

A fresh start for the regulation of independent healthcare

Working together to change how we regulate independent healthcare



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

Our purpose:

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

Our role:

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

Our principles:

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

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Note: Independent Healthcare covered in this Signposting Document includes all secondary and tertiary healthcare provided by a non NHS provider (including NHS funded care provided by a non NHS organisation), but not specialist mental health and primary care services.



Foreword from the Chief Executive

We have set out a new vision and direction for the Care Quality Commission (CQC) in our strategy for 2013-2016, *Raising standards, putting people first* and in our consultation, *A new start*, which proposed radical changes to the way we regulate health and social care services.

We developed these changes with extensive engagement with the public, our staff, providers and key organisations. Stakeholders in the care sectors have welcomed our proposals, which include the introduction of chief inspectors; expert inspection teams; ratings to help people choose care; a focus on highlighting good practice; and a commitment to listen better to the views and experiences of people who use services.

We recognise that there is much for us to do to strengthen how we regulate independent healthcare services and to better reflect its important role in the wider healthcare system. This document presents our initial thinking about the independent healthcare sector. It also sets out how we will engage with stakeholders, including our own staff, the public, providers, people who use services, their families and carers to answer these questions in order to develop a new regulatory model for the sector.

A new start set out the new overarching framework, principles and operating model that we will use; this includes the five key questions that we will ask of all services:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive?
- Are they well-led?

We are clear, however, that we will recognise differences between the sectors and will develop and apply our model for each of them accordingly.

The programme of work set out in this document is hugely important. It will help us to make sure that we deliver our purpose – to make sure services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve. If we can achieve that, we hope it will improve the lives and experiences of people who use independent healthcare services, their carers and families.



David Behan
Chief Executive



Introduction from the Chief Inspector of Hospitals

As the Chief Inspector of Hospitals, I am responsible for overseeing the regulation and assessments of quality of NHS hospital services, independent healthcare services, as well as ambulances, community and mental health services.

The development and roll-out of our new approach is gathering pace. Last summer we started this journey by focusing on developing our model for NHS acute hospitals, following this with adult social care, mental health services, community health services, GP practices and GP out-of-hours care. Building on our learning from other sectors, we are looking at the approach for the independent healthcare sector that provides secondary and tertiary healthcare services. This document identifies our proposed approach to inspecting and regulating those independent providers that deliver these services.

Independent healthcare providers deliver a wide range of services for both adults and children, including specialist and enhanced healthcare. The sector delivers many of the same types of services as acute NHS providers, and providers are increasingly being commissioned to deliver services on behalf of the NHS. However, independent providers also offer the public alternatives to NHS treatment. It is therefore important that people can easily make comparisons between providers delivering similar types of service, in order to make informed choices when selecting which services to use.

The independent healthcare sector is a diverse one with providers delivering services from an

array of settings and in a number of ways. These range from large hospitals, which operate under a single corporation with multiple locations to single specialties (for example, cosmetic surgery clinics or dialysis centres) and individuals delivering single speciality services (under practicing privileges or as standalone services). It is important that we ensure our new regulatory model, while tailored to each sector and type of service, treats providers equally when they deliver similar types of services. Ensuring that the different independent healthcare providers are regulated proportionately and appropriately will be challenging, but it is critical in order to assure ourselves and the public about the quality and safety of these services.

Where possible, we will align elements of our new model for the independent healthcare sector with other sectors, including the NHS acute and primary care sectors. We can only achieve our vision for regulating and inspecting the independent healthcare sector by genuinely engaging and working with those who deliver and receive care. We look forward to doing so.



**Professor Sir
Mike Richards**

Chief Inspector of Hospitals



Monitoring, regulating and inspecting independent healthcare

Our consultation *A new start* set out the principles that guide how the CQC will inspect and regulate all health and adult social services. It described our future ‘operating model’ which includes:

- Registration with the CQC to provide health and care services.
- Standards that those services have to meet.
- Better use of data, evidence and information to monitor services.
- Inspections carried out by specialists.
- Information for the public on our judgements about care quality, including a rating to help people compare services.
- Action to require providers to improve, making sure those responsible for poor care are held accountable for it.

These principles will guide our regulation of independent healthcare, but the detail of how we will do this may vary to accommodate the organisation and size of services. This document describes our early thinking about how we will regulate the sector.

FIGURE 1: OVERVIEW OF OUR FUTURE OPERATING MODEL



Independent healthcare services for which the Chief Inspector of Hospitals will be responsible

The Chief Inspector of Hospitals will oversee the regulation of independent healthcare services that deliver secondary and tertiary care, as well as NHS hospital, specialist mental health and ambulance services.

Independent healthcare providers are private, voluntary or non-profit individuals or organisations that are not owned or managed by the NHS. Their services may be contracted by the NHS, may be paid for by an individual or funded through healthcare insurance schemes. Some providers deliver services both privately and for the NHS. Independent providers deliver a wide range of services to both adults and children; many of which are similar to those delivered by the NHS.

“ We will align our approaches across the sectors where services have common characteristics ”

We will align our approaches across the sectors covered by our three Chief Inspectors (hospital, primary care and adult social care) where services have common characteristics or where providers deliver a range of services across our sectors. Our Chief Inspectors will work closely together so providers can be assured that we will regulate them using the approach that most suitably fits the type of service they deliver.

In addition to this publication, other Signposting Documents have also been published including:

- *A fresh start for the regulation and inspection of mental health services.*
- *A fresh start for the regulation and inspection of ambulances.*

We have also published for consultation our *Handbook for NHS acute providers*. We would strongly encourage independent healthcare providers to respond to this consultation to ensure we do not develop an approach in the NHS that would be difficult to adapt for independent healthcare or which could lead to an inability to compare services across the NHS and independent healthcare. We will also publish for consultation a handbook for independent healthcare in the autumn of 2014.

1. Main characteristics of independent healthcare services

Independent healthcare differs from health services delivered by the NHS in a number of ways:

Health policy

- Historically, independent healthcare has not been formally subject to either national or local government health policy to the same extent as the NHS; for example, independent hospitals may participate in national audits but this is on a voluntary rather than mandatory basis. However, as independent providers increasingly deliver NHS-funded services, NHS systems are being adopted more widely across the sector.
 - New regulations of Quality and Safety will be introduced in October 2014 (replacing current regulation detailed in Part 4 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010), along with two additional regulations: the Fit and Proper Person Test and the Duty of Candour. All providers will be expected to meet these regulations to register and remain registered with CQC. We will consult on guidance for providers relating to regulations and enforcement for eight weeks from July 2014.
- Within hospital groups, individual hospitals generally have a lot of local control over operations. There is always a group-wide system of governance, but it is often designed to support greater flexibility and local innovation than is the norm in the NHS.
 - The overwhelming majority of admissions are elective.
 - Independent hospitals generally provide a specified range of services and procedures, rather than the full range of ‘traditional’ hospital services. Notably, if a patient’s condition deteriorates while receiving healthcare from an independent provider, they may be transferred to the NHS in order to access urgent care facilities such as intensive care or out of hours diagnostic services.
 - Not all independent hospitals provide services for children and young people; the majority do not deliver services to children under 3 years of age.
 - Many independent organisations provide only “single specialty” services such as dialysis and termination of pregnancy services, rather than the range of services delivered in an NHS or independent hospital.

Organisation

- Independent healthcare is organised differently to the NHS:
 - Services are provided from a variety of facilities including hospitals, clinics and treatment rooms by a range of consultants and other medical and clinical specialists.
 - Five of the largest providers account for 70% of the independent healthcare market.
 - Almost 80% of patients are covered by insurance, approximately 20% self-pay and a small number are patients from overseas¹.

Staffing

- There are differences in staffing structures between independent and NHS healthcare services:
 - Hospital consultants work under practising privileges² rather than as employees, although some consultants/doctors are directly employed by providers.

¹Figures from Competition Commission, Private Healthcare Investigation: provisional findings report, Sept 2013.

²Practising privileges: means the granting of permission by a service provider to a registered clinical practitioner to practice as a clinical practitioner in a hospital managed by that service provider.

- In most cases, only medical practitioners who are permitted to work unsupervised by their professional body provide medical services in independent hospitals. This means that patients do not generally receive treatment from junior doctors.
- Consultants providing services in independent hospitals are supported by a resident medical officer at all times and in larger hospitals, there may be resident medical officers covering various specialities. This is in contrast to the NHS where junior doctors deliver treatment and support may be provided by a senior doctor, but not necessarily a consultant.

Competitive market

Independent healthcare services operate in a much more competitive market than the NHS. This means that even if a service is funded by the NHS there is competition for business and they must maintain very high standards. Revenue can be impacted if the standard of services does not meet either doctors' (who bring in patients) or patient expectations (who can seek health services elsewhere).

The shape of the sector

Our most recent data show that independent healthcare providers can generally be broken down as detailed below. Some of the numbers in the table are estimates because we are still working to identify those independent doctors that provide solely primary care services and would therefore fall under our Chief Inspector of Primary Care and those independent (private) doctors that provide independent healthcare services that fall under our Chief Inspector of Hospitals.

Provider type	Number of providers (approx.)	Number of locations (approx.)
Independent Hospitals	200	400
Single specialty services	300	600
Independent (private) doctors	To be determined	1,500

Source: CQCs registration information

Independent hospitals deliver health services across a range of specialties on both an outpatient and inpatient basis. These include surgery, high dependency care, intensive care and maternity services. Although acute independent hospitals do not have Accident and Emergency Departments, many treat minor injuries and provide some urgent care (including acute admission units).

Single specialty services focus on delivering one particular acute service, such as cosmetic procedures, ophthalmology, termination of pregnancy and fertility treatments, which may otherwise be provided as one department in a broader hospital. They may or may not have overnight beds.

Independent (private) doctors deliver a range of healthcare services which may involve consulting and carrying out secondary care treatment for example, cosmetic surgery or treatment carried out under intravenous sedation or general anaesthesia. Care and treatment is usually provided in standalone clinics or treatment rooms.

We know that some corporate providers deliver independent healthcare services from multiple locations across the UK; however, CQC will only inspect and regulate those in England. We are undertaking detailed work to ensure we know what services each provider delivers and from what location and also to ensure we know which providers deliver a combination of services that cross our sectors. For example, some providers deliver general hospital services and specialist mental health services from hospitals or clinics and also adult social care services such as nursing home care.

Figures in the CQC's 2012/2013 State of Care Report show that independent healthcare providers generally performed very well in treating patients effectively and with dignity and respect. However, overall, hospitals did not improve their performance in terms of monitoring quality. The report also indicates that there were improvements in compliance with regulations across independent providers from 2011/12 to 2012/13.

Improving data sources

There is a lack of consistent, comparable, nationally available data for non-NHS funded independent services. There are voluntary data collections, such as the quality indicators collected by the Private Healthcare Information Network (PHIN), (it is expected that this will be mandated in the future) and the Private and Voluntary Hospitals Performance Indicators set up by CQC. We already use nationally available data and local intelligence about providers, but we need to strengthen our monitoring of providers. This is mostly about improving our access to accurate, complete and meaningful data and information about services. This may mean that we change the questions we ask when new providers apply to register with us. In addition to engaging with independent healthcare providers and making bespoke requests for information to individual providers, we will also work with PHIN to help

inform our new approach to gathering relevant information where it is not currently available. We will continue to use data and information about providers to assess their risk levels and to plan our inspections.

Patient voice

There is no national patient survey for independent healthcare services, which means there is no standard, comparable information from patients across the sector. Additionally, surveys that are carried out by providers tend to focus on general patient satisfaction rather than targeting patients' views about clinical aspects of their care. However, those providers that deliver NHS funded care are subject to the Friends and Family Test introduced in 2013 which asks whether patients would recommend the NHS service to friends and family needing similar treatment. We will look at how we can use the results in our inspections as we have done with the NHS. We will be gathering patients' views in a variety of ways and on an ongoing basis (not just during inspections), which may include feedback given directly to providers. We will need to improve our access to the views of staff as well as information about differences between NHS and private services. So we will speak to staff who work in both the NHS and independent sectors.

2. The main changes to the way we will regulate independent healthcare services

Intelligent Monitoring

We aim to use a similar approach to inspecting and regulating independent healthcare to that which we have started using for NHS acute and community healthcare providers. As such we want to be able to check, on a regular basis, whether there is a risk that services are not providing safe or good quality care. It is our intention to publish each provider's performance against a

set of risk indicators (where we can), in addition to publishing the judgement made whilst carry out inspections, in the same way that we will do for the NHS. This will be called 'intelligent monitoring'.

Intelligent monitoring combines information from a wide range of data sources to give us a clear picture of the areas of care that may need to be looked at during inspection.

Our NHS acute model arranges indicators in three 'tiers':

- **Tier one:** indicators about things that have a high impact on people and because they can alert us to changes in those areas, which might indicate a concern.
- **Tier two:** indicators include nationally comparable data, such as wider sets of patient and survey results, and information from accreditation schemes. The second tier of indicators includes a much wider range of intelligence which on their own may not trigger action by us. We would check them if the first set of indicators signal a concern, to help understand the issues raised and decide what an inspection should focus on.
- **Tier three:** indicators that are not yet nationally comparable, are not routinely available or which are the result of 'one-off' data collections. We use this set to scan for those indicators which may be useful in the future as part of the first or second set of indicators.

Second and third tier indicators include those where we are seeking to influence providers and information-collecting bodies to produce the most useful indicators of safety and quality. We will explore further how this we could use this approach for independent healthcare.

Together with other factors, this information helps us to decide when, where and what to inspect. This means that we will be able to anticipate, identify and respond more quickly where services may be at risk of failing.

The indicators will raise questions about the quality and safety of care but will not be used on their own to make final judgements or to provide a rating. Our judgements will always be based on a combination of what we find at inspection, intelligent monitoring data and local information from the provider, other organisations and, importantly, the people who use the services.

“ We hope that independent healthcare providers will release appropriate staff to participate in inspections ”

Our Inspection Teams

Our inspection teams are also changing. Inspectors will have specialist skills and experience. Inspection teams will include practising clinicians, other professionals, managers and Experts by Experience (people who have experience of using the type of service being inspected). All inspection team members will have experience of the services delivered by independent healthcare providers; a number of team members will also have current experience of working in independent healthcare.

We hope that independent healthcare providers will release appropriate staff to participate as inspection team members and see the value in the learning that could be gained from these experiences.

Ratings

We intend to introduce ratings for all independent healthcare providers. Ratings will identify providers as:

- **'Outstanding'**
- **'Good'**
- **'Requires Improvement'**
- **'Inadequate'**

Ratings will only be awarded following an inspection. For the NHS acute sector we are rating individual services, hospitals and providers against our five key questions. It is our intention to adopt a similar approach for independent healthcare providers but we will test how best to rate the

range of providers as we carry out our pilot inspections.

During inspections our inspection teams will use 'key lines of enquiry' to gather evidence that will support our judgements and rating decisions. This approach will allow us to recognise where providers are delivering both good and outstanding care. Where we find that care either requires improvement or is inadequate, we will consider whether a breach of regulations has

occurred, the nature and seriousness of that breach and we will use our enforcement power proportionately.

We are exploring how to work in partnership with other regulatory bodies including where there may be opportunities to undertake joint inspections. We are also exploring how we can make best use of information from accreditation and peer review schemes to inform our regulatory and inspection processes.

3. Developing our new regulatory approach for independent healthcare

As we have identified, we aim to use a similar approach to inspecting and regulating independent healthcare to that which we have started using for NHS acute providers. However, we know we will need to adapt some elements of our approach in order for it to be as effective as possible. We will test the developing methodologies in two pilot waves, issue shadow ratings as part of that testing and evaluate and learn from the pilots before the model is rolled out more widely to the sector.

We want to engage the sector and those who use services to develop the right approach. In the next sections we have described our early thinking about how we might adapt our model for independent healthcare and identified some key questions that we will engage the sector, those that use the services and other key stakeholders in addressing.

How can we ensure that we develop our new regulatory approach in true partnership with providers, other key stakeholders and patients?

We are committed to developing our new regulatory model for the independent healthcare sector in partnership with those who deliver and use the services within it.

We have established an expert advisory group to work with us on our overall regulatory approach for the sector. This includes senior representatives from large providers, single specialties and individual providers, representatives of organisations such as the Independent Healthcare Advisory Services (IHAS), Independent Doctors Federation (IDF), NHS Partners Network, the Association of Independent Healthcare

Organisations, PHIN, practicing clinicians and other professionals.

While the expert advisory group has patient representative members on it we are also exploring how we might best engage with members of the Private Patients' Forum and other groups. In addition, patients will be invited to attend a number of events which we will hold over the coming months to contribute to developments.

We have also created an internal design group that allows us to take advantage of the knowledge, skills and experience that already exist among CQC staff, many of whom have years of regulatory and inspecting experience and who share significant experience with independent healthcare services.

We look forward to being constructively challenged and to receiving expert guidance and input to help shape our new model.

We also hope that clinicians and professionals with experience of the delivery of independent healthcare services will participate in our inspections, and that patients will participate as Experts by Experience. Information on how people can express an interest in participating in our inspections will be available shortly.

How can we tailor our inspections to ensure they are both proportionate and effective?

We want to ensure our inspection activities are appropriate for each type of independent healthcare provider. For example it would not be appropriate to use exactly the same approach for a large hospital as for an individual consultant delivering a single speciality service. We also need to ensure that patients can make comparisons about the same types of service wherever they are

delivered and that we treat all providers equally when making our judgements.

For example:

For hospitals, we could identify 'core services' that will always be looked at on inspection, as we have done in our NHS acute inspections. Some of the core services will be the same as those looked at in the NHS (e.g. surgery) whilst some may be different (e.g. cosmetic surgery), reflecting the different range of services provided in independent healthcare.

For single speciality services, we could look at the specific service provided. However, we need to ensure we look at services in the same way wherever they were delivered. For example, we will look at cosmetic surgery services in the same way whether delivered by a single specialist provider or as part of a range of services delivered by a large independent healthcare hospital.

We will also need to consider the size and composition of our inspection teams for different providers, reflecting the size, complexity and type of service being inspected.

We will engage the sector to help us do this work and to help us identify specific risks that may be associated with different types of independent providers.

Additionally, we need to carefully consider how to approach the inspection of large corporate providers which offer combined services, such as those delivering both NHS and totally private care and treatment, and those which offer services across more than one of our sectors (such as primary care and adult social care). This will also include our approach to ratings.

“ We will also need to consider the size and composition of our inspection teams for different providers ”

4. Current proposed timeline

This Signposting Document sets out our initial thoughts on a new regulatory model for the sector. We want to make changes quickly but without compromising our commitment to co-production and quality. We will actively engage independent healthcare providers, patients and other stakeholders in order to ensure we develop a regulatory model which reflects the key characteristics, risks and quality issues of the sector and is seen as fair, transparent and effective in helping improve services for those who use them.

April 2014

- Publication of the Signposting Document.

9 April 2014 (for eight weeks)

- Consultation on NHS acute sector handbook.

April to July 2014

- Wide engagement with internal and external stakeholders.
- Ongoing meetings with our internal and external advisory groups.
- Development of pilot inspection methodologies for the sector.

June to August 2014

- Formal eight week consultation on new guidance for all providers on how to comply with the new regulations and CQCs enforcement policy.

October 2014

- New regulations take effect (subject to Parliamentary approval).

October to December 2014

- Wave 1 pilot inspections: testing our new inspection methodologies for the sector.
- Evaluation, learning and amending our methodology.
- Handbook for independent healthcare providers published for consultation.

Date to be determined

- Publication of our Intelligent Monitoring Model.

January to March 2015

- Wave 2 pilot inspections.
- Initial shadow ratings for some providers.
- Evaluation and refinement of our methodologies, including the assignment of shadow ratings.

April 2015

- Rollout of the new approach for the sector; marks the formal start of our new approach and the end of the current approach.

July 2015

- Publication of formal ratings for the sector begins.

Although this is not a consultation, we would like to hear your views on any of our proposals and changes that we have set out in this document. If you would like to get in touch, please contact us at: cqcinspectionchangesIH@cqc.org.uk

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