Consultation

Our approach to regulating:

NHS 111 services

February 2015

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.

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Appendix A: Key lines of enquiry
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Foreword

NHS 111 is an important part of the urgent care system. It provides healthcare advice and information to people over the telephone. It is aimed at people with urgent but not emergency needs, and directs them to other services where appropriate. NHS 111 services were fully introduced in 2014, however some of the organisations providing the NHS 111 services have since faced some scrutiny over the quality and safety of their services.

In October 2014, we published our provider handbook for NHS GP practices and GP out-of-hours services, and we have recently consulted on our approach to inspecting ambulance services. This document builds on the approach that we developed for those services, and sets out our approach to regulating and inspecting NHS 111 services.

The way that NHS urgent and emergency care is delivered in England is changing in response to NHS England's comprehensive review, and the *Five Year Forward View* recently set out further proposals for change. These are important developments for people with urgent needs. CQC will continue to work closely with NHS England and providers of urgent care as we develop our approach to inspecting these services.

We have worked closely with providers and stakeholders to develop this guidance, and we will continue to do so while we test it during our inspections.

This consultation asks a number of specific questions and we urge you to respond to these, and any other issues relating to our proposed approach.

This consultation focuses on our approach to inspecting NHS 111 services. In the longer term, we plan to look at the quality of all urgent care services within a local area and we want to understand how well they work together to provide care to people with urgent needs.

Your views are important and matter to us. Thank you for responding.

Professor Steve Field CBE FRCP FFPHM FRCGP
Chief Inspector of General Practice

Professor Sir Mike Richards
Chief Inspector of Hospitals

1. This consultation

What is NHS 111?

NHS 111 is a telephone-based service that aims to make it easier for people to access local NHS healthcare services in England. It is used when urgent medical help is required, but when this is not a 999 emergency.

NHS 111 services are staffed by teams of trained advisers who use NHS Pathways clinical decision support software and are supported by experienced nurses and paramedics. They ask questions to assess symptoms, then either give healthcare advice or direct callers to the most appropriate local service that can best help. That could be A&E, an out-of-hours doctor, an urgent care centre or walk-in centre, a community nurse, an emergency dentist or a late-opening chemist. When calls are more complex or require further clinical assessment they are put through to NHS 111 clinical advisors (who are nurses or paramedics). Around 25% of calls are handled in this way.

NHS 111 teams book appointments for callers and notify the receiving organisation by an electronic message. NHS 111 is available 24 hours a day, 365 days a year.

The proposals in this consultation relate only to NHS 111 services. These are all currently provided by NHS ambulance trusts or GP out-of-hours providers.

Why we are consulting

It is important that our new regulatory model assures patients and the public that they will receive the same standards of care across all services. We also need to ensure that our inspection methods proportionately reflect the differences between different types of providers, so that they do not experience a ‘one size fits all’ approach.

To achieve this, we have committed to align as many elements as possible of our new model for NHS 111 services with our model for other sectors, including hospitals, GP practices and GP out-of-hours services. It is important that we treat providers equally when they deliver similar types of services, but at the same time, we must ensure that we tailor our approach to each sector and type of service where there are differences that we need to take into account.

In April 2014, we consulted on our provider handbook for GP practices and GP out-of-hours services, which we published in October 2014. We have also recently consulted on our provider handbook for ambulance services. These handbooks describe in detail our approach to regulating, inspecting and rating services. The approach we set out in the handbook for GPs and GP out-of-hours services will also largely apply to NHS 111 services.

In section 4 of this consultation document, we have set out the aspects of our approach that we think should remain consistent across our inspections of NHS 111 services, irrespective of the type of provider providing the service. We are seeking views about whether we have judged those correctly.

In this consultation, we are not seeking feedback on our approach to other urgent care settings, for example, urgent care centres, walk-in centres or minor injuries units. We are already inspecting these services using our existing approaches for inspecting acute hospitals, community health services and primary care services. Where urgent care services are provided by NHS acute hospitals, they are inspected and rated as part of the urgent and emergency care core service. To support inspections of these services we will develop additional guidance, which any inspection team can use when inspecting urgent care services – irrespective of the type of provider.

In the longer term, we aim to inspect the integrated urgent care system within a local area. We are developing an approach that will assess how well care is integrated across health economies, focusing on the extent to which people receive high quality, caring and responsive services when moving within and across provider and sector boundaries. This approach will provide the framework for examining how urgent care services work together within local areas. We are working with providers of urgent care services, patient representatives and national stakeholders to develop how we do this and we intend to begin piloting this approach from September 2015.

2. Our approach to regulating and inspecting NHS 111 services

Our consultation, *A New Start* set out the principles that guide how CQC will inspect and regulate all care services. It set out our new overall operating model, which includes:

- Registering those that apply to CQC to provide services.
- Intelligent use of data, evidence and information to monitor services.
- Using feedback from patients and the public to inform our judgements about services.
- Inspections carried out by experts.
- Information for the public on our judgements about care quality, including a rating to help people chose services.
- The action we take to require improvements and, where necessary, the action we take to make sure those responsible for poor care are held accountable for it.

When we monitor, inspect and regulate care we want to make sure that we look at the things that matter to the people who use them and that their interests are at the heart of the five key questions we ask about the quality and safety – are services:

- Safe?
- Effective?
- Caring?
- Responsive to people's needs, and
- Well-led?

Inspections of NHS 111 services

Main features of the approach:

- The same framework of the five key questions, key lines of enquiry and prompts as for GP practices and GP out-of-hours services, with minor changes to ensure they are appropriate for NHS 111 services.
- An inspection team comprised of our expert inspectors and clinical and other experts.
- The use of information, including people's experiences of care, to decide when, where and what to inspect.

- A programme of scheduled, comprehensive inspections, alongside focused inspections that are responsive to concerns, target particular issues, or update information about services in between comprehensive inspections.
- A rating for NHS 111 services using the same principles and similar characteristics of care to inform our judgements. The characteristics have been amended slightly to make them appropriate for NHS 111 services. The overall rating for a NHS 111 service will be awarded at the level of the service being inspected.

We will inspect and rate all NHS 111 services by September 2016. Thereafter, the frequency of rating will be at least once every three years.

Piloting and evaluation of our approach

From March 2015, we will pilot this approach through the inspections of three NHS 111 providers. We have selected providers of different sizes and types, and in different parts of the country, to enable us to test our approach in a range of different settings.

We developed this approach by working with representatives from the NHS 111 sector.

Following the pilot inspections, we will evaluate the effectiveness of this inspection approach, from the pre-inspection period through to publication of the final report. We will use a variety of methods to evaluate this with our inspection teams and the providers involved in the testing. We will make final adjustments at the end of our testing in April and May 2015, and intend to roll out the approach for all NHS 111 providers from June 2015. We will not publish ratings of those providers inspected in our testing phase, but we will test our ability to rate.

How we will listen to people's views

NHS 111 services are provided over the phone and there are unlikely to be people who use services in the locations when we visit on our inspection. As such, we need to adapt the approaches we take to gathering the views from people who use services.

Pre-inspection

We will ask providers to use their existing channels to communicate with people who have used their services to tell them about the upcoming inspection and encourage them to share their experiences of the service with CQC using our online Share Your Experience form. Providers could use communications channels such as the telephony system that they use to the handle NHS 111 calls (for example, messaging could be relayed during call waiting, at the immediate conclusion of calls, or using a call-back service), and any email, digital and social media channels that they may own.

We will promote the inspection and issue a 'call to action' for people to share their experiences of the service with CQC to local Healthwatch, clinical commissioning groups, councils and community and voluntary groups. We will also ask these organisations and groups to use their own channels to promote the inspection to the local population served by the NHS 111 service. We will particularly make use of local community and voluntary groups to ensure we promote the inspection to people who are hard to reach and vulnerable because of their circumstances.

We will pilot the use of social media to promote the inspection of NHS 111 services to the populations they serve by a call to action for people to tell us about their care through our Share Your Experience form.

Where we have specific intelligence that indicates potential concerns with a particular population group served by the NHS 111 service, we will use bespoke engagement activities (for example, focus groups) to support us to explore these issues in more depth.

On inspection

We will ask the provider to enable our inspection team to speak with a random sample of people who contact the NHS 111 service during the course of the inspection. This will be through telephone calls.

Consultation question 1

1. Do you agree with our proposed approach for regulating NHS 111 services? Yes / No

- How do you suggest we gather people's views of NHS 111 services?
- Are there other things we could take into account?

3. Registration

Before a provider can begin to provide services, they must apply to CQC for registration and satisfy us that they are meeting a number of registration requirements.

Registration assesses whether all new providers, whether they are organisations, individuals or partnerships, have the capability, capacity, resources and leadership skills to meet relevant legal requirements, and are therefore likely to demonstrate that they will provide people with safe, effective, caring, responsive and high-quality care.

The separate appendices to this handbook will allow registration inspectors to gather and consider comprehensive information about proposed applicants and the services they intend to provide, including where providers are varying their existing registration, and make judgements about whether applicants are likely to meet these legal requirements.

Judgements are about, for example, the fitness and suitability of applicants; the skills, qualifications, experience and numbers of key individuals and other staff; the size, layout and design of premises; the quality and likely effectiveness of key policies, systems and procedures; governance and decision-making arrangements; and the extent to which providers and managers understand them and will use them in practice.

These judgements will not stifle innovation or discourage good providers of care services, but ensure that those most likely to provide poor quality services are discouraged and prevented from doing so.

4. Specific approach for NHS 111 services

We consulted in April 2014 on our handbook for NHS GP practices and GP out-of-hours services and published the final handbook in October 2014. The handbook describes in detail our approach to regulating, inspecting and rating NHS GP practices and GP out-of-hours services. It includes our key lines of enquiry (KLOEs) that will direct the focus of the inspections and the characteristics of care at the four rating levels as they apply to these services.

All the handbooks we have developed ensure a common approach across all services. This consultation is focused on where this common approach should be applied and, where necessary, adapted for NHS 111 providers. This is to ensure that our approach to these providers is consistent whoever provides the service.

We think the following aspects of our approach need to be adapted to reflect the nature of NHS 111 services:

- We have made some minor changes to the KLOEs and prompts that inspection teams will use to help gather evidence – see the separate appendix A. Although will focus on the same five key questions (safe, effective, caring, responsive and well-led), we have adapted some of the prompts that support the KLOEs. This is to reflect the nature of NHS 111 services, which do not provide face-to–face care. Although these differences are minimal, we are seeking comments on them as part of this consultation – they will form the basis of our assessment and ratings of NHS 111 services. The differences are highlighted in grey in the appendix.
- When we inspect NHS GP practices we focus our inspections on six key population groups and we also give a rating for each group. We do not do this for NHS GP out-of-hours services because they do not have ongoing responsibilities for their population in the same way that GP practices do. We are therefore proposing that we do not rate the six key population groups in our inspections of NHS 111 services for the same reason that we do not do this for GP out-of-hours services.
- We will adjust the size and composition of the inspection teams, and the time needed on site during the visit. For example, depending on how many locations a NHS 111 service provider has. We will also consider whether to use Experts by Experience. We will request information from providers ahead of our inspection. This will include information about recent complaints, adverse events, and safeguarding referrals, as well as staffing numbers. We will also include analysis of service data in our pre-inspection planning, which may include NHS 111 Minimum Data Set (NHS England) and Intelligent Data Tool (Health and Social Care Information Centre).
- Before all of our inspections, we liaise with key local organisations such as commissioners of services. We recognise that NHS 111 services often

provide services across large geographical areas and as a result are commissioned by multiple clinical commissioning groups (CCGs) and NHS England Area Teams. Therefore, we will test the way in which we liaise with commissioners before and after inspections and, where required, we will work with the lead commissioner of the service.

- We will consider different methods for assessing the quality of care provided by NHS 111 services. Because these services are provided over the phone, with no face-to-face care or treatment provided, we are considering the ways in which we will observe these services, and gather evidence about the quality of care they provide. We want to seek views on the most appropriate methods and how we should test this in our inspections.

We would value your views on whether it is appropriate that these aspects are different.

Consultation question 2

2. Our inspections ask five key questions that aim to assure the public on how safe, effective, caring, responsive and well-led services are.

Do you agree that our proposed approach will do this for NHS 111 providers? Yes / No

- Are the KLOEs, prompts, and ratings characteristics in the appendices appropriate for inspecting NHS 111 services? Yes / No
- If not, what is missing or needs to change?
- What do you consider to be the best ways that we can observe NHS 111 services and gather evidence about the quality of care they provide?

Consultation question 3

3. We propose not to rate NHS 111 services for the six population groups and only focus on the five key questions.

Do you agree with this approach? Yes / No

5. Inspecting and rating combined providers

NHS 111 services are provided by organisations that also provide other health or care services, for example NHS ambulance trusts or providers of GP out-of-hours services.

CQC has developed a tailored approach to inspecting different types of health and social care services. We recognise that many providers have a wide range of services that will sit in more than one of our inspection approaches. NHS trusts are the most common example of this type of provider. Others include large social enterprises that provide a range of services to a local population, or an independent health provider with a range of services at one of its locations. Where such arrangements exist and the range of services are either provided from one location or to a local population, we want to assess how well quality is managed across the range of services and give ratings for the provider or the location that reflect this. Therefore, when we inspect, we use our different approaches in combination to reflect the range of services that are provided.

Our overall aims in these circumstances are to:

- Deliver a comparable assessment of the five key questions for each type of service, whether it is inspected on its own or as part of a combined provider.
- At provider or location level, assess how well quality and risks are managed across the range of services provided.
- Generate ratings and publish reports in a way that is meaningful to the public and people who use services, the provider and to our partners.
- Be proportionate and flexible to reflect the way the services are provided and consider any benefits derived from service integration.
- Use appropriate methods and an inspection team with the relevant expertise to assess the services provided.
- Wherever possible, align steps throughout the inspection process in order to minimise the burden on providers.

Because NHS 111 services are provided by a number of different types of organisations, we will often use our combined provider approach when we inspect them. This means that in some cases we will need to adapt the methodology to reflect the type of provider.

For example, where the provider of an NHS 111 service is an ambulance trust, we will need to align the process and the methodology with our approach to inspecting ambulance trusts. While this may mean that some aspects of our approach may vary across NHS 111 services, our view is that this is preferable and will ensure that we can look at all services that an organisation provides at

one time, rather than inspecting just some of the services it provides. This will also enable us to look at how the NHS 111 service works with the provider's other services. The assessment framework we use will not vary – we will always use the KLOEs and prompts for NHS 111 services and will always use specialist inspectors supported by experts in NHS 111 services. This will ensure that we reach comparable judgements and ratings about these services.

The aspect of the approach that is most likely to vary is the notice period for inspections. For example, where the provider of an NHS 111 service is an ambulance provider, we will use our approach to inspecting ambulance trusts, and give 12 weeks' notice of the inspection. Where the provider of an NHS 111 service is a GP out-of-hours service, our approach is to give them six weeks' notice of their inspection. This difference is due to the level of information we request from the two types of provider before the inspection. This will mean that the notice period for inspections will vary depending on the type of provider of the NHS 111 service.

Rating combined providers

We intend to rate each NHS 111 at service level: this is the most appropriate way to provide ratings and report in a way that is meaningful to the public and people who use services. In ambulance trusts, the NHS 111 service will be rated in the same way as a 'core service', and the rating will be included in the aggregation of ratings up to the overall trust rating. When we inspect an NHS 111 service in a provider that also provides GP out-of-hours services, we intend to rate the NHS 111 service separately to the GP out-of-hours service. We do not intend to aggregate these ratings to an overall provider rating. We will test this approach in our pilot inspections.

Consultation question 4

4. Where a provider delivers an NHS 111 service as well as other services, we believe that it is preferable to inspect the NHS 111 service during our inspection of that provider's other services using our combined provider approach.

Do you agree with this approach? Yes / No

- How do you suggest we develop our approach to inspecting combined providers in this sector?

6. Enforcement and actions

Types of action and enforcement (under existing regulations)

Where we have identified concerns with a service, we decide the appropriate action to take. The action we take is proportionate to the impact or risk of impact that the concern has on the people who use the service and how serious it is.

Where the concern is linked to a breach in regulations, we have a wide range of enforcement powers given to us by the Health and Social Care Act 2008.

We use Warning Notices to tell providers that they are not complying with a condition of registration, a requirement in the Act or a regulation, or any other legal requirement that we think is relevant.

Our enforcement policy describes our powers in detail and our general approach to using them.

We may also make recommendations, even when a regulation has not been breached, to help a provider improve and move to a higher rating.

We include in our published report any concerns, recommended improvements or enforcement action taken, and we expect the provider and local partners to take appropriate action.

We follow up any concerns or enforcement action we take. If the necessary changes and improvements are not made, we can escalate our response, gathering further information through a focused inspection. However, we always consider each case on its own merit and we do not rigidly apply the enforcement rules when another action may be more appropriate.

Relationship with the new regulations and fundamental standards

The Department of Health is introducing new regulations to replace the current registration requirements. The new regulations, which include 'fundamental standards', are more focused and clear about the care that people should expect to receive. These regulations will come into force on 1 April 2015. Until that time, we will continue to enforce against the existing regulations.

We have published guidance to help providers to understand how they can meet the new regulations and, when they do not, what actions CQC will take. The final version of this handbook will reflect the new regulations. The guidance is published on our website: www.cqc.org.uk/regulationsguidance.

New requirements

Two new requirements, the fit and proper person requirement for directors and the duty of candour, have applied from late 2014 to NHS bodies (NHS trusts, NHS foundation trusts and special health authorities), and will apply to all other providers from April 2015.

The fit and proper person requirement will play a major part in ensuring the accountability of directors (or their equivalents) of NHS bodies and all other registered providers, and will place a clear duty on health and social care providers to make sure directors and board members (or their equivalents, including interim post holders) meet the criteria set out.

The new statutory duty of candour will mean that people and, where appropriate their families, must be told openly and honestly when unanticipated things happen, which cause them serious or moderate harm. They should receive an apology, an explanation, all necessary practical and emotional support, and assurances about their continuity of care.

This statutory duty on organisations supplements the current contractual duty of candour under the NHS standard contract and the existing professional duty of candour on individuals. We will be considering this statutory duty as part of our assessment.

The Government is also introducing a new regulation that will require providers to conspicuously display their CQC ratings at their premises and on their website from April 2015. The aim of the regulation is to increase transparency about the quality of health and care services, encourage improvement and help people who use services to make choices about their care.

The Department of Health consulted on the new regulations in 2014. We have recently consulted on our guidance for providers about the requirement to display CQC ratings and on our proposed templates that providers can use. This guidance will be published soon.

Responding to inadequate care

As well as using our enforcement powers, CQC will also work with other organisations, including other regulators and commissioners, to make sure that action is taken on concerns that we identify, through our approach to special measures.

The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care do not continue to do so.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or direct providers to, other organisations in the system to ensure improvements are made.

- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to cancel their registration (or in the case of NHS trusts, look to others to take further action).

The details of these arrangements vary depending on the type of organisation that provides the service and we will publish guidance about the detail for each sector.

Challenging the evidence and ratings

We want to make sure that providers can raise legitimate concerns about the evidence we have used and the way we apply our ratings process, and have a fair and open way for resolving them.

The following routes are open to providers to challenge our judgements.

Factual accuracy check

When providers receive a copy of the draft inspection report (which will include their ratings), we invite them to provide feedback on its factual accuracy. They can challenge the accuracy and completeness of the evidence on which the ratings are based. Any factual accuracy comments that are upheld may result in a change to one or more rating. Providers/registered persons have 10 working days to review draft reports for factual accuracy and submit their comments to CQC.

Warning Notice representations

If we serve a Warning Notice, we give providers/registered persons the opportunity to make representations about the matters in the Notice. The content of the Notice will be informed by evidence about the breach, which is in the inspection report. This evidence will sometimes have also contributed to decisions about ratings. Therefore, as with the factual accuracy check, representations that are upheld that also have an impact on ratings may result in relevant ratings being amended.

Under our process for factual accuracy checks and representations about Warning Notices, unresolved issues can be escalated to managers in CQC who were not involved in the inspection.

Request for a rating review

We will test our ability to rate performance in our pilot inspections. When we fully implement our new inspection approach for NHS 111 services, we will rate them.

Providers can ask for a review of ratings.

The only grounds for requesting a review is that CQC did not follow the process for making ratings decisions and aggregating them (combined inspections).

Providers cannot request a review on the basis that they disagree with the judgements made by CQC, as such disagreements would have been dealt with through the factual accuracy checks and any representations about a Warning Notice if we served one.

Where a provider thinks that we have not followed the published process properly and wants to request a review of one or more of its ratings, it must tell us of its intention to do so once the report is published. We will reply with full instructions on how to request a review.

Providers will have a single opportunity to request a review of their inspection ratings. In the request for review form, providers must say which rating(s) they want to be reviewed and all relevant grounds. Where we do not uphold a request for review, providers cannot request a subsequent review of the ratings from the same inspection report.

When we receive a request for review we will explain on our website that the ratings in a published report are being reviewed.

The request for review process will be led by CQC staff who were not involved in the original inspection, with access to an independent reviewer.

We will send the outcome of the review to the provider following the final decision. Where a rating is changed as a result of a review, the report and ratings will be updated on our website as soon as possible. It should be noted that following the conclusion of the review, ratings can go down as well as up.

The review process is the final CQC process for challenging a rating. Providers can challenge our decisions elsewhere – for example, by complaining to the Parliamentary and Health Service Ombudsman or by applying for a judicial review.

Complaints about CQC

We aim to deal with all complaints about how we carry out our work, including complaints about members of our staff or people working for us, promptly and efficiently.

Complaints should be made to the person that the provider has been dealing with, because they will usually be the best person to resolve the matter. If the complainant feels unable to do this, or they have tried and were unsuccessful, they can call, email or write to us. Our contact details are on our website.

We will write back within three working days to say who will handle the complaint.

We'll try to resolve the complaint. The complainant will receive a response from us in writing within 15 working days saying what we have done, or plan to do, to put things right.

If the complainant is not happy with how we responded to the complaint, they must call, email or write to our Corporate Complaints Team within 20 days and tell us why they were unhappy with our response and what outcome they would like. The contact details are on our website.

The team will review the information about the complaint and the way we have handled it. In some cases we may ask another member of CQC staff or someone who is independent of CQC to investigate it further. If there is a more appropriate way to resolve the complaint, we will discuss and agree it with the complainant.

We will send the outcome of the review within 20 working days. If we need more time, we will write to explain the reason for the delay.

If the complainant is still unhappy with the outcome of the complaint, they can contact the Parliamentary and Health Service Ombudsman. Details of how to do this are on the Parliamentary and Health Service Ombudsman website.

Conclusion

We have been working hard to develop the new regulatory approaches for the NHS 111 sector.

We know there is more to do and we are grateful for the help and support that providers and numerous people have given us to jointly produce each new approach.

Whether you've helped us get this far or not, we are interested in hearing everyone's views. Please do take the time to respond.

Please also see the separate appendices document:

Appendix A: Key lines of enquiry

Appendix B: Characteristics of each rating level

Appendix C: Ratings principles

How to respond to this consultation

You can respond to our consultation in the following ways. Please send us your views and comments by **24 April 2015**.

Online

This is the quickest way to respond - use our online form at:

www.cqc.org.uk/nhs111consultation

By email

Email your response to:

CQCchanges.tellus@cqc.org.uk

By post

Write to us at:

CQC consultation: How we inspect, regulate and rate
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On the next page, we repeat the consultation questions we have asked throughout this document.

Consultation questions

1. Do you agree with our proposed approach for regulating NHS 111 services? Yes / No
   - How do you suggest we gather people's views of NHS 111 services?
   - Are there other things we could take into account?

2. Our inspections ask five key questions that aim to assure the public on how safe, effective, caring, responsive and well-led services are.

   Do you agree that our proposed approach will do this for NHS 111 providers? Yes / No
   - Are the KLOEs, prompts, and ratings characteristics in the appendices appropriate for inspecting NHS 111 services? Yes / No
   - If not, what is missing or needs to change?
   - What do you consider to be the best ways that we can observe NHS 111 services and gather evidence about the quality of care they provide?

3. We propose not to rate NHS 111 services for the six population groups and only focus on the five key questions.

   Do you agree with this approach? Yes / No

4. Where a provider delivers an NHS 111 service as well as other services, we believe that it is preferable to inspect the NHS 111 service during our inspection of that provider's other services using our combined provider approach.

   Do you agree with this approach? Yes / No
   - How do you suggest we develop our approach to inspecting combined providers in this sector?

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