasise how we will involve carers in our inspections and capture their experiences. They also wanted us to clarify how we will check that services are listening and involving carers.

Our response

Our discussions with the public were particularly helpful in helping to define things that are

important to them in different types of care and the words used to describe them.

Our thinking on the fundamentals of care is evolving. Our aim is to clarify and simplify our proposals so the public are clear about the quality of care they can expect whenever, or wherever, they receive care. All of the very many helpful comments we have received are helping us to develop our proposals further.

Our current thinking is that we will develop guidance on how we will rate care services. This will include clear statements about what we expect to see when services provide good or outstanding care. We will also develop guidance on how we will rate services that require improvement or are inadequate, and the action we will take in response. We will do this in partnership with the public, people who use services, providers and organisations with an interest in our work. It will be tailored for each sector and for some services within each sector.

The action that we take in response to care that requires improvement or is inadequate will be underpinned by the regulations that give us our legal powers.

The Department of Health is using the feedback we have received to inform their thinking on how the fundamentals of care should be written into the regulations (registration requirements). Subject to the will of Parliament, the regulations will set fundamental standards that providers must not breach. The Department will consult on the regulations in Autumn 2013.

In December 2013 we will be publishing a consultation on our guidance for NHS acute hospitals. Guidance for other sectors is in the development stage and we will consult on it in 2014.

We agree that our approach needs to place more emphasis on the important role the five million carers in England play and how that is reflected in our work. The report into the failings at Mid Staffordshire NHS Trust highlighted that the voices of carers were not heard. Our guidance will specifically mention carers and will make sure that the voices of carers, advocates and families are as important as the voices of people who use services in our work. We will make sure that we listen and respond better to the views and experiences of carers about the quality and safety of services, and involve them more in our work, including in our inspections as Experts by Experience.

Expert inspection teams, led by Chief Inspectors of Hospitals, Adult Social Care and General Practice

What people told us

There was strong support for the introduction of expert inspection teams led by Chief Inspectors of Hospitals, Adult Social Care and General Practice.

Providers of acute hospitals particularly favoured our proposals for a clinically led approach and peer review. Providers of adult social care services supported our proposals to regulate different services in different ways. The public agreed that we should increase the number of Experts by Experience in our inspection teams. Organisations with an interest in our work supported the use of bigger teams to reduce the risk of subjectivity. Many people recommended using the inspection model used in the inspections of acute hospitals led by Bruce Keogh last year as a starting point to learn from and refine. The Royal Colleges, professional regulators and other bodies offered advice and practical help in sourcing experts.

The main concern raised was whether we would have the resources and capacity to deliver on our proposals, in particular our ability to recruit, train and maintain a pool of experts.

There were also concerns about the importance of maintaining a focus on care pathways to make sure we have an overall understanding of what a person using health and adult social care services experiences as they move through a service and between different services.

Some mental health representatives expressed disappointment about the lack of a Chief Inspector of mental health services particularly given our unique responsibilities under the Mental Health Act. People also wanted us to clarify the changes we will make in relation to our regulation of mental health services.

The public wanted to see the introduction of 'secret shoppers', particularly in residential care services. By 'secret shoppers' we mean people who inspect the service without the service being aware of it.

Our response:

In relation to concerns about CQC's resources and capacity, we greatly appreciate the offers of help in sourcing experts to support our new inspections. We are following up these offers and actively recruiting to make sure that we have access to the broadest possible pool of specialists across all fields - people using services, delivering care and managing services. We are making connections with a range of organisations including medical Royal Colleges, patient groups and organisations representing care providers. We are putting dedicated resource in place to make sure that we are effectively managing the deployment of this important resource.

More generally we are reviewing the way we organise ourselves and our resources, bringing our inspectors together into specialist teams under the leadership of our new Chief Inspectors. We are also making sure that our staff have the support and development they need with the launch of the CQC Academy, which places a new focus on specialist learning and personal development.

In relation to people's concerns about the need to look across care pathways, we agree it is important to look across a range of services to make sure we have an overview of people's experience of health and adult social care. We will continue to develop our approach to themed inspections that look at local health and social care systems and we will comment on how it functions as a whole.

Its is intended that our Chief Inspectors will be carrying out joint inspections that assess how the different services interact and work together for people passing between them.

In relation to concerns about changes to the way we regulate and inspect mental health services, we are developing our approach with key stakeholders, providers, the public and people who use services. Our monitoring of the Mental Health Act will be integrated into our inspections, including continuing to run a programme of visits to people who are subject to the Mental Health Act to speak with them in private as we are required to do under the Act.

The work will be led by our Chief Inspector of Hospitals, Professor Sir Mike Richards. He is planning to appoint a Deputy Chief Inspector with mental health expertise as soon as possible to assist him in this.

The approach we will use to inspect mental health inpatient services, both NHS and independent healthcare, will be similar to the approach developed for NHS acute hospitals, although we will tailor our assessment according to the sector and services. Sir Mike will lead larger inspection teams, headed by a senior clinician or executive working alongside our senior inspectors. The teams will include a Mental Health Act specialist and our inspection reports will include an assessment of how the provider is carrying out its responsibilities under the Mental Health Act. The Experts by Experience will include people with experience of detention under the Mental Health Act.

We will also be developing our approach to inspecting community based mental health services – both in terms of methods and through an increased focus on these services. We will also develop the methods we use to get feedback from people who use mental health services and to raise awareness about how people can tell us about their experiences.

In November 2013 we will set out how we will develop this work in partnership, and our latest thinking on our approach.

In relation to mystery shoppers, our Chief Inspector of Adult Social Care, Andrea Sutcliffe has confirmed that CQC wants to have an open and honest conversation about this, alongside things

like the use of hidden cameras – whether that is by the provider, the public, or by CQC.

Ratings to make clear the quality of care and to help people choose between services

What people told us

There was mixed support for the introduction of a ratings system; however there was overwhelming consensus on what the most important factors of such a system should be.

All groups said we should be clear and transparent on how a rating will be achieved and the systems that will support the process. They also said it was essential that we publish information about it in a comprehensive and understandable way.

All groups also wanted clarification about how we intend to take account of commissioning when inspecting and rating services because of the significant impact it can have on the quality of care. For example, providers may be commissioned to deliver a service that is safe but is not in line with National Institute for Health and Care Excellence (NICE) guidelines which may prevent them from achieving an outstanding rating.

Our response:

We are testing our ratings approach through the 'shadow' rating of three trusts during autumn 2013. We will evaluate the experience of doing this to develop the approach to ratings. We will continue to consult on this and will publish more detail about our ratings system in December 2013, followed by further detail in April 2014.

In the future, subject to the passage of the Care Bill, CQC's special reviews will be the only means of considering commissioning issues. Periodic reviews of commissioning will no longer be possible. These special reviews, subject to approval, could be focused on a specific policy issue. In addition, the results of our inspections and our intelligence monitoring may highlight commissioning issues at national, regional and local level which will help to promote improvement amongst clinical commissioning groups and local authorities.

Section 4

How we will inspect and regulate NHS and independent acute hospitals – what people told us

This section summarises 'what you said' in response to the questions we asked about our more detailed proposals for intelligence monitoring of NHS acute hospitals; changes to how we inspect NHS and independent acute hospitals; the action we will take to tackle poor care; and ratings for NHS acute hospitals.

What we asked in this section

Intelligence monitoring of NHS acute hospitals

7. **Do you agree with the proposals for how we will organise the indicators to inform and direct our regulatory activity?**
8. **Do you agree with the sources we have identified for the first set of indicators?**
9. **Which approach should we adopt for publishing information and analysis about how we monitor each NHS trust? Should we:**
   - **Publish the full methodology for the indicators?**
   - **Share the analysis with the providers to which the analysis relates?**
   - **Publish our analysis once we have completed any resulting follow up and inquiries (even if we did not carry out an inspection)?**

Inspections

10. **Do you agree with our proposals for inspecting NHS and independent acute hospitals?**
11. **Should the rating seek to be the 'single authoritative assessment of quality and safety'? Although the sources of information to decide a rating will include indicators and the findings of others, should the inspection judgement be the most important factor?**
12. **Should a core of services always have to be inspected to enable a rating to be awarded at either hospital or trust level?**
13. **Would rating the five key questions (safe, effective, caring, responsive and well-led) at the level of an individual service, a hospital and a whole trust provide the right level of information and be clear to the public, providers and commissioners?**
14. **Do you agree with the ratings labels and scale and are they clear and fair?**
15. **Do you agree with the risk adjusted inspection frequency set out which is based on ratings, i.e. outstanding every 3 to 5 years, good every 2 to 3 years, requires improvement at least once a year and inadequate as and when needed?**
16. **The model set out in this chapter applies to all NHS acute trusts. Which elements of the approach might apply to other types of NHS provider?**

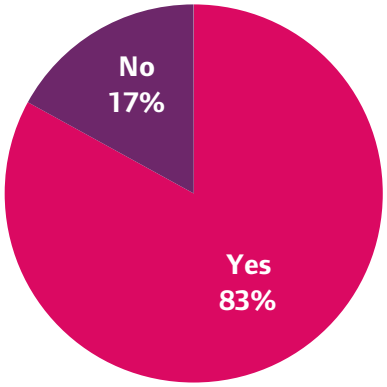
Intelligence monitoring of NHS acute hospitals

We said that we would monitor information and evidence to anticipate, identify and respond more quickly to acute hospitals that are failing, or are at risk of failing. We said that we would use indicators to raise questions about the quality of care provided in an acute hospital. The indicators

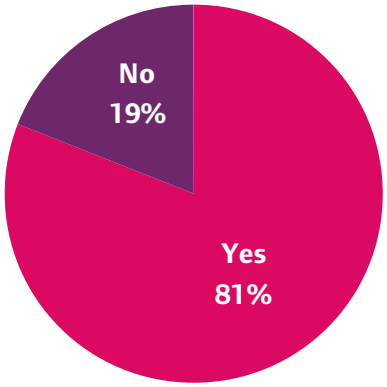
on their own will not be used to draw definitive conclusions or judge the quality of care they guide us when we decide when, were and what to inspect.

What people told us

People's views on whether they agree with the proposals for how we will organise the indicators to inform and direct our regulatory activity



People's views on whether they agree with the sources we have identified for the first set of indicators



There was strong support for the indicators and for the information sources for the first set of indicators. All groups agreed that indicators cannot be used to reach a decision, they can only support a professional judgement. All groups suggested additional indicators and refinements to improve accuracy.

There was some criticism from organisations with an interest in our work and providers of acute hospital services of our decision to use proprietary indicators. Providers in particular questioned our decision to use data sources that are not routinely accessible to providers, which will prevent them from being able replicate the indicators themselves.

Our strategic partners emphasised the importance of aligning our data sources and indicators as far as possible. This makes sure we develop systems for sharing information that is relevant to each organisation, reduces the burden on providers and enables each organisation to develop a joined up picture of care.

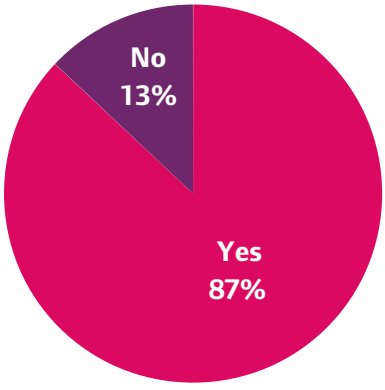
Our response:

These suggestions have been collated and considered alongside the indicators listed in the consultation annex and we will use them as we develop the further. We will also learn from the first wave of new-style inspections of acute trusts.

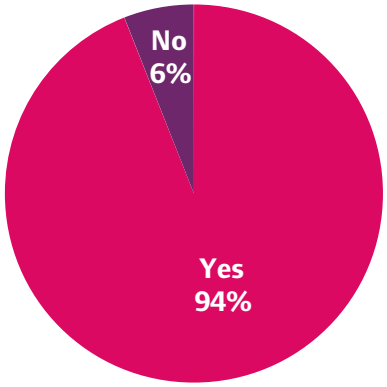
We are working with Monitor, NHS England, and the NHS Trust Development Authority to develop how we will make sure that the way we use and share information between us is more efficient and joined up.

For example, as we have been developing our intelligence monitoring model for NHS acute hospitals we have been sharing it with Monitor, NHS England and NHS Trust Development Authority so they can think about how to align their indicators and intelligence model. We intend to use similar data sources and indicators where possible whilst ensuring we gather information that enables us to deliver our purpose.

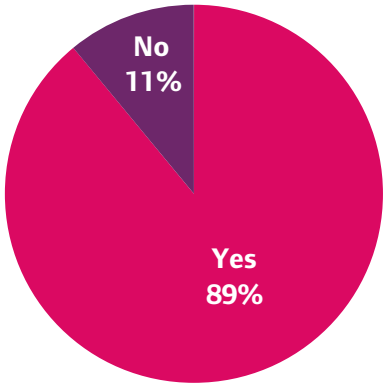
People's views on whether we should publish the full methodology for the indicators



People's views on whether we should share the analysis with the providers to which the analysis relates



People's views on whether we publish our analysis once we have completed any resulting follow up and inquiries (even if we did not carry out an inspection)



There was strong support for publication of the full methodology for the indicators and for publication of the analysis.

All groups felt it would increase public confidence in our judgements and improve our credibility. The only concern was about the potential use of inaccurate data and the need to offer providers the opportunity to challenge any data prior to publication.

Our response:

We will publish the analysis that we create and the corresponding methodology documents explaining the analysis approach and individual indicator definitions. We have identified indicators in relation to a set of principles to try and create the most robust set of indicators possible. The quality of the underlying data is a key consideration when we identify and develop indicators for use in the surveillance model. We consider issues such as timeliness, completeness and recording consistency in making these assessments.

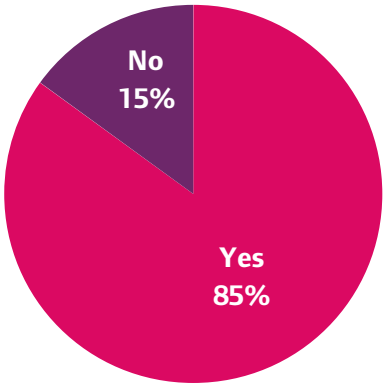
The majority of the data sets we use are taken from national data collections, or use information from the public or providers provided directly tous. We recognise that very few data sets have perfect data quality, but part of our role and intention in using some of these is also to help improve the data quality of information across the health and social care system, so that we have better access to information about the quality of care.

Changes to how we inspect NHS acute and independent hospitals

We said that our Chief Inspector of Hospitals will lead teams of specialist hospital inspectors, clinical and other experts, who will carry out inspections on a rolling basis.

What people told us

People's views on whether they agree with our proposals for inspecting NHS and independent acute hospitals



There was strong support for our proposals for inspecting NHS and independent acute hospitals. The only criticism came from providers about the potential impact on patient care of having an inspection team on site for a longer period as it may distract staff from their daily routine.

There was also some anxiety about the pace of change, particularly amongst providers of acute hospitals. There was a desire for us to introduce these changes over a reasonable timescale, to manage expectations and allow providers time to understand the new approach and adapt their services to take account of the changes.

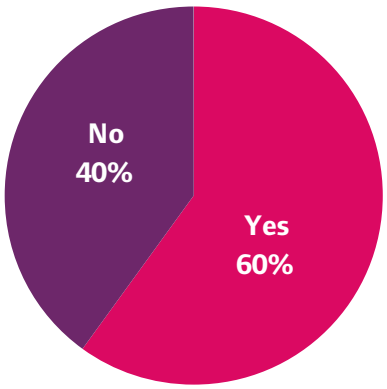
Our response:

We are developing and evaluating these changes as we carry out our new-style inspections of acute hospitals over the next few months so that we can make sure we finalise an approach that has the best impact on the quality of care. We will continue to involve the public, people who use services, providers and organisations with an interest in our work in the development of these changes.

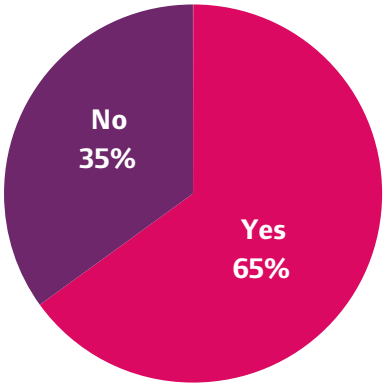
Ratings for NHS acute and independent hospitals

What people told us

People's views on whether we should seek to be the single authoritative assessment of quality and safety



People's views on whether the inspection judgement should be the most important factor when deciding a rating



There were mixed views from all groups about whether our rating should seek to be the single authoritative assessment of quality and safety and whether the inspection judgement should be the most important factor in a rating.

The public felt that there is a lot of information available about NHS hospitals and that it would be simpler if our rating was the single, authoritative assessment.

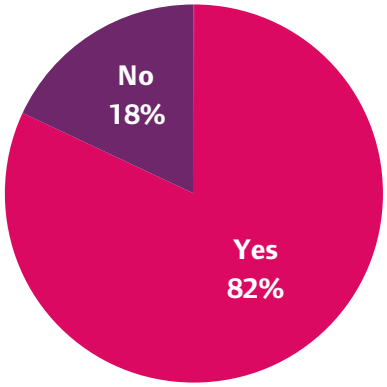
However, providers and organisations with an interest in our work wanted assurance that a judgement and rating will not be based on a single moment in time, but on the quality of care provided over a period of time, including the period an inspection is carried out. They were concerned that a service may be penalised for something that happens on a single day rather than being judged on how they deliver care on an on going basis.

Providers and organisations with an interest in our work asked for clarification of how different sources of information are weighted, in particular accreditation schemes, and how these will influence a service's rating.

Our response:

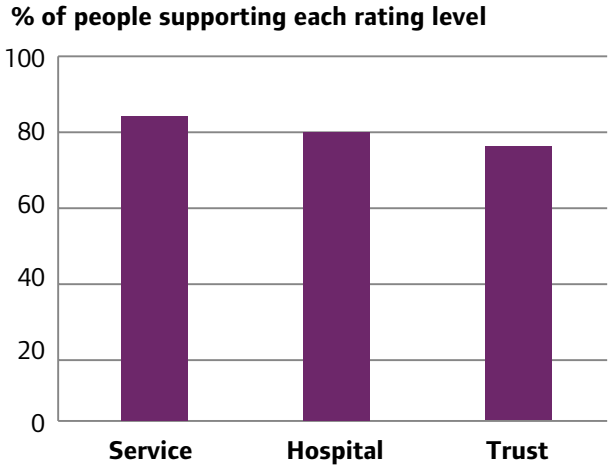
Ratings will be derived from a balanced judgement of what inspectors find on their visits and existing information (including quantitative metrics, the findings of other organisations and feedback from the public). The rating will not be a snapshot related only to the day(s) on which the inspection took place.

People's views on whether a core set of services should always be inspected to award a rating at hospital and trust level



In relation to a rating of a hospital and a trust, there was strong support for the need to inspect a core set of services to allow benchmarking and to provide some degree of consistency when aggregating.

People's views on whether we should rate services, hospitals and trusts



There was strong support from all groups for the introduction of a rating at service level as this is what the public come in to contact with on a day to day basis. People said it would expose the quality of care rather than disguising it through aggregation. Some people even suggested a rating at ward level.

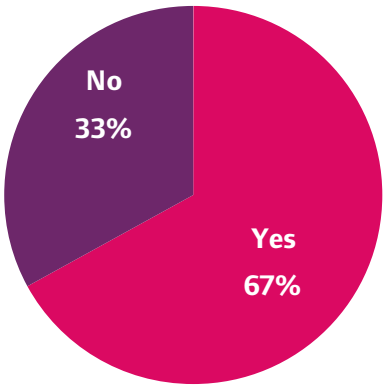
Many were in favour of a rating of a hospital and trust.Our staff in particular favoured a hospital rating. Providers and stakeholders supported ratings of trusts as they felt this encouraged competition and reflected the quality of leadership at Board level.

All groups raised concerns about the potential impact on patient care where a service or hospital is given a poor rating and a patient does not have a choice of what service they can use, such as a mental health service where a patient is detained. This may cause additional anxiety for the person using the service, their carer or family.

Our response:

The levels at which ratings will be provided for NHS trusts is still in development. Currently we intend that ratings will be provided for each of the core services at each hospital for each of the five key questions. At the level of the whole trust we will also provide ratings for each of the five key questions and one overall trust rating.

People's views on whether the rating labels and scale are clear and fair



There were mixed views from all groups about whether the labels and scales we suggested were clear and appropriate. Some felt there should be a five point scale rather than the suggested four of outstanding, good, requires improvement and inadequate. There were differences of opinion, however, about where the additional level should be. Our staff, the public, people who use services and providers suggested adding another level between 'inadequate' and 'requires improvement', which would give poor performing services a bigger range to progress through whilst improving. Others suggested adding a label between 'requires improvement' and 'good' because of the jump between the two scales.

There were mixed views from all groups about the names of the labels. Some felt the wording was too emotive while others felt it should be stronger and suggested changing 'inadequate' to 'poor'. All groups felt that 'poor' better defines the difference between 'inadequate' and 'requires improvement'. The public and people who use services suggested that the labels could be simpler and that we should use symbols or pictures to describe them.

Providers challenged our proposal that to be outstanding they need to be providing innovative, rather than traditional care exceptionally well.

Our response

We believe the four-point scale we suggested is right as we want to make sure there is a clear bar that describes when a service is providing good care.

The words that we use to describe the scales will be consistent across all of the services we regulate but we will work with others to clarify them, for example whether or not inadequate should be changed to "poor".

We think that for a service to be rated outstanding there would have to be broad support from the people using the service, their families and carers that the care was of high quality.

People's views on whether they agree with the inspection frequency based on the proposed ratings scale

There was general support for a risk based approach for determining the frequency of inspection for NHS and independent acute hospitals. However many responses from the public, people who use services, providers and stakeholders raised concerns that an inspection every five years was not enough for services rated as 'outstanding'. People felt that the quality of care could deteriorate significantly over this period of time. Three years was thought more appropriate as a maximum time between inspections. There was general consensus that the only way a risk-based inspection frequency can work is if we have an effective mechanism for identifying concerns. Our intelligent monitoring approach needs to be sensitive enough to be able to identify changes in the delivery of care before serious issues occur.

Our staff suggested that inspection frequency should be determined by the rating of a service rather than the rating of a hospital or trust. This would make sure we were targeting poor care and encouraging improvement of what patients come into contact with every day. It would also make sure poor services were not disguised through an aggregated rating.

Some people noted that aspects of the new inspection model should apply to other types of NHS providers to ensure consistency of approach, but that we should also tailor our approach to suit different types of services, for example community services and GPs. Overall, people reiterated the need to develop an approach to inspection that takes account of the characteristics of each type of service.

Our response:

We agree that it is more appropriate for the maximum time between inspections to be three years.

Section 5

Changes to CQC's regulations

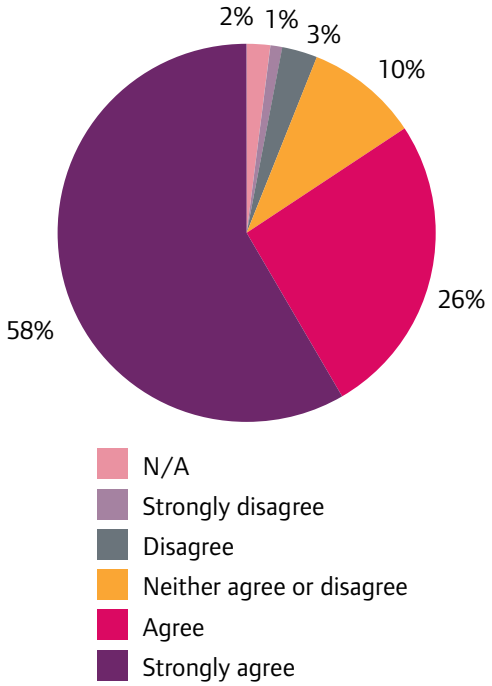
This section refers to the amendments to the 'registration requirements' that are set out in secondary legislation known as regulations. They included the introduction of a statutory duty of candour as one of the organisational requirements on all providers registered with us.

Questions we asked in this section

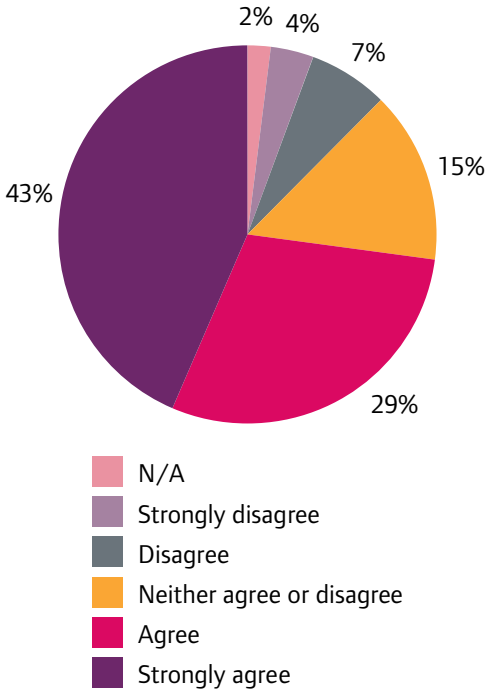
17. **Do you agree that a duty of candour should be introduced as a registration requirement, requiring providers to ensure their staff and clinicians are open with people and their families where there are failings in care?**
18. **Do you agree that we should aim to draft a duty of candour sufficiently clearly that prosecution can be brought against a health and care provider that breaches this duty?**
19. **Do you have any other comments about the introduction of a statutory duty of candour on providers of services via CQC registration requirements?**

What people told us

People's views on whether they agree a duty of candour should be introduced as a registration requirement



People's views on whether duty of candour should be drafted so providers breaching this duty can be prosecuted



There was strong support for the introduction of a duty of candour, particularly from the public and acute providers. They felt it would increase public confidence and introduce accountability across all sectors.

There was a desire for more information about how and when it would apply and clarification on the definitions. People who challenged it were concerned it would prevent a learning environment as people would not be open and honest about near misses or serious incidents, especially if individuals were prosecuted as a result of it.

Our response:

The Department of Health intends to put in place a statutory duty of candour as a registration requirement. This duty of candour will require all registered providers to inform people if they believe treatment or care has caused death or serious injury, and provide an explanation and, where appropriate, an apology.

We would decide when to take enforcement action for a failure to meet the duty of candour, including whether to bring a prosecution. The Department intends to publish the draft duty of candour regulation for consultation in Autumn, as part of the consultation into the new registration requirements.

Regulatory Impact Assessment and Equality and Human Rights Impact Assessment

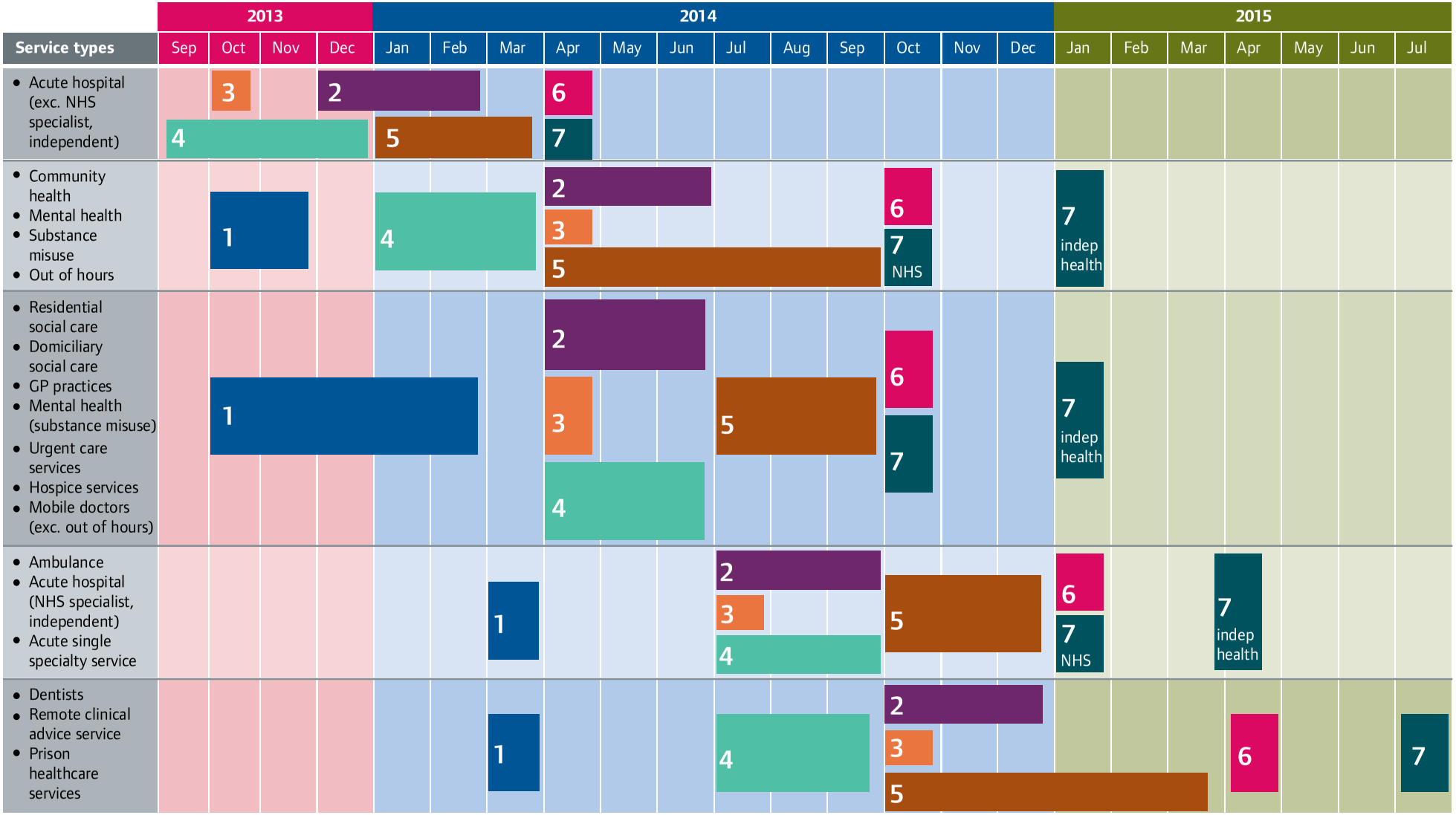
We will be publishing what people told us about our Regulatory Impact Assessment and Equality and Human Rights Impact Assessment, and our response to that, when we publish our next consultation in December.

Annex 1

20 most popular fundamentals of care identified by the public

1. Hygiene
2. Negligence
3. Staff training / qualifications
4. Adequate food and water
5. Personal care
6. Checking medical records
7. Trustworthy staff
8. Medication
9. No decision about me without me
10. Communication
11. Staff have suitable personal qualities
12. Abuse
13. Reviewing
14. Dignity and respect
15. Correct treatment
16. Health and safety
17. Nutrition
18. Confidentiality
19. Lack of discrimination
20. Social engagement

Annex 2: Current proposed timeline for changes for all sectors



Care Quality Commission

How to contact us

Call us on: **03000 616161**

Email us at: **enquiries@cqc.org.uk**

Look at our website: **www.cqc.org.uk**

Write to us at: **Care Quality Commission**
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Follow us on Twitter: **@CareQualityComm**

Read more and download this report in other formats at **www.cqc.org.uk**.

Please contact us if you would like a summary of this report in another language or format.

CQC-216