

Response to the consultation on our
provider handbooks

**Residential adult social care services,
community adult social care services and
adult social care hospice services**

October 2014

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

Our purpose:

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

Our role:

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

Our principles:

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

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Foreword

From 9 April to 4 June 2014, we consulted on our plans for regulating, inspecting and rating residential and community adult social care and hospice services. These set out radical changes to the way we regulate and inspect, in line with our April 2013 consultation, *A new start*, and the signposting document, *A fresh start for the regulation and inspection of adult social care*.

For the consultation we published our draft handbooks for providers to use – to understand how we will regulate and inspect in each sector, from registration and monitoring through to inspection and ratings.

Over the last 18 months we have co-produced our proposals with people who use services, carers, providers, our staff and representatives from charities, trade associations, local Healthwatch and voluntary groups and other national bodies.

We have also tested our new approach, using larger and more specialist teams of inspectors and experts, in two waves of inspections. An evaluation programme – incorporating feedback from CQC inspectors, Experts by Experience and specialist advisers and providers – has been in place across all sectors.

I would like to thank everyone who has taken the time and effort to respond to the consultation, participate in the co-production work, and work with us during our test inspections to help us develop our new approach. We could not have got this far without you.

We have listened closely to what people have told us. This document sets out the detail of what people said during the consultation and our responses. Overall, the respondents:

- Stressed the importance of CQC ensuring that its assessment framework supports consistent regulatory judgements and, to underpin this, the need for an expert, well-trained inspection workforce.
- Queried whether our proposed ratings principles and the level at which we would set outstanding care were tough enough.
- Made various suggestions for changes to the key lines of inquiry and ratings characteristics, to ensure greater clarity and focus in reaching our judgements.

We recognise the need to ensure consistency for both providers and inspection teams in how we measure quality and what good care looks like. Our intention therefore is not to change the core elements of our assessment framework – key lines of enquiry, characteristics of good care and other rating levels, and ratings principles – until all services in a sector have been comprehensively inspected and rated at least once. We may update prompts, evidence sources and inspection tools if necessary, in response to our continued listening, learning and engagement with providers, partners and, most importantly, with the public and people who use services.

I hope you find this document helpful to explain how the consultation has informed the final shape and design of the provider handbooks. Thank you for your interest.

Andrea Sutcliffe

Chief Inspector of Adult Social Care

Section 1: Our consultation

Introduction

From 9 April to 4 June 2014, CQC consulted on our 'provider handbooks' that set out our proposals for inspecting and rating providers of health and adult social care services. This consultation on our new approach built on our 2013 consultation, *A new start*, which proposed radical changes to the way we inspect and regulate health and adult social care.

We published provider handbooks for consultation for each sector – this report sets out the responses from our handbooks on residential adult social care services, community adult social care services and hospice services.

The consultation documents (the provider handbooks) outlined how we will carry out inspections, which includes gathering information and engaging with people who use services and the public beforehand, the inspection visit itself, and our process for awarding a rating, where appropriate.

They included a standard set of key lines of enquiry (KLOEs), which our inspection teams will use to direct the focus of their inspection. The KLOEs directly relate to the five key questions we ask of services – are they safe, effective, caring, responsive and well-led? Our proposals on how we will rate services included detailed descriptions of the characteristics we will use to decide whether a service is outstanding, good, requires improvement or inadequate, the principles that we will use to apply these ratings and the review process for providers to challenge ratings.

Alongside this consultation, we continued to test, evaluate and develop the new approach through pilot (wave) inspections. These started in April 2014 for adult social care services.

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

Incorporating learning from our waves of inspections

We have embedded evaluation within each new wave of inspections for every sector. This has incorporated a range of methods including surveys, interviews and focus groups with providers, CQC staff and associate inspectors (specialist advisors and Experts by Experience) and observations from the inspections themselves. We used the findings to inform changes to policy, process and practice between and during our waves of inspections, and before full implementation. For adult social care, we also commissioned an independent research agency to carry out interviews with providers who have been through the entire process of our test inspections.

How we engaged and who we heard from

To gather feedback about our consultation we organised 19 events across the country for providers of adult social care services, members of the public and CQC staff (see appendix B for details). These were attended by more than 650 people. They were generally hosted by senior members of CQC staff and included presentations followed by table discussions focusing on different aspects of the consultation document. The events included:

- Eight provider consultation events in Birmingham, Bristol, Bury St Edmunds, Leeds, London (twice), Manchester and Nottingham. Each event was attended by 30 to 50 providers from across residential and community adult social services and hospice services.
- Four public events for people who use services across all regulated care services sectors in Birmingham, London, Manchester and Southampton.
- Seven events for CQC staff.

We also held events on specific issues, including:

- Three roundtable discussions focusing on the five key questions about whether services are safe, effective, caring, responsive to people's needs and well-led.
- A roundtable discussion on how CQC might take account of accreditation or best practice schemes in its work.
- A roundtable discussion on the use of covert surveillance.
- One meeting of our Children and Young People's group for all sectors.

At later events, we also used a self-completion form to capture any additional comments attendees wished to make. We received 190 of these forms and the information in them has been incorporated into the findings from the events.

We also used our regular communication channels to promote the consultation with providers and professionals, including:

- Monthly newsletters to all registered healthcare providers.
- Our online community for providers and professionals (around 7,500 members).
- Our Twitter accounts.

Engagement events with our online communities

Provider community

We held a series of online engagement events for adult social care during the consultation period and received 92 responses. Events included:

- A live Q&A on our consultation on Friday 2 May
- A review of ratings characteristics and key lines of enquiry
- A review of local relationships, and gathering and using information
- A review of ratings, Mental Capacity Act, and mystery shoppers/hidden cameras.

Public community

The materials we shared at our events were also used to consult members of the public registered with our online community. We received 39 responses from them during our consultation period. We also ran a 'discussion thread' with them that looked at the specific question of 'What does good look like?'

During the consultation, we organised two Q&As on Twitter – an innovative way of capturing the views of people who wished to engage with the process in this way. CQC also monitored and responded to tweets throughout the consultation. We received 49 tweets with 218 re-tweets. The tweets brought up some interesting themes and good suggestions that correlated with ideas from other elements of the consultation.

We also asked members of the public to send, using social media, photographs of themselves holding up boards with their own definitions of what good care looks like written on them. We analysed these comments on the photographs and took the views into account as part of the consultation. This was an excellent way of publicising the consultation and engaging the public in a creative way.

We used our monthly telephone calls with local Healthwatch representatives to promote the consultation.

We also used a webform to make it easier for people to give us feedback to the consultation online. We received 208 forms relating to adult social care.

As well as the forms completed online, we received 175 written submissions referring to adult social care services.

Other research

We also used two other sources of public comment in considering our responses:

- Public research defining 'good' in healthcare undertaken by Research Works Ltd on behalf of CQC. Research Works interviewed 40 people (clients and carers)

about inspection proposals in adult social care. Where applicable to a particular sector findings from this research have been included.

- Focus groups with a range of people who are classified as hard to reach due to their circumstances, carried out on behalf of CQC by an advocacy organisation, relating to all sectors.

How we analysed feedback from the consultation

We commissioned Quality Health, an independent healthcare consultancy, to support the consultation process. Quality Health have reviewed, analysed and reported on all the feedback collected from all aspects of the consultation.

Please note that, due to the complex nature of this consultation across a number of sectors and engagement channels, the consultation questions used in this response document have been collated and summarised from the various versions used throughout the engagement process.

Section 2: Key changes to our approach to inspecting

Our provider handbooks, which were the subject of this consultation between April and June 2014, set out in detail how we will regulate, inspect and rate adult social care services.

In response to what we heard during the consultation and what we learned during the testing of our new approach, we have made improvements throughout the handbooks to clarify and confirm the inspection process.

The detailed feedback from the consultation and our responses are set out in Section 3 under the different themes of the consultation. The following are the key specific changes we are making to our original proposals:

Provider Information Return (PIR)

We plan to have a Provider Information Return that is continuously open in the future, once our online services system is fully rolled out. In the meantime we will contact providers in batches to ask them to complete the Provider Information Return.

Focused inspections

Along with our colleagues in other sectors we have clarified the circumstances under which a focused inspection may take place. We have also provided more details about the circumstances in which a focused inspection might influence a change to ratings.

Assessment framework (key lines of enquiry, characteristics of ratings, ratings)

- We have reduced the number of key lines of enquiry (KLOEs) from 23 to 21, and increased the number of mandatory KLOES from 13 to 16, ensuring a wider coverage and more consistent base for comprehensive inspections and ratings judgements.
- We have made our descriptions of each rating level clearer so that they better reflect the differences between the four levels.

Along with our colleagues in other sectors we have:

- Rationalised some of the KLOEs and prompts to reduce areas of duplication that were in the framework we consulted on. Our test inspections also helped us to identify where some of elements of the assessment framework needed to be set out more clearly. For example, we have made the distinction between what is covered in our assessment of 'effective' and 'responsive' much clearer.

- We have introduced new KLOEs to reflect specific areas that were lacking in the right level of focus:
 - For example, the Mental Capacity Act, Deprivation of Liberty Safeguarding (DoLS) and best interests decision making were previously referred to under the key questions of 'safe' and 'effective'. We have now introduced a KLOE on consent, under effective, which brings together all these issues.
- We have reviewed the language of the KLOEs and prompts to make sure that we are using terms that reflect current practice and that we do not use jargon.
- We have reviewed the format of the prompts and changed them from being short bullet points to questions. This is so that they provide more detail and clarity about what topics are covered under each KLOE.
- We have made sure that the characteristics of outstanding truly demonstrate outstanding care so that our approach to ratings provides the necessary challenge and stretch.

We will publish information for the public and providers on the use of covert and overt surveillance and the issues to take account of in considering its use.

Training our staff

CQC is committed to the learning and development of our staff. We are developing programmes of learning that will ensure that, as an employer, we have competent and confident staff working for us. Learning activities are developed at three levels: awareness, core skills and specialist. In this way we ensure our staff have the right training at the right level at the right time. Our flexible and blended approach to learning also encourages staff to learn at the right time for them.

In response to the consultation and the evaluation of our pilots we have developed a training programme that all inspectors will attend before they begin inspections from 1 October. The programme focuses on the assessment framework, and provides opportunities for practice in a safe learning environment so that inspectors will begin their inspections with understanding and confidence. This should ensure a consistent approach.

Ratings principles

The majority of people responding to our consultation thought that for a service to be outstanding there should be at least three ratings of outstanding at key question level. However, we have decided not to do this. This is because our pilot inspections showed that if we set the overall rating at this level there would be fewer than 1% of outstanding services, whereas we want outstanding to be a rating that providers can truly strive to achieve.

Section 3: What you told us and our response

Gathering and using information

What we said in our consultation

During our inspections of adult social care services and hospices, we will use a number of methods to gather information from the public about their views of the services provided. We will also maintain good local relationships with all stakeholders in our work, including providers, commissioning bodies, MPs and other members of the local health and care system. We will combine the local insight we obtain from these groups with other information, such as safeguarding alerts, to inform our Intelligent Monitoring. By gathering and using the right information we can make better use of our resources by targeting activity where it is most needed.

Consultation questions

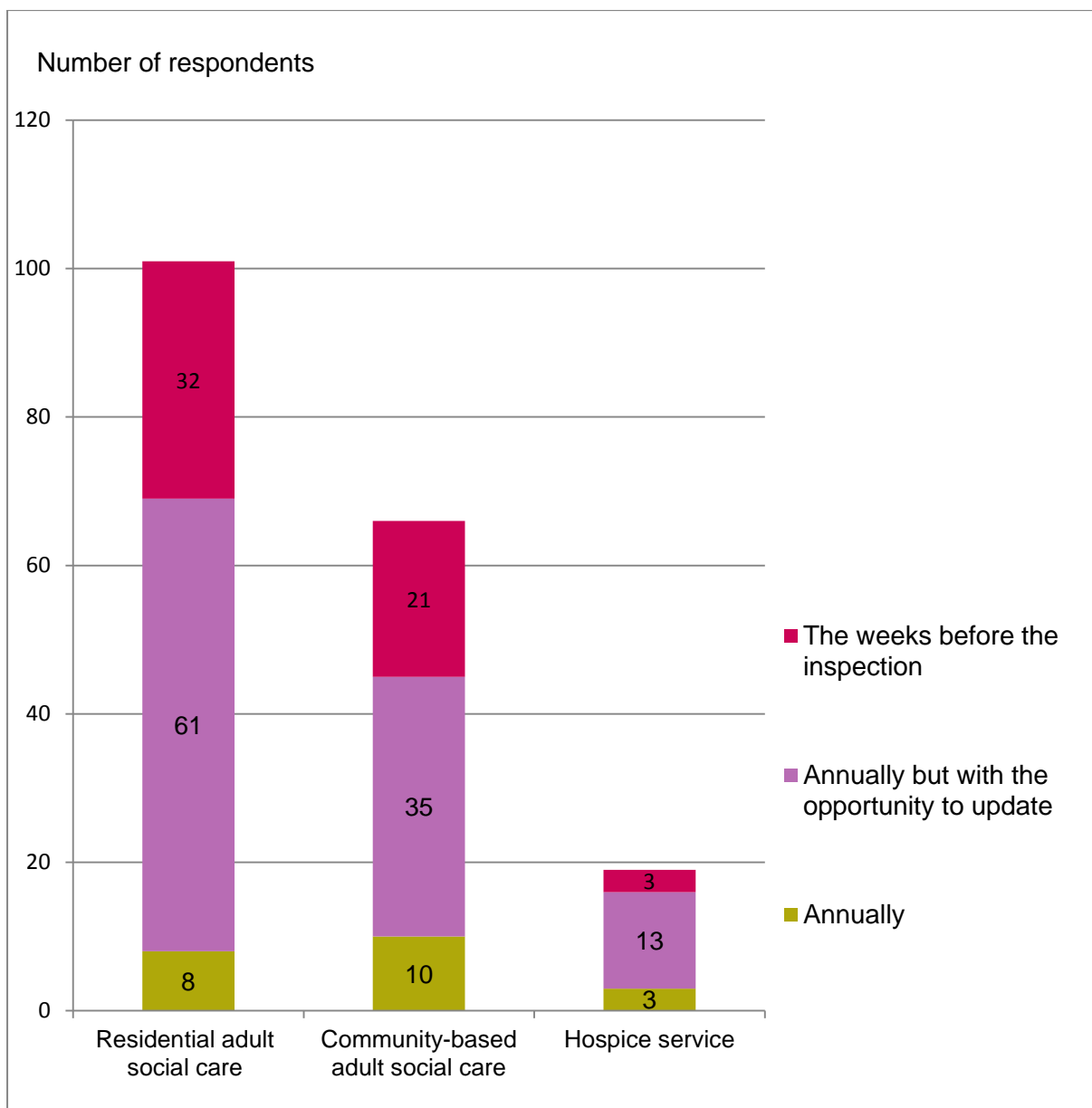
- How confident are you that the sources of information we plan to look at will identify risks of poor quality care and good practice?
- We have described the key people and organisations we will work with and how we will do this. Do you think that this approach is likely to be effective in supporting our work? What other ways could we gather the views of all the people we need to hear from including seldom heard groups?
- Do you think the best time to request information from providers is in the weeks before the inspection, annually or annually with the opportunity for providers to update at any time?

What you said

- There were mixed views about whether Intelligent Monitoring will help to identify both good and poor practice in adult social care services. More than half of those responding online were not confident or were unsure about its effectiveness. Reasons for this included concerns about the quality of data and the ability of inspectors to interpret it. Although the written submissions generally supported our proposals, there was some concern that Intelligent Monitoring needed to be contextualised by both local and national benchmarking.
- The vast majority of those responding online were confident that the local relationships and ways of gathering information set out in the handbooks will be effective in supporting CQC's approach. However, there was a need for partnership working and information sharing with local authorities and other local agencies, partly to avoid duplicate information requests.

- Many providers wanted CQC to work in a more collaborative way with them and develop ‘two way’ communication.
- A number of suggestions for sources of information were made, including from groups of people, such as those with learning disabilities, non-English speakers, and people using maternity services, and from staff surveys and social media.
- Most respondents to our online form would prefer the information that we request from providers (the Provider Information Return) to be an annual return with the opportunity for updates (see chart below).

Online responses: Do you think the best time to request information from providers is in the weeks before the inspection, annually or annually with the opportunity for providers to update at any time?



Our response

We recognise the shortage of nationally reliable data for adult social care and are working hard to improve both the quantity and quality of information we hold and share about adult social care services.

We are taking a number of steps to increase our information gathering capacity and activity, for example we have:

- Linked submitting statutory notifications to the ratings scheme to encourage providers to submit information to CQC.
- Developed questionnaires to send to people, their carers, families and friends, care staff and community professionals.
- Begun to develop information exchange relationships with commissioners such as local authorities.

The information we gather from these and other sources is analysed and added to information packs that are used by inspectors when planning inspections or considering what to do after receiving information of concern. This analysis includes benchmarking, so that inspectors are able to better understand the context of the information.

In addition to information sharing arrangements with local authorities and other statutory bodies, we have begun a new programme of work to improve our contacts with Healthwatch and other community groups. These new relationships will be a rich source of information, and the data they gather will be added to information packs in due course.

We are developing new online services which providers will be able to use to submit applications, notifications, provider information returns and other information. For example, we are looking at how we can create a Provider Information Return that is always open for providers to update.

Key lines of enquiry (KLOEs)

What we said in our consultation

To focus our inspections, inspection teams will use a standard set of key lines of enquiry (KLOEs) that relate to the five key questions – are services safe, effective, caring, responsive and well-led. Within this set we have identified a number of mandatory KLOEs that inspectors must use on every inspection to help ensure consistency and transparency over what we look at and to provide a basis for a credible and comparable rating.

Each KLOE is accompanied by guidance (or ‘prompts’) on quality issues that inspection teams will focus on as part of their assessment.

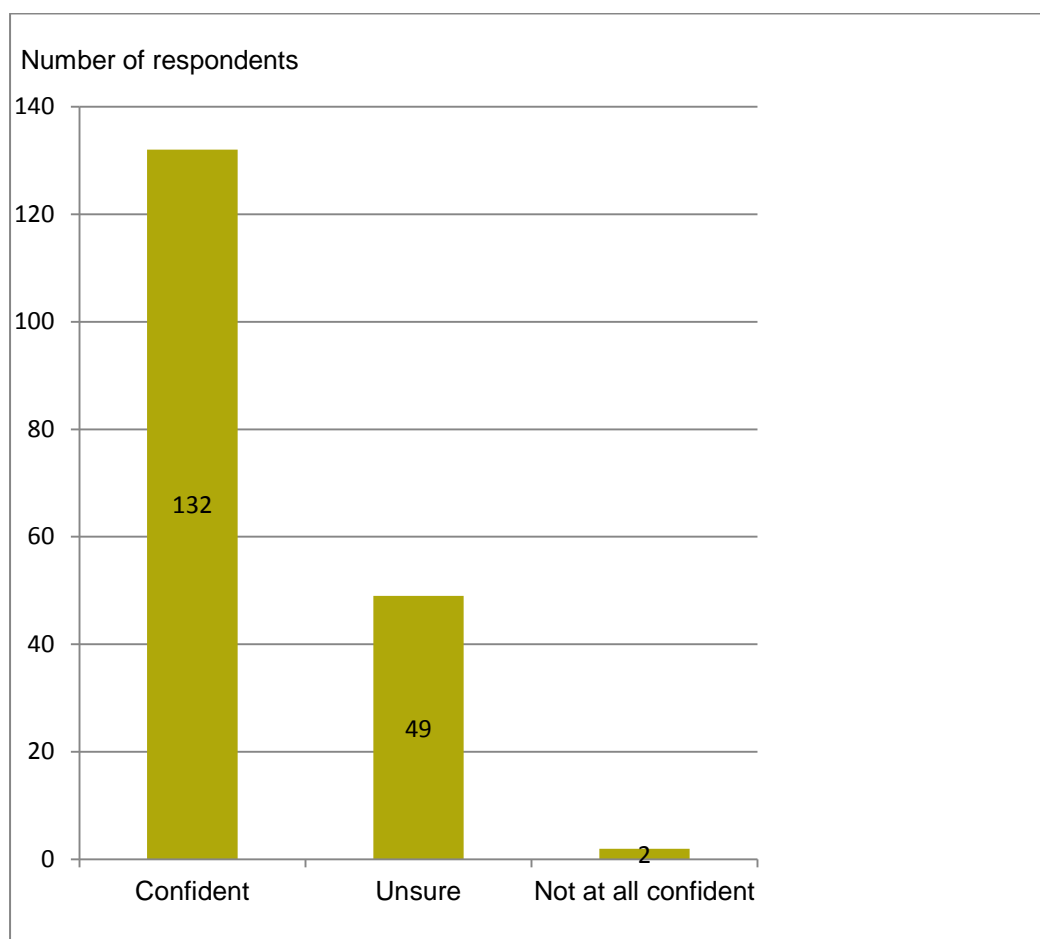
Consultation question

- **Do you feel confident that the key lines of enquiry and the list of prompts will help our inspectors’ judge how safe, effective, caring, responsive and well-led adult care services are? Is there anything we are missing?**
- **Do you think that inspecting against the mandatory key lines of enquiry, plus additional ones, selected on the basis of what our intelligence tells us, will enable us to make credible and comparable judgements about services?**

What you said

- Most people at our events (see chart below) and respondents to our online form, including people who use services, were confident that the KLOEs and prompts would help inspectors to judge services as the chart below shows. However, there was slightly less confidence in the hospice sector, with views that the KLOEs and prompts were not focused enough on hospice care generally and in particular for children’s hospice care.

Event responses: Do you feel confident that the key lines of enquiry and the list of prompts will help our inspectors' judge how safe, effective, caring, responsive and well-led adult care services are? Is there anything we are missing?



- Providers and our staff supported the focus on the views of people who use services and carers in the KLOEs.
- However, some of our staff and providers would like the KLOEs and prompts to be less vague, with more detail and more examples and less crossover between them. Others felt KLOEs needed to be matched to the regulations.
- Both our staff and providers suggested that the language of KLOEs and prompts should be clearer.
- Providers felt there should be a greater emphasis in the KLOEs on safeguarding and on communication between the service, people who use services and carers.
- Aspects viewed as missing or in need of strengthening from the KLOEs included provider accountability, pain relief and cancer care, end of life care, how long people were left without help, staff development, health outcomes, and specialist care in learning disabilities.
- Other queries included whether the KLOEs would evolve over time and how they would drive improvement by encouraging progression from one rating level to the next.

- Providers wanted clarification on how CQC will inspect services of different sizes and levels of commissioning costs, as well as providers with multiple sites – both to ensure consistent judgements and to ensure they have the right corporate governance.
- It was felt that most KLOEs should be mandatory, and some providers thought they all should be, but especially those related to eating and drinking and medicines management.
- There was general agreement from our staff and providers that CQC inspectors needed more training, that specialist inspectors are important, and that the new process should support whistleblowing – especially from those in residential care.

Our response

As a result of the consultation feedback, we have reviewed and strengthened our key lines of enquiry to make sure that they are fully focused on people who use services. This has included simplifying the language used in the KLOEs so that they follow plain English principles and are easier to understand.

We have placed greater emphasis on key themes such as safeguarding, communication and provider accountability in the safe and well-led key questions.

We have made aspects of KLOEs less repetitive by providing greater clarity about where they fit within the framework and reducing the crossover between them. This has meant that we have been able to merge some KLOEs and reduce the overall number from 23 to 21.

To provide further breadth and depth to our KLOEs, and ensure our inspections are focused and targeted, we have added a further column into the KLOEs which signposts inspectors to where they might find evidence to help them plan and carry out their inspections. The column suggests aspects of the KLOE that inspectors may want to explore when they talk to people using the service and staff. It sets out aspects of the service they may want to observe and the types of records they may want to review in order to help them gather evidence about the quality of the service.

New mandatory KLOEs

Responses to the consultation confirmed that assessing whether providers meet the Mental Capacity Act 2005 and its associated regulations is critical if we are to make sure that people's rights are promoted and met. In our consultation proposals this was a prompt within the KLOE in the 'safe' question relating to bullying, abuse and human rights. To recognise its importance we have now made 'consent to care and treatment' an independent KLOE that sits in the 'effective' question. This new KLOE is a mandatory one that must be covered at every comprehensive inspection. People who responded to our consultation felt strongly that the KLOEs for medicines and for eating and drinking should become mandatory KLOEs. We agree and have made both mandatory KLOEs.

There are now 16 mandatory KLOEs that will be assessed during comprehensive inspections.

What we are not able to change and future plans

We do not have any current plans to map the KLOEs to regulations. We will, however, publish separate provider guidance to explain how to meet the new regulations which are due to be implemented in April 2015.

We recognise that we have further work to do to make sure that the KLOEs for hospices, hospice at home services and hospice services for children properly reflect the unique aspects of the services they provide. We will be working closely with the sector to develop these further and strengthen them ready for publication at the end of October 2014.

We want to explore how we might assess the quality of the key question of 'well-led' with corporate providers and will work with them to co-produce our final approach over the coming months.

We have tried to make sure that the KLOEs have sufficient breadth to provide a framework that takes account of people with a range of needs across the different types of services that we regulate. We will keep this under review and take action to strengthen the model if we find this approach is not robust

Key changes at a glance

- Provided greater clarity about the difference between effective and responsive – assessment, review and care planning have been moved into responsive.
- Consent to care and treatment is an additional KLOE and will be a mandatory KLOE.
- Medicines management has been made a mandatory KLOE.
- Supporting people to have sufficient to eat, drink and maintain a balanced diet is now a mandatory KLOE.
- Well-led 5 (open and transparent communication) has been removed and the prompts merged into Well-led 1 (positive, person-centred, open, inclusive and empowering culture).
- Well-led 6 (responsibility and accountability is understood) has been merged into Well-led 2 (demonstrating good management and leadership).
- Addition of a new column which sets out potential sources of evidence for each KLOE.
- Simplified language.
- 16 mandatory KLOEs to be looked at in every inspection*.
- 21 KLOEs overall.*

* for both residential and community services

Characteristics of ratings

What we said in our consultation

We plan to rate the performance of adult social care and hospice services against each of the five key questions as well as the service overall. When we rate services we will use the following four point scale: outstanding, good, requires improvement or inadequate. We have developed a description of each of the four ratings, for each of the five key questions. These characteristics provide a framework which, together with professional judgement, will guide our inspection teams when they award a rating.

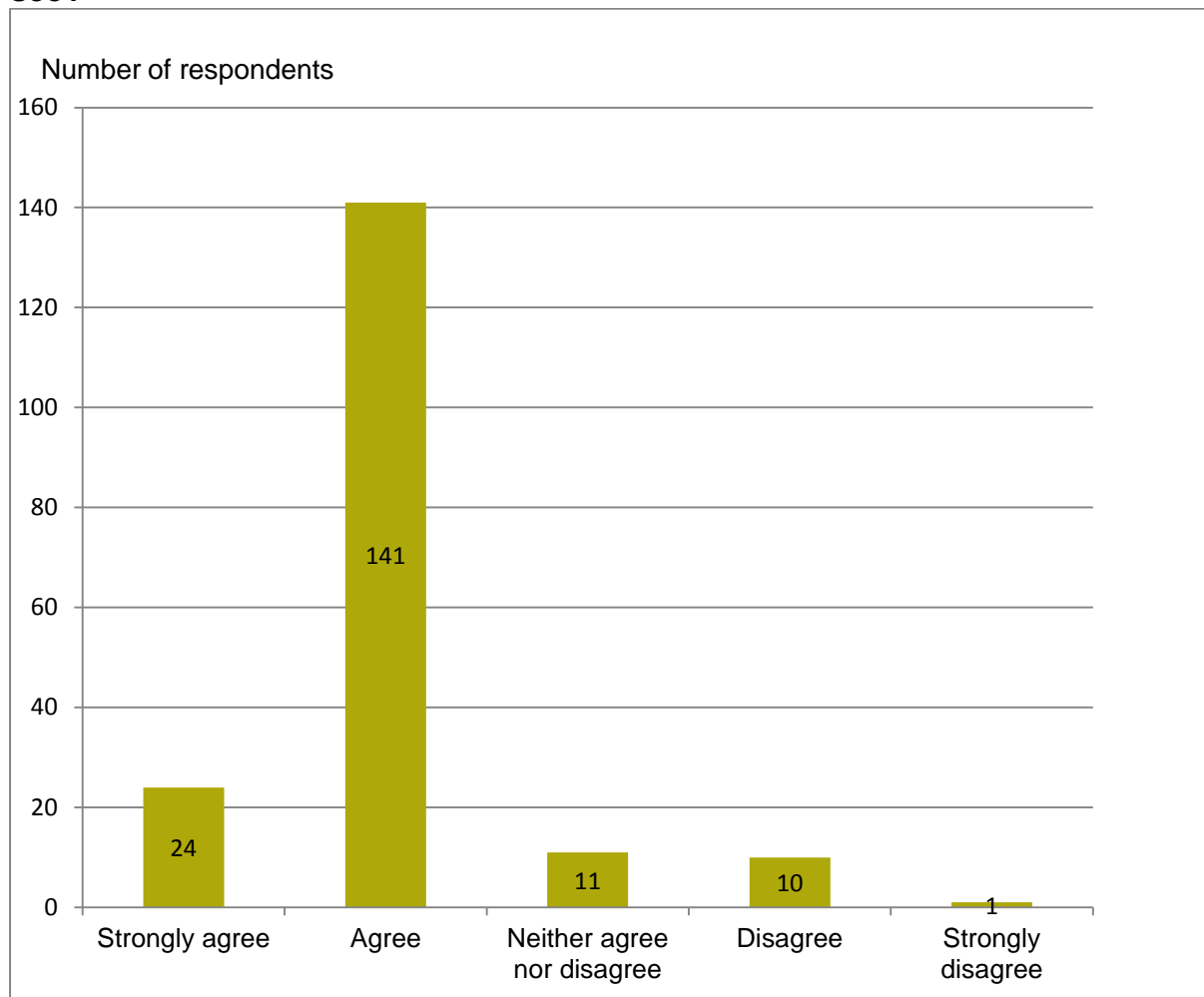
Consultation question

- We have described characteristics of good, outstanding, requires improvement and inadequate for each key question. Do you agree that these characteristics are what you would expect to see in a service?
- Are there ways in which we could promote learning between providers and services, particularly those where we have identified outstanding care?

What you said

- There was strong support for the CQC descriptions of outstanding, good, requires improvement and inadequate care in adult social care services. For example, many of those at our events said the description of 'good' in each of the key questions was what they would expect to see and helped to support the prompts in the KLOEs (see the chart below).

Event responses: Are the characteristics of good what you would expect to see?



- However, some said there needed to be a stronger emphasis on the needs of and risks to people who use services. Also, there should be greater regard in the definitions to staff levels and staff turnover. It was felt that the characteristics for hospice services needed particular attention.
- Both our staff and providers at a number of events, as well as people who use services online, questioned the distinctions between the ratings.
- Many providers were concerned about the different approaches needed between services (for example, residential compared to domiciliary), including within different parts of the same services, and how inspectors would judge services with specialisms compared to generic services. Some asked whether we would work with commissioners of services to ensure there was a common understanding of what good provision is.
- Some suggestions for promoting learning included forums for providers and managers, using managers of outstanding or good homes as part of inspection teams or as mentors, and sharing good practice more through our inspectors and our website or at local meetings with key partners.

Our response

We have reviewed and strengthened the characteristics of ratings. We have paid particular attention to ensuring that the content is more consistent across the five key questions and included a greater emphasis on staffing levels and staff turnover. Following further work with the sector, the characteristics for hospices will be more specialised and relevant to the sector.

We have simplified the language used throughout the characteristics of ratings so that they follow plain English principles and are easier to understand. We have made sure that the descriptions within the four levels are now much clearer and better reflect the differences between the four rating levels.

We have strengthened the description for outstanding, making sure that it properly reflects the type of characteristics that an outstanding service should have.

To make sure that our inspectors apply the characteristics of rating consistently and proportionately, we have strengthened the introduction to be clear that:

- Characteristics are not a checklist and are not exhaustive.
- They link to the prompts in the key lines of enquiry but they are not meant to map across exactly.
- A service does not have to meet every area covered in the characteristics to fit into that rating section.
- Some of the characteristics may not always be appropriate for different types of service.

The characteristics of ratings do not provide examples of practice for each of the four rating levels. Their purpose is to identify the unique characteristics that an outstanding, good, requires improvement or inadequate service might have. However, we recognise that it is important that examples of, in particular, outstanding practice are shared. As we begin to rate services from October 2014 reports for those services will start to appear on our website and will be publically available so that everyone can learn from them. We will be exploring other ways we can identify and share examples of good and outstanding practice.

Applying and reviewing ratings

What we said in our consultation

To ensure we make consistent decisions about ratings we intend to use a set of principles and guidelines. We proposed that the five key questions have equal weighting and contribute equally to the overall location rating. Overall ratings are produced using principles for all the possible combinations of five key question ratings. These principles are:

1. If two or more of the key questions are rated inadequate, then the overall aggregated rating will normally be inadequate.
2. If one of the key questions is rated inadequate, then the overall rating will normally be requires improvement.
3. If two or more of the key questions are rated requires improvement, then the overall rating will normally be requires improvement.
4. At least two of the five key questions would normally need to be rated outstanding before an aggregated rating of outstanding can be awarded.

There are a small number of events and circumstances that are sufficiently serious that they should limit a rating judgement. Where we have decide that the limiter should be applied the inspector will make a further judgement about the impact on people who use the service considering the severity of the harm caused and whether the relevant question should be rated as 'inadequate'.

CQC will have a process for providers to ask for a review of their rating. We want to ensure that providers can raise legitimate concerns about the way we apply our ratings process, and have a fair and open way for resolving them.

Consultation question

- Do you agree that the five questions are equally important and should be equally rated when reaching our overall rating for the service?
- Do you agree with the principles, guidelines and limiters above for arriving at an overall rating? Is there anything else we should include?
- Do you agree the test of 'severity of harm' is the right test for our inspectors to apply when determining whether the key question should be rated requires improvement or inadequate?
- Do you agree with the grounds on which providers can challenge their inspection reports and ask for a review of their ratings? Do you feel confident that the proposed reviews process is sufficiently clear and robust?

What you said

- Most of those responding online and in written responses, including local and national bodies, strongly agreed with the ratings principles, limiters and guiding indicators.
- Most responding online, including people who use services, also agreed that the test of severe harm should limit a rating.
- Nearly all those responding online agreed with the grounds on which providers can challenge their inspection reports and ask for a review of a rating. However, there needed to be clarity on how to appeal to an independent reviewer.
- There were extremely mixed views as to whether the key questions should be weighted or not. Many CQC staff and providers felt that all key questions were equal, while others thought that some were more important than others – particularly well-led, safe and caring.
- There was a view from CQC staff, providers and in written submissions that ratings should be tougher. In particular it was an overwhelmingly held view that to be rated as outstanding a service should have to achieve at least three individual outstanding ratings (out of five), if not all five.
- Both CQC staff and providers in all settings mentioned the need for consistency across the country and between inspection teams – particularly since, for example, ratings of inadequate or requires improvement would affect contracts from commissioners.
- Some providers and CQC staff spoke of the importance of the individual key question ratings as well as the overall rating, and that people who use services must be able to see the ratings for all the five key areas.
- People asked when a provider was rated as ‘requires improvement’, would there be a clear statement of what needed improving and the time frame for doing it. Also, when publishing the results of inspections, many of our staff felt that reference should be made to the service rating being achieved on a particular date.

Our response

We have developed the process for submitting requests for reviews of ratings to be as simple and clear as possible. This includes an online form for submitting them which will help providers to make sure that they have set out which ratings they want to be reviewed, and why. We are in the process of recruiting the independent reviewers and the staff who will support the request for review process. The reviews team will administer all requests, to help ensure a fair and independently overseen process.

Actual or potential harm to people is a critical consideration in both the key lines of enquiry, and in the characteristics of ratings. While it is not one of the additional formal limiters in our ratings scheme, it is a key consideration in the KLOEs and characteristics for the safe question, and will always be an important and mandatory element in our inspections and rating judgements.

We have confirmed that the key questions will be equally weighted. There was no consensus on this in responses to our consultation. As our comprehensive inspections are designed to look at services in the round and take into account all aspects of how they are run, we have taken the view that it is appropriate to equally weight them to give balance and ensure a thorough, across the board assessment of their quality and safety. We will review the impact of this approach as part of our continuous improvement activity.

Ratings for all five key questions and the overall rating for each location will all be clearly shown both in words and graphically in both our reports and on our website. Our reports are clearly dated, and show when ratings were awarded.

Despite the majority of people saying that for a service to be outstanding there should be at least three ratings of outstanding at key question level, we have decided not to do this. The testing in the adult social care wave inspections showed that if we set the overall rating at this level there would be fewer than 1% of outstanding services. If we leave it as two ratings of outstanding at key question level (plus the other three key questions rated good) there would be approximately 3% of services rated outstanding. We have also stretched the characteristics of ratings so they demonstrate truly outstanding care. We want outstanding to be attainable and something providers strive to achieve, and we believe where we have set the bar for outstanding will enable us to do that.

Our reports will clearly show why a key question had been rated as requires improvement or inadequate. Where the problem was also a breach of a regulation we will be very clear about both this and what we have told the provider to do, or what action we will be taking, as a result. We will always follow up on what the provider has done about the problem, with the timescale for this set according to the likelihood and impact of harm or other poor experiences for people occurring.

Where a regulation has not been breached we will sometimes make recommendations about what a provider should take into account or do to address the problem.

Recommendations will normally be used when a rating of requires improvement has been given. This is because we particularly want to encourage providers rated as requires improvement at key question level to reach a good rating. However, there will be occasions, especially under the well-led question, where a rating of inadequate might be given and a breach of regulations may not have occurred and it might still be appropriate to make a recommendation. At other rating levels we won't normally suggest a recommendation for how the provider could improve. This is because if the rating is 'inadequate' there would usually be a breach of regulations. Therefore the action to be taken will be clear in the enforcement action we have specified.

Our recommendations will normally be written in a way that signposts the provider to sources of information and advice.

Compliance with the Mental Capacity Act

What we said in our consultation

We inspect and report on how well health and social care services, including adult social care and hospice services, meet the Code of Practice in the Mental Capacity Act. The code applies when staff are assessing whether people aged 16 and over have the mental capacity to take particular decisions, and when they take decisions on people's behalf – for example where a service works with people who may have cognitive difficulties due to dementia or a learning disability.

Consultation question

- **How best do you think we can ensure that providers improve the way they conform with both the wider Mental Capacity Act and the Deprivation of Liberty Safeguards?**

What you said

- Respondents said that the Mental Capacity Act and Deprivation of Liberty Safeguards were not well understood by providers and CQC staff alike, and further guidance and training is required.
- Some suggested that Mental Capacity Act should link with some of the prompts for the key lines of enquiry for 'Effective', and that human rights legislation and Deprivation of Liberty Safeguards need to be more strongly expressed in the KLOEs generally.
- Giving sufficient weight or importance to the Mental Capacity Act and Deprivation of Liberty Safeguards in what good looks like and applying limiters if necessary received the most positive responses from people.

Our response

We are aware of the need for improvements in training and awareness across the sector. Guidance about both the Mental Capacity Act in general and the Deprivation of Liberties Safeguards in particular is available on our website and to our own staff. We have also published a briefing note on the recent High Court Judgement to explain its impact and implications for providers. This guidance is being reviewed and will be improved.

The CQC Academy is currently developing new training for our own staff about the Act and the Deprivation of Liberty Safeguards.

We have added expanded and clearer Mental Capacity Act and Deprivation of Liberty Safeguards related content to the 'effective' key question, and boosted the clarity of human rights related KLOEs in general as part of the improvement work we undertook in the light of this consultation and our testing activity. This included ensuring that good practice in this context is an important part of the ratings characteristics for a good service. We will not make it a limiter on ratings.

Covert surveillance and mystery shoppers

What we said in our consultation

We said that we wanted to have an open dialogue about the use of hidden cameras within adult social care regulation, both in terms of whether families with concerns about their loved ones should install them and whether CQC should consider using them. The same applies to consideration of using mystery shoppers to check on the quality of care provided.

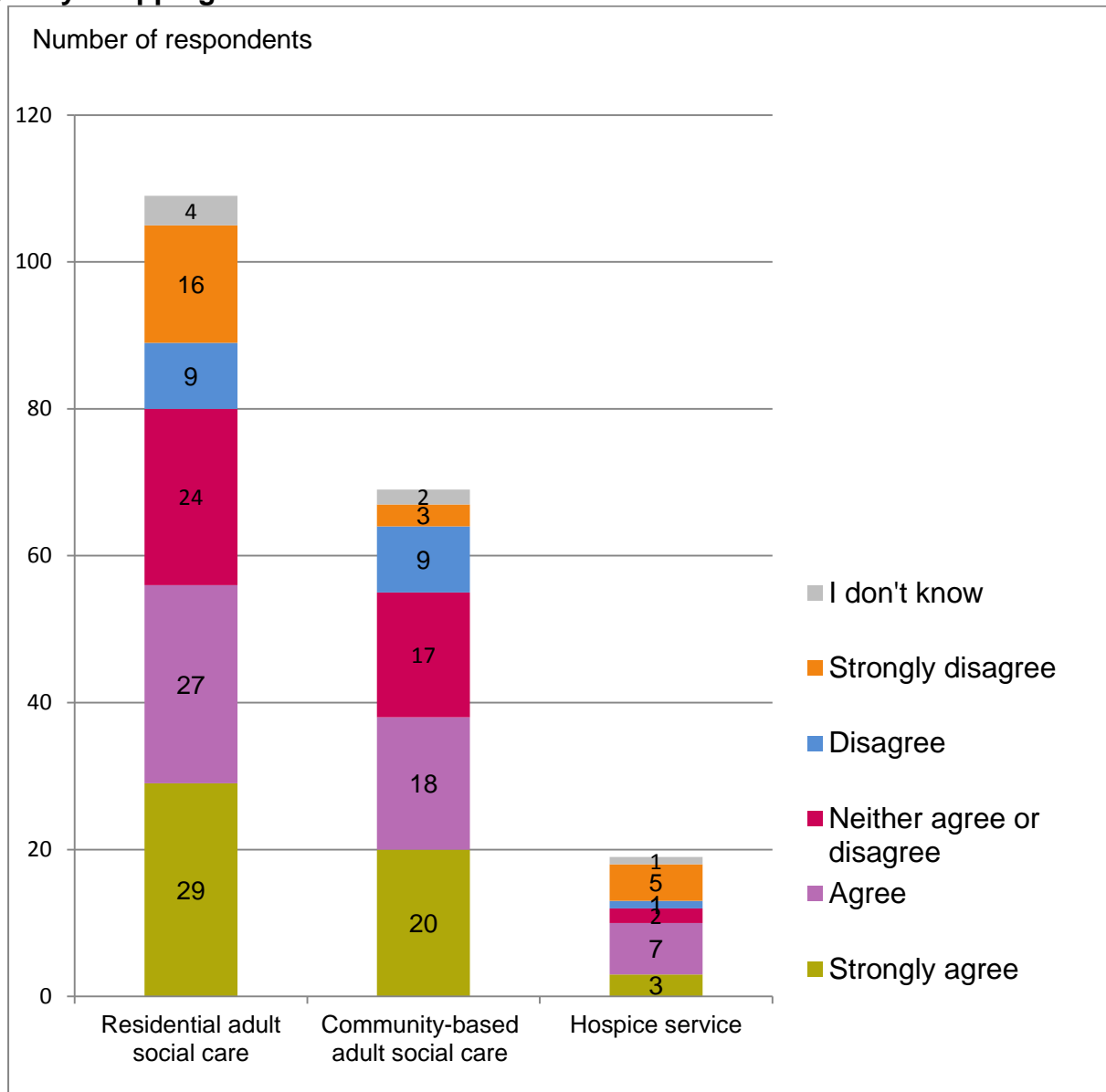
Consultation questions

- Is it the role of CQC to undertake covert surveillance and mystery shopping?
- If so, when is covert surveillance justified?
- Would mystery shopping improve CQC's ability to assess the quality of care?

What you said

- There were hugely mixed views from those responding online about whether CQC should carry out surveillance activity (as shown in the chart below). Generally, however, people agreed this was an area of concern that required further thought. At the round table people also expressed a wide range of opinions. It was clear there was no consensus on this issue.

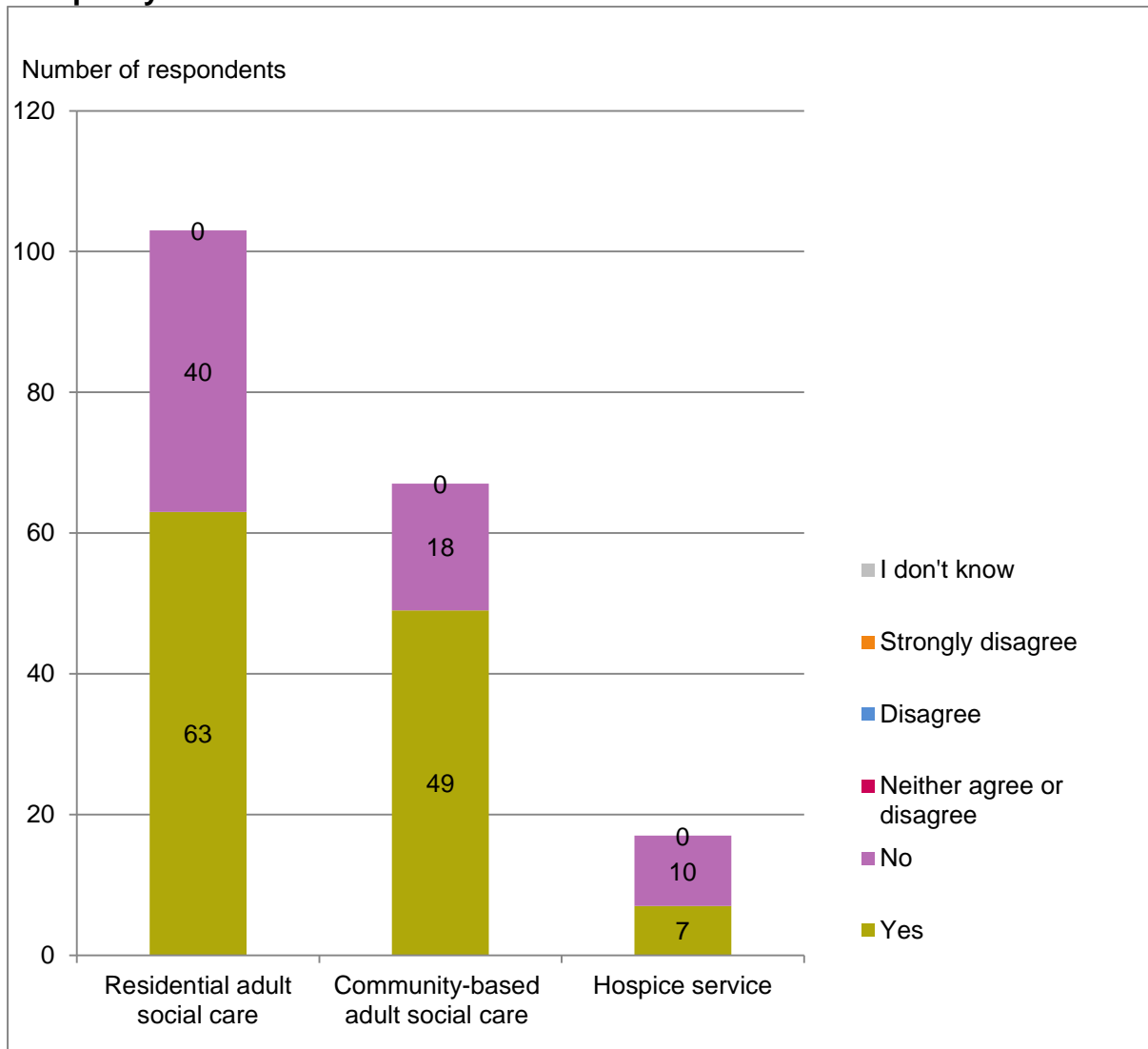
Online responses: Is it the role of CQC to undertake covert surveillance and mystery shopping?



- Participants in the CQC round table discussions thought covert surveillance should be used as the last resort, guidance would need to be produced, and safeguarding measures would need to be in place. They also suggested that CQC had greater powers than any other body to carry out mystery shopping, as CQC could visit services anytime.
- A number of organisations did not believe that covert surveillance is a job for the CQC but for the police and safeguarding committees.
- There was no support for the use of covert surveillance to monitor hospice services.
- There was a mixed response from those submitting written responses to the use of mystery shoppers and some respondents stressed the importance of more dialogue with relatives, families and carers.

- There was particular concern about the use of mystery shoppers in relation to children’s hospice services.
- The chart below shows that there were also mixed views online, particularly in residential care, about whether mystery shoppers would improve CQC’s ability to check the quality of care, although the majority are in favour of their use.

Online responses: Would mystery shopping improve CQC’s ability to assess the quality of care?



Our response

There are clearly complex issues to understand in relation to both the use of surveillance (such as covert and overt recording technologies) and alternative and covert methods of gathering information (such as mystery shopping).

From our consultation on this issue, we came to several conclusions:

- Covert surveillance and mystery shopping are potentially useful and powerful tools which, in some circumstances, will be an effective way to uncover information about the quality and safety of care that may otherwise not be available. They are tools that should be available to CQC to use.
- Any use of covert surveillance or mystery shoppers by CQC must be carefully considered and properly authorised, as required by law. We should not use these techniques where other, less intrusive, options are available.
- The use of surveillance techniques must be proportionate and considerate, particularly in relation to the potential impact it will have on people's rights to privacy and dignity.
- The use of surveillance – whether overt (such as CCTV) or covert – in health and social care services raises legal and ethical issues. This is especially the case in places where intimate care is being delivered, or where the care service is also a person's home. There is a need for additional guidance to assist providers and the public.
- Media attention and developing technology appear to be driving an increased use of covert surveillance (especially hidden cameras) among people who use services and their families.

We are developing guidance for providers, and for members of the public on the use of covert and overt surveillance to help them make decisions about their use.

CQC's overriding aim is to ensure that both providers and the public are well-informed in relation to surveillance and are better able to make decisions about the best possible outcomes for people using care services.

CQC is registered to authorise and carry out 'directed surveillance' and for the use of 'covert human intelligence sources' under the Regulation of Investigatory Powers Act 2000. To date, we have not used these powers but, as a result of the consultation, it is our intention to do so in future. We will use these powers where we consider that this is the best and most appropriate way to gather information, and where it is lawful and proportionate. We do not expect our use of these powers to be extensive or routine. We are revising and developing our policies and processes to ensure that any use of these powers is properly considered and authorised, and carried out in a way which is effective while minimising the impact on privacy.

Our Human Rights Approach

We consulted on our approach to human rights in our regulation of care services. We received 188 online responses and 11 written submissions from the public, providers, commissioners, CQC staff, health and social care professionals and national stakeholders.

What we said in our consultation

We believe that our human rights-based approach to regulation, inspection and monitoring care services is the best method to ensure that we promote equality and human rights in our work. We have integrated the human rights principles into our key lines of enquiry (KLOEs), ratings descriptors, Intelligent Monitoring, inspection methods, learning and development for inspection teams and into our policies around judgement making and enforcement. Our human rights approach to regulation looks at a set of human rights principles – fairness, respect, equality, dignity, autonomy, right to life and rights for staff – in relation to the five key questions we ask.

Our approach will ensure that we meet our duties under the Human Rights Act 1998 to respect, protect and fulfil people's human rights, and under the Equality Act 2010 to have due regard, when delivering our functions, to the need to eliminate discrimination, advance equality of opportunity, and foster good relations between groups in relation to the 'protected characteristics' of age, disability, gender reassignment, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

Respecting diversity, promoting equality and ensuring human rights will mean that everyone using health and social care services receives good quality care.

Consultation questions

- Do you think our strategy for integrating human rights into the way we inspect, monitor and regulate services is the right approach? Are any changes needed?
- Do you think we have selected the right 'set' of human rights principles?
- Do you think the definitions of each human rights principle is the right one? Are any changes needed?
- Are any changes needed to our human rights topics list?
- Do you have any comments on how we propose to:
 - Identify risks to human rights?
 - Inspect for human rights?
 - Provide learning and development on human rights for our registration and inspection teams?
- Are there other ways that we should apply our human rights approach?
- Are our principles for applying our human rights approach the right ones?
- Are there any other ways we can help to encourage improvement in equality and human rights for people who receive care?
- How should we evaluate the success of our human rights approach?
- Would you like to be involved in the development of our human rights approach in the future? How should we involve people who use services, the public, providers and other stakeholders in the development of our human rights approach?
- Do you have any other comments about our human rights approach?

What you said

- The majority of online respondents (92%), as well as responses from written submissions and the broader consultation, agreed that our strategy is the right approach on human rights. However, there were still concerns that it was being viewed as an 'optional extra' and that it should also include factors such as socioeconomic deprivation.
- Other changes suggested included putting the focus on outcomes for people who use services, and making it explicit that our approach includes children and young people as well as adults.

- Nearly all online respondents (94%) agreed that we have selected the right set of human rights. In addition to fairness, respect, equality, dignity, and autonomy (FREDA), and right to life and staff rights, some felt that it was also important to add 'personalisation' and 'empowerment'.
- Again, 94% of online respondents agreed that the definition of each human rights principle is the right one.
- There was support for our human rights list of topics, but one person suggested that services users will need to be proactively supported to make sure they have the 'right to freedom of expression' in creative and person-centred ways.
- Overall, respondents were supportive of how we proposed to identify risks and inspect for human rights, as well as our plans for training and development of our registration and inspection teams. One charity, however, was concerned about how we would monitor human rights related risks and when any risks identified merit further inspection.
- Nearly all online respondents (95%) agreed that our principles for applying our human rights approach were the right ones.
- Half of all online respondents (51%), and a number of organisations submitting written responses, said that they would like to be involved in the development of the human rights approach in the future. Focus groups, surveys, and public meetings were some of the suggestions made for gathering information.

Our response

We have:

- Made some minor changes to the definitions of our human rights principles, based on consultation feedback, and confirmed that 'personalisation' is part of the autonomy principle and that our 'equality' principle includes multiple discrimination or disadvantage.
- Explained the relationship between the human rights approach and work on health inequalities.
- Added more about children's rights.
- Confirmed that we will carry out work to look at 'triggers' for when risks to human rights should prompt a responsive inspection.
- Added a new section about communicating our human rights approach to providers, people who use services and others
- Added more about how we will evaluate our human rights approach, based on consultation feedback. We have also added all the respondents who were interested in being involved in the development of the approach to a database, so that we can let them know about future opportunities to be involved in this work.

Regulatory impact assessment and equality and human rights impact analysis

We also published an interim regulatory impact assessment and an equality impact analysis for this consultation on our proposed provider handbooks.

Regulatory impact assessment

What you said

- We received a small number of responses about our interim regulatory impact assessment for adult social care providers. The feedback, which was positive, included a view that the additional resources for more thorough inspections and greater use of the views of people who use services are welcome.

Our response

We have published our final regulatory impact assessment, alongside this consultation response and the final provider handbooks, providing more information about our view of the costs and benefits of our new inspection model.

Equality and human impact analysis

What you said

- In general, respondents were supportive of our approach to equality and human rights impact analysis. Where concerns were raised, these were around: making sure the approach was strong enough to deal with denial by providers; the amount of work for some providers, and the issue of training for staff.

Our response

Our approach to inspecting adult social care continues to draw on our overall human rights approach described in the consultation handbook equality and human impact analysis. Our pilots successfully tested the new person-centred approach described in the consultation document and we will continue to use these methods.

We have built on and strengthened the human rights elements from the consultation feedback and threaded this through our new methodology. We have further embedded the human rights principles into our key lines of enquiry. And we have carried this through into the training for inspectors to make sure the core human rights principles are a key part of their inspection of adult social care services.

A number of issues highlighted in the equality and human impact analysis needed to be resolved because of their potential to impact negatively on equality and human rights. We have successfully addressed most of these areas as follows:

1. A need to ensure that our Intelligent Monitoring measures for adult social care services cover key human rights topics.

We have added more detailed questions in our tools to strengthen the intelligence we gather. For example, at pre-inspection stage we gather more relevant information on the Mental Capacity Act and Deprivation of Liberty Safeguards, death notices, complaints, equality and diversity than before.

2. For many equality and human rights topics, the only source of evidence is the views and experiences of people using the service or people close to them, but many people using adult social care services face barriers in expressing or giving their views to CQC.

We have introduced a new questionnaire process that seeks to overcome some of those barriers for people who use community services and are isolated in their own homes. Questions are asked from a human rights perspective and are sent to relatives and friends as well as people using the service. Questionnaires are also available in easy read format and a number of different languages. Additionally, telephone calls capture the views of those unable to complete questionnaires, with an option to speak to a relative or friend if the person prefers.

For residential services we continue to use the Short Observational Framework for Inspection, and have increased our use of observation generally. We work more regularly with specialist advisors and Experts by Experience with relevant specialisms, for example, in dementia care.

3. We need to ensure appropriate weight is given to the evidence and views of all members of inspection teams – inspectors, Experts by Experience (ExE) and specialists.

During the pilot, Experts by Experience and specialist advisors were seen as an integral part of the inspection team involved in the end to end process. We continue our focus on making sure that their involvement in inspections continues to far exceed that of the previous approach.

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

National charities

Action against Medical Accidents (AvMA)	Marie Curie
Action on Hearing Loss	Mencap
Alzheimer's Society	Mind
Alzheimer's Society – Community Health	National Aids Trust
Alzheimer's Society – NHS Acute Hospital	National Children's Bureau
Autism Alliance	Parkinsons UK
Big Brother Watch	Patients Association
Bliss	Positive Signs
Brap	Public Concern at Work
Carers UK	Relatives and Residents Association
Carers UK - Community Health Services	RNIB
Carers UK - NHS Acute Hospitals	RNID
Children's Rights Alliance for England	Scope
Diabetes UK	Sense
The Disabilities Trust	Shared Lives Plus
Independent Age	SIGN Health
The Lesbian and Gay Foundation	Stonewall
LGB&T Partnership	Together for Short Lives
Macmillan	Women's Health and Equality Consortium

Professional representatives

BMA – NHS Acute Hospitals	Royal College of Paediatrics and Child Health
British Psychological Society	Royal College of Physicians
Foundation Trust Network	Royal College of Physicians - Edinburgh
Medical Defence Union	Royal College of Psychiatrists
Medical Protection Society	Royal College of Radiologists
Royal College of Anaesthetists	Royal College of Surgeons
Royal College of General Practitioners	Royal Pharmaceutical Society
Royal College of Nursing	Society and College of Radiographers
Royal College of Obstetricians and Gynaecologists	

Strategic partners

Association of Directors of Adult Social Services	Local Government Ombudsman
Department of Health	National Institute for Health and Care Excellence
Department of Health Citizen Insight Team	NHS England
Equality and Human Rights Commission	NHS England – Director of Nursing
General Medical Council	Parliamentary and Health Service Ombudsman
Health and Safety Executive	Public Health England
HMIP	Social Care Institute for Excellence
Local Government Association	Skills for Care
	UKAS

Trade associations

Associated Retirement Community Operators	NHS Clinical Commissioners (NHSCC)
British Medical Association	NHS Confederation
Care England	Registered Care Providers Association
Help for Hospices	Registered Nursing Homes Association
Independent Mental Health Service Alliance	UK Homecare Association
National Care Forum	VODG
Natspec	

Think tanks

Diabetes Think-tank
Health Foundation

Other organisations

Committee of Directors of Postgraduate Education
Director of Postgraduate Education HEE
Gold Standards Framework
LaingBuisson
My Home Life
National Clinical Assessment Service
NHS London Leadership Academy

Appendix B: Consultation engagement events for people who use services, providers and staff and responses

Events for people who use services

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

Events for providers of adult social care services

- 25 April, Manchester – 49 participants
- 1 May, Leeds – 54 participants
- 6 May, London – 37 participants
- 13 May, Nottingham – 33 participants
- 20 May, Bristol – 47 participants
- 23 May, London – 45 participants
- 28 May, Birmingham – 45 participants
- 3 June, Bury St Edmunds – 42 participants

Events for CQC staff

- 13 May, Nottingham – 15 participants
- 19 May, Newcastle – 23 participants
- 20 May, Bristol – 22 participants
- 23 May, London – 44 participants
- 28 May, Birmingham – 40 participants
- 3 June, Bury St Edmunds – 35 participants
- 3 June, Manchester – 17 participants

Responses received

The number of responses to the consultation received on our website was:

- Residential adult social care – 112
- Community-based adult social care – 74
- Hospice services – 22

As well as the forms completed online, we received 175 written submissions referring to adult social care services. There is a list of organisations submitting responses in appendix A.