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Shaping the future

CQC strategy consultation

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Between 25 January and 14 March 2016 the Care Quality Commission (CQC) consulted on its proposed strategy for 2016-2021. The consultation document *Shaping the future* described CQC's vision for regulation of the quality of health and adult social care services, and identified six themes that would be central to the delivery of the vision. The strategy proposals built on results from earlier engagement, which took place throughout 2015.

The consultation process included an online questionnaire as well as a series of consultation events hosted by CQC. There were 12 half-day events in various locations across England. Some of the events were for public participants; others were for care providers and/or strategic partners – including national sector organisations and other regulators. A total of 304 people participated in the consultation events.

The consultation questionnaire consisted of eight open questions of which six were preceded by a closed question seeking respondents' overall opinion of each theme of the proposed strategy. The total number of responses to the consultation was 768. Almost half of the responses were from care providers or professionals; more than 140 responses were from members of the public.

CQC also used other engagement methods to talk with the public, its staff and its external stakeholders, including targeted focus groups, online discussions and internal events. Outputs from these activities were included in the analysis.

The analysis of consultation responses and event notes, of which this report is the output, was conducted by OPM Group, an independent specialist company.

Findings

CQC's vision for quality regulation

CQC's vision underpinning the proposed strategy (as set out in the consultation document) was the subject of the first consultation question; it was not specifically addressed at consultation events. A clear majority of respondents (494 out of 573) indicated that they agreed with the vision. Respondents who made further supportive comments thought that CQC's implementation of the vision would improve outcomes for people who use services, as well as making the care sector more efficient and transparent. Another benefit that respondents associated with the vision was the potential for better collaboration within the care sector, supporting the drive for integration and new models of care.

Respondents citing specific reservations about CQC's vision included many of those who indicated overall support. They commonly agreed with the aspirations of the vision, but questioned whether CQC could realise its aims, especially given constraints of time and money. Some comments implied that the vision underestimated the magnitude of the challenge, with

respondents calling for detailed proposals as to how CQC's strategy would deal with the complexity of the health and social care sectors.

Respondents expressed concern that an unsuccessful or incomplete implementation of the vision would undermine beneficial outcomes for people who use services and providers, potentially affecting public trust in regulation and successful collaboration within the sector.

Respondents who commented on the vision's implications for those who work in the care sector were somewhat divided, with some crediting the vision with reducing the burden on providers or improving CQC's own use of resources, and others worrying that the vision would increase the regulatory burden for providers or require too much of CQC's resources.

Some respondents argued that the vision should be bolder or expand beyond its current scope, suggesting for example that it should state an aspiration for CQC to regulate commissioners or care services that are presently outside its remit. There were also calls for CQC to raise its own profile through communications with the public or by being more outspoken in its advocacy role.

Improving CQC's use of data and information

CQC's proposed strategy comprises six themes – the first of these is improving CQC's use of data and information. A clear majority of consultation respondents (454 out of 533) indicated that they agreed with CQC's proposal for this. Participants to the consultation events made generally supportive comments too.

Respondents commented that better use of data and information would assist CQC's ability to form balanced judgements of care providers and underpin its decisions, which they argued was instrumental to identifying and addressing risk. Event participants agreed that the proposal would help make CQC's decision-making more transparent, giving the public greater confidence in the regulation process.

It was important to consultation respondents that the views of people who use services (and their carers or representatives) would be part of CQC's assessment of providers. Some respondents thought the proposal would achieve that, others emphasised a need to enhance the collection and analysis of feedback from people who use services. Alongside other suggestions, respondents cited CQC's Expert by Experience programme as a suitable way of giving due prominence to the views of those who use care services.

Respondents thought that ideas about data sharing in CQC's proposal would benefit the care sector, potentially making the work of regulators, local authorities and national bodies more efficient. They commented that some practical challenges would need to be addressed for data sharing to have the desired impact. Respondents also made a range of suggestions as to who CQC should work with, and what these collaborations should look like.

Many respondents questioned whether data could be sufficiently relied on for assessing the quality of care. Consultation respondents as well as event participants highlighted issues with the accuracy of data from external sources and in particular information from providers' self-assessments. Respondents recommended that CQC addresses this risk by ensuring that its

assessments incorporate sufficient qualitative data, preferably including information obtained from inspection visits.

Another frequently voiced concern was that currently available data, systems and data collection methods would hamper CQC in its efforts use data effectively. Respondents thought that variations across the care sector would complicate CQC's task to draw meaningful conclusions from data, or expressed concern that the work involved in gathering and analysing data would be a drain on the organisation's resources. Other respondents thought the proposed approach risked increasing the administrative burden on providers.

Consultation respondents made various suggestions about specific data (sources) that might be appropriate for CQC to consider. Event participants were keen to see future approaches to using data and information operating in real-time and be extended to include commissioning data and indicators of risk such as mergers and senior staff changes.

Implementing a single shared view of quality

Implementing a single shared view of quality is another theme underpinning CQC's proposed strategy. A clear majority of consultation respondents (421 out of 509) indicated that they agreed with this proposal. While some participants in the consultation events thought the proposal was a good idea, others were less keen on a single shared view of quality.

Some consultation respondents as well as some event participants said that the proposal represented an opportunity to build a shared understanding of quality across the sector, which they thought would benefit the quality of care. Others expressed scepticism about the feasibility of the proposal, suggesting that different interpretations of quality would be hard to reconcile into a single view.

While some participants and respondents lauded the potential embodied in the proposal for closer collaboration between CQC, local authorities, commissioners, Healthwatch and other organisations, others thought this would be difficult to achieve. In particular, local authorities were seen as a possible obstacle as they were seen to define quality differently. Some respondents argued that the proposal would need to acknowledge the sector's complexity and variety and be flexible in order to be successful. Respondents also stressed that a single shared view of quality should not be synonymous with a basic level of quality, but encapsulate a drive for continuous improvement.

Respondents who made supportive comments about the proposal welcomed how the implementation of a single shared view of quality – if done in a collaborative manner – would empower providers to develop or improve their approach to monitoring quality. However, others expressed concern about the element of self-assessment comprised in the proposal, voicing doubt whether providers would always be forthright in acknowledging weaknesses in their record.

Respondents who thought the proposal would allow for more effective regulation through greater alignment and less duplication argued that this would benefit providers, as they would experience less bureaucracy. Respondents who made sceptical comments about the proposal

suggested the opposite, saying the approach could result in a greater burden on providers, as they would be required to take on greater responsibilities to assess their own performance.

Respondents and participants were also rather divided on whether a single shared view of quality would enhance clarity and transparency. Those who believed it would said that the proposal could help reduce confusion about how quality is measured and generate useful information for providers and the public. Those who thought it would not questioned whether the public would understand a shared view of quality. Some respondents were concerned that the proposed approach would not deliver tangible benefits for people who use services.

Targeting and tailoring CQC's inspection activity

Respondents and participants raised various points on the theme of targeting and tailoring CQC's inspection activity from CQC's proposed strategy. A clear majority of the consultation respondents (470 out of 584) indicated they agreed with the proposal. Many of them commented that the proposal would offer positive outcomes for people who use services, a sentiment that was echoed in comments at consultation events. Respondents generally welcomed the idea of targeting inspection activity based on risk, but some highlighted that the proposal lacked detail on how such an approach would work.

Some consultation respondents said that targeting and tailoring inspection activity would be effective at identifying and addressing risk through offering tailored support to struggling providers. Other respondents, as well as event participants, expressed concern that the proposal would increase the risk to people who use services as provider inspections would be less comprehensive. While those who supported the proposal argued that it would bolster public trust in the sector, others cautioned that public confidence depended on the reassurance offered by regular provider inspections.

Respondents thought the proposal would allow CQC to use its resources more efficiently and focus on providers that were more likely to require monitoring and support. They also welcomed that the approach would reduce the regulatory pressure on well-performing providers. However, participants and respondents said CQC should continue to regularly visit all providers, so that changes in their performance – positive or negative – would be recognised in a timely manner and trigger an appropriate response. While suggestions for the ideal inspection frequency varied, many respondents and participants agreed that an element of unannounced inspection activity (alongside scheduled inspections) would benefit the effectiveness of the regulatory regime, discouraging provider complacency.

According to respondents and participants, the proposal would offer opportunities to improve collaboration between CQC and partners, such as better data sharing and the tailoring of inspection activity for different sectors, especially adult social care. As in other themes, some respondents raised caution about relying on data too much, saying that shortcomings of the data could jeopardise the robustness of the approach. Respondents also emphasised the importance of using feedback from people who use services to inform the targeting and tailoring of inspections.

Developing a more flexible approach to registration

Another theme underpinning CQC's proposed strategy is developing a more flexible approach to registration. A clear majority of respondents (363 out of 438) indicated that they agreed with this proposal. Event participants made comments indicating general support. Consultation respondents welcomed the prospect of less bureaucracy and duplication, and thought streamlined registration for providers with a good track record was appropriate, particularly for administrative changes such as an office move.

Respondents thought that greater flexibility would encourage innovation in the sector and facilitate CQC's regulation of new models of care. Some suggested that reducing administrative barriers for providers with an excellent quality record would ultimately improve the quality of care services and benefit those who need them. Other respondents disagreed, saying that without sufficient scrutiny upon registration, unfit providers might operate for a relatively long time before CQC would intervene, and people who use such services would be exposed to poor care. Respondents warned that some providers might seek to exploit the flexibility of the registration process, emphasising a need for CQC to have appropriate safeguards in place.

Respondents and participants indicated that CQC could alleviate some hesitation about the proposal by providing greater detail about its implementation. For example, some suggested that the approach comprises sufficient direct contact between CQC's registration staff and providers registering new services, such as face-to-face interviews or visits to provider premises. They also suggested that CQC provides further guidance and support to providers and that the registration process also serves as a means to identify and share good practice.

Developing methods to assess quality for populations and across local areas

The final theme underpinning CQC's proposed strategy is developing methods to assess quality for populations and local areas. A clear majority of consultation respondents (479 out of 583) indicated that they agreed with the proposal. Participants to the consultation events also made predominantly supportive comments. However, support was sometimes qualified with questions about the feasibility of the proposal, as well as requests for greater detail on its implementation.

Participants and respondents thought the proposed approach would offer many benefits, such as helping to identify care needs and gaps in provision, providing insight into commissioning, holding local authorities and commissioners to account, and supporting the integration of services. Some identified particular benefits to people who use services, citing for example that the proposal would support a patient-based view of care and that people would be able to make more informed choices about their care.

While participants and respondents often agreed with the need for assessments focusing on places and populations, many were sceptical about how the proposal would achieve the benefits associated with such assessments. Respondents emphasised the complexity of the care landscape and thought that it would be difficult to collect and analyse data in such a way

that the resulting assessments would be accurate as well as meaningful. Some respondents questioned the merit or purpose of the proposed assessments altogether.

Consultation respondents as well as event participants wondered how CQC would use the information generated through the assessments, highlighting that it might be difficult to assign accountability or responsibility for a failing (local) care system. They thought that CQC might not have the appropriate powers to hold local authorities or commissioners to account, and worried that individual providers might be punished for issues outside their control. Several suggested that the assessments, as well as CQC's regulatory remit, should cover the quality of commissioning.

Other participants and respondents said they did not think CQC's remit justified carrying out assessments focusing on places and populations, suggesting that other organisations might be better placed. Many respondents highlighted the importance of CQC's role in regulating the quality of care delivered by individual providers, and expressed concern that proposed assessments would take resources away from what they considered the organisation's core activity.

Impact on equality and human rights

Roughly half of the respondents who expressed an overall view about the proposals' impact on equality and human rights said they would have a positive impact, while a very small number of respondents thought the impact would be negative. Most others thought there would not be a discernible impact either way. Some respondents who made specific comments said that that the draft impact assessment lacked detail or that achieving a positive impact would depend on successfully implementing the proposals outlined in the proposed strategy.

Introduction

This report summarises feedback received by the Care Quality Commission (CQC) as part of its formal consultation on *Shaping the future*, a document setting out the organisation's proposed strategy for 2016-2021.

The consultation process

CQC started conversations about its new strategy in March 2015 when it invited feedback on its proposals set out in a document also titled *Shaping the future*. This informed a second round of engagement, organised around the discussion document *Building on strong foundations.* Feedback from these engagement activities was incorporated in the strategy proposals that formed the basis of the formal consultation.

The consultation ran from 25 January to 14 March 2016. The consultation document described CQC's five-year vision for regulation of the quality of health and adult social care services, and identified six themes that would be central to the delivery of the vision.

The consultation document included eight open consultation questions, inviting respondents to comment on CQC's vision, five strategic themes and the impact of the proposals on equality and human rights. Six of the open questions were preceded by a closed question, asking respondents to indicate to what extent they agreed or disagreed with elements of the proposed strategy. The consultation did not include a question on the sixth theme, relating to CQC's work on the use of resources, as the commission plans to consult on this in a separate consultation.

CQC used a mix of engagement methods to talk with the public, health and social care organisations, individual health and social care professionals, commissioners of services and CQC staff. Engagement methods included written consultation through an online form, public and provider events across England, e-bulletin requests and online discussions. CQC also held targeted focus groups to listen to people in communities whose voices are sometimes not heard, as well as numerous internal meetings and events, which were attended by approximately 1,400 members of staff. Where available, outputs from engagement activity were included in the analysis.

CQC are using this summary report alongside the full response data so that they can pick up on essential details in individual consultation responses. While this report is specific to feedback received as part of the consultation, CQC will consider feedback received throughout the entire engagement process to produce its final strategy.

Collection and analysis of feedback

Consultation events

Between 25 and 29 January 2016, CQC organised a series of events as part of their consultation on *Shaping the future*, proposals for CQC's strategy 2016 to 2021. There were 12 half-day events in various locations across England. Some of the events were for public participants; others were for care providers and/or strategic partners. A total of 304 people participated in the consultation events.

At each event, participants had a number of table conversations chaired by a CQC facilitator. Each table conversation addressed a specific theme from CQC's vision for quality regulation, with prompting questions asking the participants to identify opportunities and benefits or challenges and barriers associated with the conversation theme.

The notes were captured on bespoke templates and then transcribed by CQC staff and submitted for independent analysis by OPM Group. A total of 95 table conversation transcripts were submitted and analysed. The analysis consisted of tagging comments with codes, so that related points could be reported on together and that no points would be missed out.

Readers should be aware that the findings in this section of the report are based on concise transcript notes provided by CQC to OPM Group. The purpose of the events was as much about raising awareness of the consultation and understanding of CQC's proposals as well as gaining feedback on specific theme areas.

Consultation responses

CQC provided an online form which respondents could use to submit their response to the consultation. Alongside this, there was a dedicated email address allowing for responses in different formats.

CQC also produced and commissioned summary notes from engagement activity during the consultation period, such as focus groups and staff events. These were submitted for analysis along with the consultation responses, and included in the response count.

The collection of responses was managed by CQC. The analysis of responses, of which this report is the output, was conducted by OPM Group, an independent specialist company. Responses were transferred in weekly batches from CQC to OPM Group via a secure data link. OPM Group carried out data entry for responses submitted by email and imported all response data into its analysis database.

The analysis of responses consisted of two strands. For the responses to the closed questions, the analysis team conducted quantitative analysis resulting in numeric data sets. For the responses to the open questions, analysts carried out qualitative analysis through manually coding the content of responses, with the help of a comprehensive coding framework. This resulted in a large searchable qualitative data set which was made available to CQC.

Consultation respondents

By the end of the consultation period, 768 responses had been received. A total of 439 respondents had used the online form to participate in the consultation; additionally, 192 email responses were received.

Among the responses received by email there were a few that included an amalgamation of individual responses. In these cases, the individual responses were manually entered so that each respondent's view could be included in the quantitative analysis. This accounts for the remaining 137 responses.

Respondent categories

Respondents using the web form were asked to indicate, choosing from a list, in what capacity they were responding to the consultation. For responses received by email, the CQC strategy team provided categorisation based on the information provided by respondents. Where quotes have been used in this report we have indicated which category of respondent the quote has come from.

Table 1 below provides an overview of the respondents to the consultation.

Table 1 Overview of respondent numbers per category

I am responding primarily as:	
A member of the public	142
Provider/professional: I work at or am associated with a care service	359
Acute healthcare	25
Adult social care	140
Primary medical care	112
Mental health	22
Dental	17
Other	11
No answer	32
Member of CQC staff	33
Voluntary and community sector representative	42
A carer of someone who uses health and social care services	8
Member of a local Healthwatch of local Healthwatch staff	3
Member of a foundation trust council of governors	5
Member of an Overview and Scrutiny Committee	4
A CQC Expert by Experience	10
Parliamentarian	1
Local councillor	1
Member of an arm's length body	16
Local government officer	12
Worker for another regulator	4
Researcher/student	3
Other	39
No answer	86
Total responses	**768**

A very small number of the responses featured in table 1 above consist of notes from engagement activities such as staff events and focus groups. Four of the responses included in the count of responses belonging to members of CQC staff were notes from CQC internal strategy events and were attended by a total of 103 staff. A handful of summaries of focus groups and online discussions with public participants are included in the count of responses from members of the public.

As is common in public consultations, the number of responses per question varied, as not all respondents chose to respond to all questions. Table 2 below provides an overview of the number of responses received to each question. For the quantitative questions we have provided the number of responses. For the qualitative questions we have included the number of responses to this question, as well as an indication of the number of general responses (i.e. responses that do not make reference to specific consultation questions) that include comments relevant to this question.

Table 2 Number of responses or comments made to each question.

Question number	No. of responses	No. of comments in other responses
1a	573	N/A
1b	400	190
2a	533	N/A
2b	360	50
3a	509	N/A
3b	400	30
4a	584	N/A
4b	420	120
5a	438	N/A
5b	400	100
6a	583	N/A
6b	380	10
7	350	10
8	414*	N/A

* Includes all responses that did not reference the consultation questions

Reading the report

Structure

The structure of this summary report mirrors the structure of the consultation document: it covers the vision themes in the order that they appear in *Shaping the future*. For each theme, the report includes separate summaries of the feedback from consultation responses (including an overview of responses to the closed question, displayed in a chart) and that from consultation events. The sections summarising comments are further broken down so that

they distinguish between opportunities and benefits, challenges and barriers, and suggestions. The themes covered and their corresponding chapters are:

1. CQC's vision for quality regulation
2. Improving CQC's use of data and information
3. Implementing a shared view of quality
4. Targeting and tailoring CQC's inspection activity
5. Developing a more flexible approach to registration
6. Developing methods to assess quality for populations and across local areas.

Further chapters are included covering responses on the impact on equality and human rights (chapter 7) and comments that were not specific to any of the vision themes (chapter 8).

Guide to the narrative

This report contains an overview of the quantitative analysis findings as well as a summary of the findings from the qualitative analysis, which provides a flavour of the views expressed by respondents.

The purpose of this report is to provide an overview of participants' feedback on the consultation proposals, allowing the reader to obtain an idea of their views. The report does not aim or pretend to cover all the detail contained in the consultation responses and events and should be seen as a guide to their content rather than an alternative to reading them.

As with any consultation of this kind, it is important to remember that findings are not representative of the views held by a wider population, chiefly because participants and respondents do not constitute a representative sample. Rather, the consultation was open to anyone who chose to participate.

It is common in consultations that respondents provide greater detail or variety in critical comments than they do in supportive comments. Readers should therefore note that the relative length of sections (i.e. 'opportunities and benefits' compared to 'challenges and barriers') is not necessarily a reflection of the balance of opinion.

Sections summarising consultation responses refer to those who expressed their views as 'respondents'; sections summarising feedback from events refer to those who expressed their views as 'participants'. The sections of the report describing the comments made in response to open questions intend to reflect the range of issues addressed in consultation responses and do therefore not include precise indications of how many respondents or participants expressed particular views.

The sections covering comments made in responses to consultation questions include quotations from responses to illustrate issues raised by respondents. The quotations should not be interpreted as an indication that the represented view has greater significance than others. Nor should quotations be interpreted as representative of the views of other respondents of the same type.

Throughout the sections covering comments made in consultation events, the narrative uses the word 'participants' in a non-specific manner. It is not intended to suggest that there was

broad consensus on any of the views summarised in the report. The events were not designed to seek consensus, but rather as an opportunity to gain insight in the range of views and opinions that are held by those with an interest in CQC's work. The notes from the events were not specific about who said what and whether others agreed and neither is this report. Some of the views summarised below may indeed have been the opinion of a single participant.

In the sections covering the events, key words are emphasised in bold to aid the reader.

The report has two appendices: Appendix 1 provides a summary of feedback received via social media during the consultation period; Appendix 2 consists of the consultation questionnaire.

Chapter 1: CQC's vision for quality regulation

This chapter gives an overview of respondents' views on CQC's overarching vision for quality regulation as set out in the consultation document. First, it shows to what extent respondents indicated they agreed with the vision (responses to consultation question 1a), then it summarises respondents' comments relevant to the overarching vision (responses to consultation question 1b).

1.1. Responses to question 1a

1a. Do you agree with the vision we have set out for regulation of the quality of health and adult social care services in 2021?

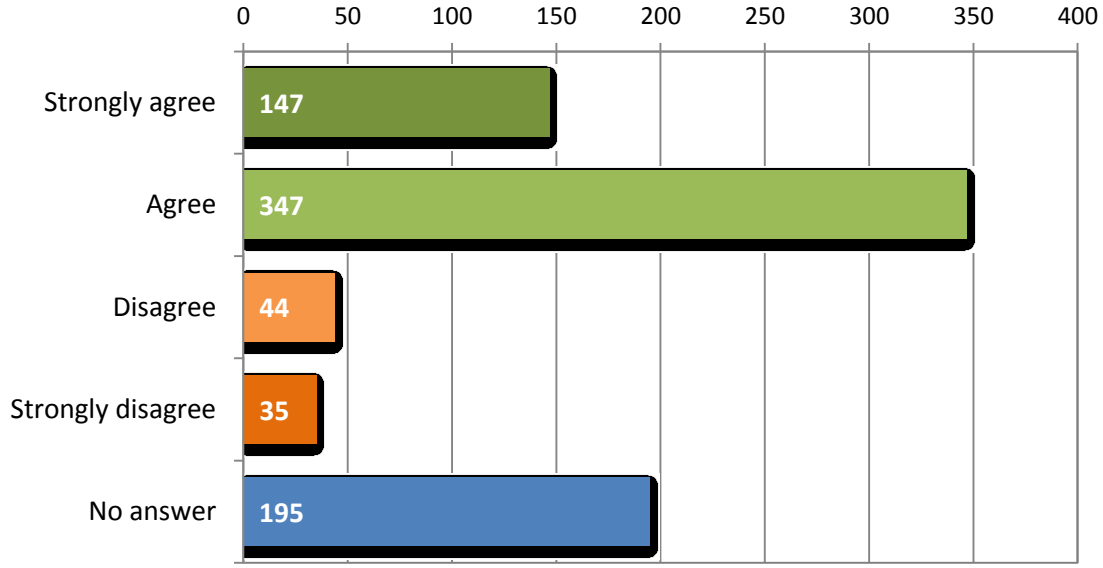

Figure 1 Overview of responses to consultation question 1a.

Of the 768 consultation respondents, 573 answered this question, which asked: *Do you agree with the vision we have set out for regulation of the quality of health and adult social care services in 2021?* A clear majority of these respondents agreed or strongly agreed with the proposal, while a small minority expressed disagreement.

- The picture for most groups of respondents, including members of the public and members of CQC staff, was roughly in accordance with the distribution as shown in Figure 1 above.
- Respondents who identified themselves as providers or professionals in the adult social care sector or in mental health were particularly supportive of the proposal: only a very small number of these respondents said they disagreed.
- Respondents who identified themselves as providers or professionals in the primary medical care sector were divided: a substantial minority of these respondents said they disagreed, including 21 respondents who indicated that they strongly disagreed.

1.2. Responses to question 1b

Question 1b asked respondents: *What do you agree with, or not agree with, about the vision?* Approximately 400 respondents made comments in response to this question. Additionally, some 190 respondents commented on the vision as part of a general response.

1.2.1. Opportunities and benefits

Of respondents who made positive comments about the vision, many made general statements expressing or confirming that they agreed with the vision. Often, these respondents emphasised that they thought the vision was adequate and that they would like to see CQC implement it. Several respondents said that in their opinion the approach to regulation that CQC proposed in its vision would be appropriate for the next five years.

"We agree that the vision that the CQC sets out over the next five years to become more efficient and effective regulator is a good one." (Voluntary and community sector representative)

Alongside respondents stating outright support for CQC's vision, there were numerous respondents who offered qualified support, often saying that they agreed with the vision 'in principle' or with CQC's aims for regulating the care sector. Usually these comments were accompanied by specific thoughts about how the vision could be improved and/or clarified.

"Although we applaud the ambitious tone of much of the strategy document, we feel the CQC must be realistic about what it can achieve with limited resources." (Provider/professional – adult social care)

Several respondents thought that the vision would result in positive outcomes, usually making general statements about how the proposed regulatory approach would benefit the quality of care. Similarly, respondents commented that people who use services were likely to benefit from the proposals.

"This vision appears to set the right balance between the CQC's duty to people who use services, and its role in supporting providers to deliver safer, better quality care." (Provider/professional – acute healthcare)

A prominent theme in respondents' supportive comments about the vision was the notion that it could increase transparency as well as the public's confidence in the care sector.

"CQC regulation engenders confidence in our services among both service users and the professionals we interact with." (Provider/professional – other)

Respondents also identified ways in which the vision might benefit care providers, with numerous comments emphasising the potential of collaboration between CQC and providers, including CQC's intention to support providers by disseminating good practice.

Respondents thought that the vision would help achieve (greater) integration between and within the health and social care sectors, welcoming the vision's focus on new models of care.

"We agree that the inspection process should tell us more about how services work together so that it provides a more coherent reflection of people's experience of health and social care." (Voluntary and community sector representative)

Other benefits and opportunities that respondents identified in relation to the vision included: making the regulatory system more efficient and reducing duplication, preserving the independence of the regulator, improving clarity about CQC's activity, adequate use of feedback from people who use services, the scope for working with other organisations effectively, and a fair regulatory system and a proportionate approach to enforcement.

"Transparency and independence are good - to have a regulatory system that will act when care falls below an acceptable standard is vital." (A member of the public)

1.2.2. Challenges and barriers

Several respondents – fewer than those who made general supportive comments – made general negative comments about the vision, dismissing it entirely or questioning its merit. In some instances these comments were related to respondents' overall opinions of CQC.

"I'm very disappointed in this "vision" and its emphasis on vague promises about data and the desire to re-invent or impose new systems." (A carer of someone who uses health and social care services)

Where respondents expressed specific reservations about the vision, these often concentrated on its implementation. Respondents, including many citing overall support, indicated that they were not convinced that it would be achievable for CQC to turn the aims of the vision into outcomes. Potential barriers, according to respondents, would include the complexity of the health and social care landscape, limitations as to what can be measured, and the lack of an action plan or similar accompanying the vision.

"How will these proposals and the effectiveness of the CQC be monitored, how often, and will the outcomes be made available to the public?" (A member of the public)

Respondents made a variety of comments questioning the delivery of the vision, stating that the cost of the proposed approach would be (too) high or that it would be difficult to meet the objectives with the resources available. Similar comments focussed on CQC's ability to

successfully address all elements of the vision, or questioned whether the vision was compatible with CQC's remit.

"The vision needs to be strong and coherent yet it will, inevitably need to reflect the reduced resources that will occur over time. Better regulation deserves better funding - you pay for what you get." (Provider/professional – dental)

Many of the themes respondents had highlighted as potential benefits of the vision also came up as challenges. For example, a small number of respondents wondered how the vision would instil or build trust in the care system and its regulation among the public. Similarly, some respondents questioned how it would make a difference for people who use services, or highlighted barriers to fruitful collaboration between CQC and other organisations.

"We think that listening to people who use services is important. However, public involvement must be credible so methods of engagement must be robust and fit for purpose." (Voluntary and community sector representative)

There were several comments about the potential impact of the vision on care providers, expressing concern about the regulatory burden or the level of bureaucracy. Respondents said that currently providers are sometimes experiencing disproportionate amounts of bureaucracy and inspection visits, with some emphasising the perceived regulatory burden on general practitioners. Such observations were often accompanied by comments that the vision should put greater emphasis on reducing bureaucracy for care providers.

"The principles of good regulation devised by the Better Regulation Task Force include proportionality and accountability. In our view the vision of the Care Quality Commission should place greater emphasis on these two principles." (Member of an arm's length body)

Some of the comments on the vision were aimed at the wording and presentation of the relevant section of the consultation document. Respondents thought that the vision could be improved in terms of its language and framing, stating for example that 'encouraging' organisations to improve quality is not strong enough or that words such as 'effective' and 'efficient' are too vague. Similarly, some respondents said that the vision in its current form lacked detail.

"Effective and Efficient - everyone uses the phrase. Has it become meaningless. Maybe something on 'accountable for decision'." (Provider/professional – adult social care)

Also, respondents suggested that important issues had been omitted from the vision, including human rights issues, CQC's thematic reports, and how CQC will address concerns about financial stability in the care sector. In similar comments, respondents expressed concern about the scope of the vision, with some saying that they would prefer CQC to focus on their existing core tasks and others suggesting that the scope of its remit should be widened to

include local commissioning or care services that are not currently regulated. A few respondents thought the vision could have greater focus on how public views are incorporated in decision-making.

"We suggest that the new model of regulation must include establishing how well patients and the public are involved and invoking sanctions to remedy poor performance." (Researcher/student)

Other concerns respondents expressed about the vision included: worries that the outcomes would be predominantly negative, comments that the vision is not sufficiently clear and transparent, comments about CQC's independence and its approach to working with providers, and suggestions that the vision lacks ambition.

"We feel that a vision of a future where organisations are 'encouraged' to improve quality is not an ambitious enough vision. The CQC's vision should be of a care landscape that is of a higher quality than the current one." (Voluntary and community sector representative)

1.2.3. Suggestions

Several respondents made suggestions about the overall philosophy that they would like the vision to incorporate. These suggestions included an emphasis of the importance of outcomes for people who use services, a need to adapt to the changing care landscape, and a call for CQC's approach to regulation to be proportionate.

"The need for regulation of services to people with health or care needs should be based on the level of risk and the type of care or service being provided." (Local government officer)

Many suggestions made by respondents in relation to the vision highlighted a particular theme or topic that respondents wanted CQC to include in its vision, or grant greater prominence. Some of these suggestions reflected issues highlighted as omitted from the vision, such as regulation of commissioners and regulation of currently unregulated care services. Respondents also suggested that CQC should concentrate on its advocacy role and seek to influence the funding situation in parts of the care sector that are currently thwarted by financial woes, including adult social care. Some of these comments also highlighted the importance of considering feedback from provider staff.

"The CQC should be taking steps to ensure that poor working conditions (which often prevent or contribute to preventing the delivery of good quality care) are highlighted and that they should be able to recommend that they are rectified." (Other)

Respondents further recommended that CQC focuses on the quality of care experienced by people with chronic conditions and the quality of end-of-life care. There were also suggestions to increase CQC's effort to ensure that children are given high-quality care, that they are safe and listened to. A few suggestions specifically mentioned the NHS Constitution and/or the

Care Act, calling for CQC's vision to align with the aims included in these documents, particularly in relation to person-centred care. Access to care was mentioned in a few responses, with respondents requesting that the scope of CQC's vision incorporates this.

"There may be scope to include access to services as part of regulating the delivery of quality care. For example, a social care provider may offer a service that is rated highly but this is of no benefit to potential service users who cannot access it." (Member of an arm's length body)

Some other suggestions focussed on how the vision should be presented and communicated to others in the sector and to the general public. For instance, respondents suggested that CQC should aim to raise public awareness of its activities, work on getting positive media coverage to counterbalance some of the negative exposure in the past, and celebrate excellent care and effective regulation. Respondents also recommended that CQC makes its publications more accessible to the public.

"the regulator has an important role in championing quality of provision across all care services and settings in a way which is accessible to the public" (Voluntary and community sector representative)

There were also several suggestions emphasising either the need for CQC to work together with other organisations (including NHS Improvement, sector representative bodies, local commissioners), or offers from particular organisations to support CQC in the delivery of its vision.

Respondents made various recommendations about the implementation of the vision, often including suggestions relevant to specific themes, such as targeted and tailored inspections or assessing quality for places and populations. They also suggested changes to the language and framing of the vision presented in the consultation document.

"The CQC should also take account of the Five Year Forward View and resulting work, in particular to the theme set out in chapter two, of building a new relationship between people and the health and care system." (Voluntary and community sector representative)

Chapter 2: Improving CQC's use of data and information

This chapter gives an overview of respondents' views on CQC's proposal for improving its use of data and information as set out in the consultation document. First, it shows to what extent respondents indicated they agreed with the proposal (responses to consultation question 2a), then it summarises respondents' comments relevant to the proposal (responses to consultation question 2b). The final section of the chapter summarises feedback on the proposal expressed at consultation events.

2.1. Responses to question 2a

2a. Do you agree with our proposal to make greater use of data and information to better guide us in how we identify risk, and how we register and inspect services?

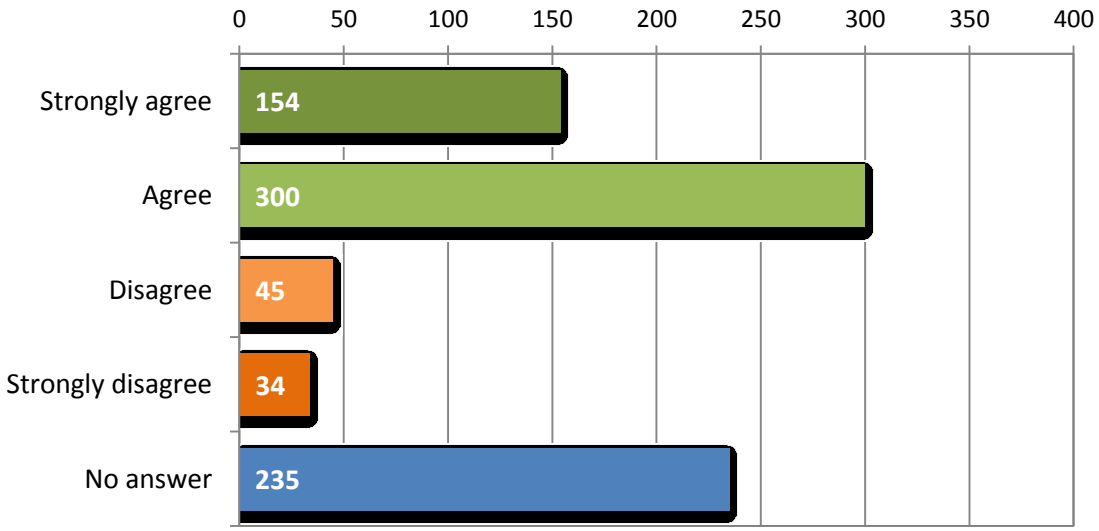

Figure 2 Overview of responses to consultation question 2a.

Of the 768 consultation respondents, 533 answered question 2a, which asked: *Do you agree with our proposal to make greater use of data and information to better guide us in how we identify risk, and how we register and inspect services?* A clear majority of these respondents agreed or strongly agreed with the proposal, while a small minority expressed disagreement.

- The picture for most groups of respondents was roughly in accordance with the distribution as shown in Figure 2 above.
- Respondents who identified themselves as providers or professionals in the adult social care sector were very supportive of the proposal: only a very small number of these respondents said they disagreed.

- Respondents who identified themselves as providers or professionals in the primary medical care sector were less supportive, as were members of the public: while most respondents in these categories agreed with the proposal, there were also substantial minorities who expressed disagreement.

2.2. Responses to question 2b

Question 2b asked respondents: *What do you agree with, or not agree with, about greater use of data and information?* Approximately 360 respondents made comments in response to this question. Additionally, approximately 50 respondents commented on the proposal as part of a general response.

2.2.1. Opportunities and benefits

Many respondents made general positive comments about the proposal, stating their agreement or emphasising the potential merit of greater use of data and information. Approximately half of those who expressed general support did so with a caveat, saying they supported the aims or the theory of the proposal, but had some degree of doubt about how they would succeed in practice.

"Targeting limited resources towards providers who need the most help to improve their services and spreading good practice makes excellent sense. However, the success of the intelligence led programme will depend on the accuracy and reliability of the data." (User 1570, Other) Respondents frequently emphasised the proposal's potential to deliver beneficial outcomes, either stating that they would improve the quality of care or highlighting specific positive outcomes, such as CQC's ability to form balanced judgements of a care provider and underpin its decisions. Respondents also identified potential positive outcomes for others, saying that better (sharing of) data will allow other organisations – including local authorities and professional bodies – to work more efficiently, and that data will help the public make informed decisions about their care. They also suggested that providers might be encouraged to improve data capture and that data and information would support benchmarking.

"CQC must realise the potential opportunity under their new strategy to play a greater role in enforcing consistent data collection to ensure the quality of care is monitored effectively and improvements enforced." (Voluntary and community sector representative)

In related comments, some respondents suggested that a greater use of data and information would help improve CQC's (and others') understanding of care quality issues. They argued that the data would help CQC to transcend the 'snapshot' assessments that provider inspections are perceived to be. Respondents also emphasised the potential of the data to help develop an image of the care provision in a particular area.

"As a local authority with market shaping duties under the Care Act it is important for us to have as detailed an understanding of the local care market as possible." (Local councillor)

Some respondents believed that the proposal would assist CQC in identifying risk or failure more effectively. They emphasised the importance of robust and reliable intelligence within a risk-based regulation model, often in general terms. Respondents also made positive comments about the sharing of information implied in the proposal, stating that this would benefit providers, regulators and the public, either in terms of efficiency or in terms of outcomes.

"Information sharing underpins our Memorandum of Understanding with CQC and we recognise that patients and providers of care should have confidence that regulators, under appropriate circumstance and consistent with legal provisions, are sharing information about the safety of health and care services." (Worker for another regulator)

Giving greater prominence to experiences from people who use services was another element of the proposal that some participants valued. This was sometimes mentioned in the context of using a variety of data sources, while other comments simply emphasised the importance of listening to patients and others who use care services. Some respondents specifically expressed support for (expanding) CQC's Experts by Experience programme to support access to better information from people who use services.

"We strongly agree that using Experts by Experience is an effective method of gathering qualitative information about a service and the care and support it provides." (Voluntary and community sector representative)

Other positive comments about the proposal for a greater use of data and information included: a reduced pressure on resources, both for CQC and for care providers, opportunities to collect and consider feedback from provider staff, and opportunities for CQC and other organisations to work together in an effective manner.

"We hope that the CQC can work with the sector to review the data that both provider boards and the CQC currently use to gain assurance on quality, and jointly identify an agreed set of quality measures which all parties can adopt." (Member of a foundation trust council of governors)

2.2.2. Challenges and barriers

A relatively small number of respondents made general negative comments about the proposal to make greater use of data and information. Many respondents did highlight specific concerns. These included numerous comments citing concern about the implementation of the proposal; some of these generic, others specifying issues that respondents believed might hinder the proposal's effectiveness.

Respondents mentioned a variety of factors complicating a successful implementation, such as the need to find a balance between standardisation and differentiation in order to obtain meaningful information about sectors that are organised very differently. Respondents also

highlighted that once it had collected appropriate data, CQC would be faced with a challenge in understanding the information and putting it to appropriate use, such as equipping inspection teams with meaningful and understandable data. A few respondents concluded that the CQC Insight model needed to be properly implemented.

"We feel that this new strategy will depend on how well the CQC can accumulate and analyse the information it has gathered." (Member of a local Healthwatch or local Healthwatch staff)

Respondents frequently mentioned the issue of data quality, saying that good-quality data would be crucial to the success of the proposal. They stated concern that data might be inaccurate or unreliable and highlighted that this would undermine regulatory efforts. In particular, respondents worried that providers would not always be honest and transparent if they identified quality issues within their organisations, and that there are important differences in the (availability of) quality monitoring data between the healthcare and social care sectors. Some respondents also thought that feedback from people who use services might be unrepresentative and stressed that providers should be able to respond or challenge.

"Data provided by people using services or their family is likely to often be negatively skewed, and data provided by care providers is likely to be positively skewed. Developing an independent system of data collection will be a significant issue that will need the backing and confidence from providers and the public." (Voluntary and community sector representative)

In relation to concerns about accuracy of data, some respondents questioned whether CQC would be sufficiently equipped to identify risk and failure if it were to embrace an approach that relies too much on data from others. Respondents reiterated points about the need to understand data within its context, suggesting that this would involve sophisticated analysis as well as ensuring some measure of triangulation. Similarly, some respondents expressed caution about the limitations of data analysis and warned that conclusions drawn from data alone are likely to paint a different picture than the one that would be obtained from an inspection. A small number of respondents questioned CQC's ability to make effective use of data and information, sometimes citing past efforts that were perceived as unsuccessful.

"We believe that any regulatory regime should implement a contextualised view of quality that is not necessarily rooted in readily available numbers." (Member of an arm's length body)

Some respondents who expressed concern about the proposal for a greater use of data and information argued that the focus on data could take resources away from other regulation activity, in particular CQC inspections. A few respondents thought that the adult social care sector and the independent sector might be disadvantaged as data collection in these sectors is less developed or aligned than in the NHS.

"The increased use of data and the increased number of people working within "CQC Insight" appears to be primarily to produce the regional reports of quality across the range of services. This is primarily driven by Government objectives and will have limited value to service providers nor people looking for specific services" (Provider/professional – adult social care)

Numerous respondents expressed concern about the proposal's impact on providers, saying that providers are currently experiencing a relatively heavy burden from regulators' data collection and reporting requirements and that any additional burden would be unwelcome. Some respondents linked the administrative burden from CQC to the fees they pay CQC and called for a more equitable arrangement.

"As a small provider, I want to support effective systems that go some way to improve the quality of care, but I also acknowledge that I do not have capacity to produce large amounts of data and this should be kept in mind for all smaller providers such as us." (Provider/professional – adult social care)

Other concerns mentioned by respondents included questions on whether organisations would be willing and able to accommodate the necessary data sharing, and on how the proposal would address issues around data protection and privacy. A few respondents raised issues around the effectiveness of the Provider Information Request (PIR), while others mentioned the potential impact on CQC's resources, or called on CQC to clarify what data it intends to use and how the data will be used to underpin its regulatory activity. Other comments expressed scepticism about the quality and reliability of data collected from social media, or complained that the proposal lacks detail.

"Sensitive identifiable information should not be obtained without a patient's knowledge; this is a key concern for patients." (Voluntary and community sector representative)

2.2.3. Suggestions

Many comments included suggestions about specific data or data sources that respondents believed CQC should consider as part of their approach. Some respondents pointed to information that their organisation could supply; many others drew attention to data that they believed would be valuable in shaping CQC's insight into the quality of care. Examples included:

- Sector-specific information, such as specific indicators to measure the quality of – among other types of care – nursing, end-of-life care, and mental health. Respondents highlighted that in some instances an appropriate data set does not exist for particular types of care, and recommended that this data was compiled to enable effective monitoring
- Data already available to CQC, such as findings from the registration process and information from thematic reviews

- Data collected and used by partner organisations, such as (benchmarking) data collected by commissioners, information gathered by voluntary organisations and intelligence from local Healthwatch organisations
- Indicators specific to GPs such as data specific to prescribing, referrals and admissions, 360 degree appraisals of GPs, and financial information about practices
- Equality and health inequality data, including information about specific populations such as gypsy and traveller communities
- Specific information sets from specialist organisations, including accreditation data and information from sources such as the National Clinical Audit and Patient Outcomes Programme.

"There needs to be a common set of performance measures against which all hospices / palliative care providers should be measured. The OACC [Outcome Assessment and Complexity Collaborative] palliative care outcome measures currently being produced by Kings College London would be a good start." (Provider/professional – other)

In related comments, several respondents made suggestions to ensure the inclusion of feedback from people who use services in the data CQC uses to monitor care providers. Alongside comments essentially highlighting the importance of these views, there were suggestions for how this data could be collected and how CQC should use it – ensuring that feedback from people who use services is supported by evidence from other sources.

"Firstly, there should be a very user friendly way for the public to give feedback about services, including consultants' services, while avoiding the widespread use of anecdotal evidence that is not sufficiently triangulated." (Other)

Some respondents thought CQC's Experts by Experience programme was a useful way to take account of the views of people who use services; other respondents pointed to other data sources such as complaints made by care home residents and their relatives. A few respondents emphasised a need to look beyond those who readily offer feedback and work with vulnerable groups who may find it difficult to express their views.

"We would like to see information collected on residents who have been asked to leave care homes, together with information about complaints made by them to care providers. Relatives have a genuine fear of making a complaint because of the potential repercussions, including having their relative's contract terminated 'if they are not happy'." (Voluntary and community sector representative)

More generally, many respondents highlighted the importance of qualitative data being considered alongside any quantitative data CQC analyses in order to gain insight into care quality and provider risk. Some respondents recommended that data analysis takes place alongside site visits – not necessarily comprehensive inspections – so that CQC continues to have up-to-date knowledge of the situation on the ground.

"However qualitative data can be much more informative than quantitative so both are needed with safeguards for the privacy of those agreeing to provide qualitative. It gets behind the figures and may be critical to identifying why there are certain broad trends in certain places within the quantitative data." (A carer of someone who uses health and social care services)

Respondents also made various suggestions about collaboration, encouraging CQC to work with (or learn from) other organisations including providers, commissioners, voluntary sector organisations and NHS organisations.

"There is an opportunity for partnership working to support the improvement of equality data through the development of a Unified Equality Information Standard that NHS England is currently leading on." (Member of an arm's length body)

Further suggestions specific to the implementation of the proposal included detailed points on how CQC could assess particular data sets and how experienced CQC inspectors could assist in structuring and interpreting data. There were also further recommendations as to how CQC could link up with commissioners in order to improve how data is shared.

Other suggestions with regard to a greater use of data and information included making stronger provisions to ensure provider staff feedback is considered, and supporting providers so they are better able to collect and share appropriate data.

"CQC could consider increased accessibility to its information repository to enable providers to identify those organisations that are performing well in specific areas, as this would facilitate shared learning and networking opportunities." (Provider/professional – acute healthcare

2.3. Feedback from consultation events

2.3.1. Opportunities and benefits

Participants said that the proposals for improving CQC's use of data and information could enhance the **credibility** of CQC judgments along with improving **public expectations** of CQC. With regard to the public, participants also mentioned that the proposed approach could help CQC demonstrate **transparency** and that it could enhance opportunities for people who use services to influence the quality of care.

Vis-à-vis providers, participants thought that the proposals would have benefits in terms of **shaping the market**, through the sharing of key market data, informing market position statements which would assist providers in their decision-making. Similarly, there was a mention of the proposed approach involving a continuous two-way process that would help **benchmarking**. Another potential benefit, according to participants, was that the proposals created a useful starting point for co-regulation between providers and CQC.

Participants also thought the proposals would benefit CQC, as it would save on its **resources** by moving from comprehensive inspections to quicker visits and spot checks.

2.3.2. Challenges and barriers

There were suggestions from participants that improving CQC's use of data and information would only work if accompanied by:

- Clear expectation about what it would achieve
- An open culture in the NHS
- Clarity and agreement on what quality means
- A collaborative relationship between providers and CQC.

Participants also identified issues with **data collection methods** and the **accuracy of data**. They warned that comparing very different data sets could be difficult, that it might be difficult to ensure the **reliability of data from providers**, and that information from complaints might not be meaningful. Another concern mentioned was that information would only be valuable if it was collected in **real-time**, otherwise it might be out of date. Participants raised an example of a provider with a 'good' rating whose quality had rapidly deteriorated since. The need to compare data from different sources was also mentioned.

Participants further suggested that providers wanted access to information so they could **challenge** CQC's conclusions if necessary.

There was one remark from participants that questioned CQC's ability to manage this in the scope of the next five years.

2.3.3. Suggestions

Participants suggested that CQC's approach to using data and information should extend to **commissioning data**. Another suggestion from participants was that CQC needs to understand how secondary care contributes to outcomes in primary care.

They also thought that evidence should be **updated continuously** and therefore detached from the provider summary report. Participants suggested that this should be done collaboratively between CQC and providers.

According to participants, **indicators** that CQC could use to identify risk could include mergers, senior staff changes and retirements, and how open providers are about the quality challenges they encounter. Another suggestion was the use of accreditation information.

Participants mentioned a few **examples** that CQC could explore in order to improve its use of data and information: the Healthwatch quality statements model (central guidance to help local Healthwatch organisations carry out their statutory tasks) and Stockton's local shared dashboard, where CQC and the local clinical commissioning group (CCG) collaborate to monitor care homes.

Chapter 3: Implementing a single shared view of quality

This chapter gives an overview of respondents' views on CQC's proposal for implementing a single shared view of quality. First, it shows to what extent respondents indicated they agreed with the proposal (responses to consultation question 3a), then it summarises respondents' comments relevant to the proposal (responses to consultation question 3b). The final section of the chapter summarises feedback on the proposal expressed at consultation events.

3.1. Responses to question 3a

3a. Do you agree with our proposal for implementing a single shared view of quality?

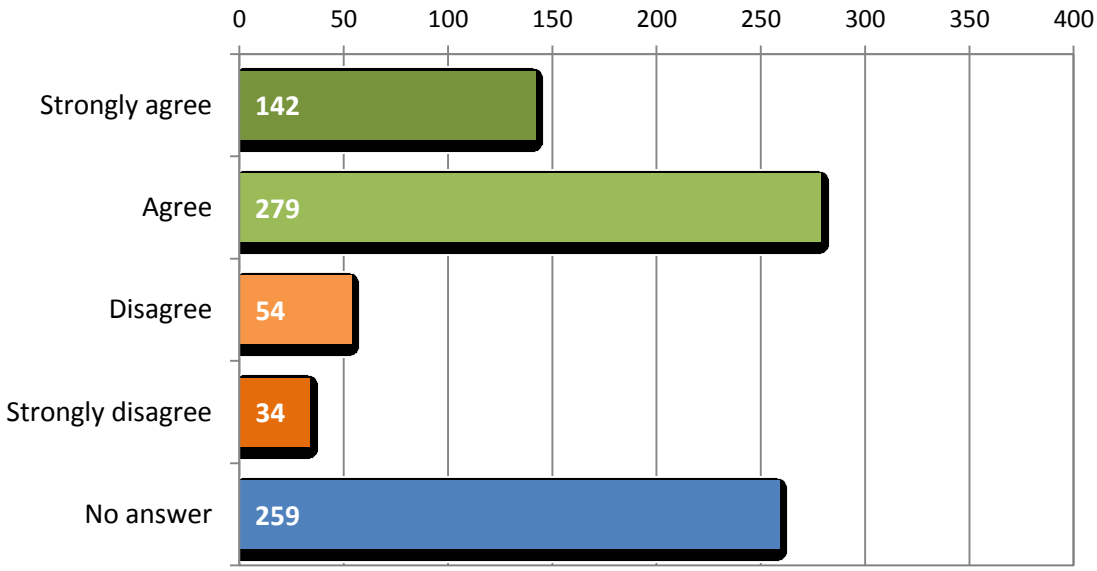

Figure 3 Overview of responses to question 3a.

Of the 768 consultation respondents, 509 answered question 3a, which asked: *Do you agree with our proposal for implementing a single shared view of quality?* A clear majority of these respondents agreed or strongly agreed with the proposal, while a small minority expressed disagreement.

- The picture for most groups of respondents, including members of the public and members of CQC staff, was roughly in accordance with the distribution as shown in Figure 3 above.
- Respondents who identified themselves as providers or professionals in the adult social care sector or in mental health were very supportive of the proposal: only a very small number of these respondents said they disagreed.

- Respondents who identified themselves as providers or professionals in the primary medical care sector were divided: a large minority of these respondents said they disagreed, including 16 respondents who indicated that they strongly disagreed.

3.2. Responses to question 3b

Question 3b asked respondents: *What do you agree with, or not agree with, about a single shared view of quality?* Approximately 400 respondents made comments in response to this question. Additionally, some 30 respondents commented on this proposal as part of a general response.

3.2.1. Opportunities and benefits

A large number of respondents made general positive comments about the proposal for implementing a single shared view of quality. Roughly one-third of those who expressed general support did so with a caveat, stating that they agreed with the gist of the proposal but had some reservations about how it would be realised.

"I certainly agree that there should be a shared view and more done to ensure level of care is consistent and of the same standards everywhere." (A member of the public)

Where respondents made specific comments about what they thought was positive about the proposal, they often said that they expected a single shared view of quality to result in positive outcomes, in terms of better care quality or more effective regulation. Specific outcomes that they thought the proposal might deliver included a drive among providers to develop their own quality measuring systems, as well as less confusion about quality standards among commissioners and providers. A few respondents emphasised the benefit of establishing a single point of authority, which they thought would help settle any misunderstandings.

"Therefore it makes sense for CQC to work with this - Inspectors need to be able to challenge and ask for evidence or justification about how judgements have been arrived at and if other bodies auditing or inspecting services (Commissioners, Health Watch etc.) can also be persuaded to adopt the CQC view of quality that would be beneficial." (Voluntary and community sector representative)

Several respondents said that a single shared view of quality would help increase efficiency and reduce duplication, through better alignment between organisations involved in regulating care providers. Some respondents emphasised the potential benefits of a closer collaboration between organisations, especially between CQC, local authorities and clinical commissioning groups.

"We agree that the oversight system would be more efficient if all national and local oversight bodies used the CQC's inspection framework based around five questions." (Other)

As well as improving efficiency from the regulators' points of view, respondents thought that the proposal would assist in reducing the burden on providers, which would have fewer different information requests to respond to, and potentially less inspections they would need to dedicate time to. A few respondents also mentioned the benefit of greater clarity, which they believed would increase confidence about inspections among care providers.

"If achieved, this will be a positive step for us as a provider, as it will relieve the burden of meeting various standards of quality across the bodies that oversee them." (Provider/professional – adult social care)

Some respondents thought that the proposed approach could help generate and release useful information for providers and public alike, enabling people to compare care providers more easily and allowing for benchmarking. Respondents believed that a single shared view of quality would also reassure members of the public about regulation and bolster their confidence in the quality of care.

"Consumers will not be as confused, the current number of quality messages is complex, this approach will help with areas such as 'choice' and bring in an element of transparency which can only be a good thing." (Member of a local Healthwatch or Healthwatch staff)

The key lines of enquiry (KLOEs) were mentioned by numerous respondents and several offered support for this approach to determining quality.

"We have applied the five domains identified by the CQC, to guide our quality governance processes and Quality Assurance Reviews which work extremely well as a result." (Provider/professional – not specified)

Other positive comments about the proposal included: the relevance and necessity of a single shared view of quality in the context of greater integration of services, a sense that the proposal would support greater consistency at inspections and a level playing field for providers, that it would help achieve equal quality of care across the country and across types of health services. A few respondents emphasised that the proposal instilled confidence that the views of people who use services inform quality standards.

"If all services, and I know this is difficult, have the same quality of care, not dependent on your post code, this would improve the service for everybody." (A member of the public)

3.2.2. Challenges and barriers

Several respondents made general negative comments about the proposal for implementing a single shared view of quality. A few others commented that in their view the proposal lacked detail and that they were unable to consider it as a result.

"I think the single view is actually rather a dangerous strategy and will tend to produce quality ratings that will be far too simplistic." (A member of the public)

A broad range of comments were made by respondents about practical barriers to achieving a single shared view of quality. Many of these were generic in nature, questioning the feasibility of achieving and implementing this successfully within a five-year period or stating that CQC needed to better explain the process. Some specific comments about implementation touched upon the need for flexibility as well as continuity, the need for a legislative framework and the need for clear quality criteria. A few respondents raised specific concerns about the inclusiveness of the process for developing a single shared view of quality and the willingness of providers to share data from internal quality monitoring.

"It is clearly desirable but there is little in the way of concrete proposals as to how this can be achieved other than reference to discussions with other regulatory bodies." (A member of the public)

Many comments focussed on how 'quality' could be defined in a meaningful way. Respondents highlighted that differences between care sectors and even differences between providers would complicate the task of achieving a common definition of quality. Several respondents said that a 'one-size-fits-all' approach would not do justice to the complex nature of the care sector and that this would represent a backward step. Some respondents questioned whether there would be sufficient scope for incorporating public views of quality in the definition. Furthermore, a few respondents expressed concern about the potential for conflict resulting from the implementation of the proposal.

"Ultimately, there is a degree of subjectivity in the assessment and that will vary between providers, service users and others. Pulling together a range of different views into a coherent single shared view may risk losing some of the nuances and specifics which are important to the delivery of a service." (Provider/professional – adult social care)

Another issue raised by several respondents was that of agreeing quality standards between a number of organisations and authorities with existing roles in monitoring quality. They highlighted potential difficulties in getting local authorities, commissioners, providers and other bodies on the same page as CQC, emphasising that many organisations currently work with different models for evaluating quality and will have differing perspectives and priorities.

"Problems anticipated with all regulators accepting each other's views and evaluations. Local regulators and oversight bodies will have varying quality." (Provider/professional – acute healthcare)

The aspect of self-assessment by providers, incorporated in this proposal, was subject to a range of cautionary remarks. In comments similar to those made about the accuracy of data supplied by providers, respondents expressed concern that not all providers would conduct

their self-assessments in the spirit of the proposal, and instead polish or omit weaker parts of their quality record. Respondents suggested that even if providers would take a conscientious approach to self-assessment, they might not be able to identify quality issues for what they are. Some emphasised the need for triangulation, often suggesting that CQC inspections should accompany providers' self-assessments. A few respondents expressed concern that provider self-assessment would erode CQC's independence, or the public perception thereof.

"However, it is critical that the CQC maintains a full inspection regime to ensure that the information services are self-reporting is matched by evidence and experience of people who use services." (Voluntary and community sector representative)

Several respondents expressed concern about the potential outcomes of the implementation of a single shared view of quality, often stating general concern that the approach would not deliver tangible benefits for people who use services. One of their concerns was that the quality framework would settle on a relatively basic level of quality, reducing the incentive for providers to continue to improve or operate at an 'outstanding' level of quality. A few respondents expressed concern that a failure to implement this successfully would severely impact on the trust placed in CQC by the public, providers and other organisations, sometimes referring to situations in the past that had impacted on CQC's reputation.

"We would also be interested in exploring how this shared view of quality would lead to a coordinated view of how to drive improvement." (User 100233, Worker for another regulator)

Respondents commonly suggested that the proposal could result in a greater burden on providers, as they voiced concern that the implementation would increase the reporting duties for care providers, sometimes stating that self-assessment implies a transfer of CQC duties to providers. A few respondents were concerned that a single shared view of quality would not reduce duplication. Others argued that CQC's information requests should be proportionate, suggesting that at the current time, CQC does not make effective use of all the data it gathers.

"Self-assessment can be extremely onerous and the resources required to do this well could be counter to the financial pressures that organisations find themselves in." (Acute healthcare)

Other concerns expressed by respondents included the need to factor in differences in local demographics and socio-economic factors in the implementation of a single shared view of quality, as well as concerns about the accuracy or reliability of data to inform quality monitoring. Likewise, a few respondents expressed concern about inconsistency in the information generated through the key lines of enquiry. There were a few respondents who raised concern about the cost involved with the process or about the effectiveness of Provider Information Requests.

"Despite the lengthy list of KLOEs, there remains inconsistency in the way evidence is interpreted." (Provider/professional – adult social care)

3.2.3. Suggestions

Respondents offered a wide range of suggestions with regard to how CQC and other organisations could collaborate to implement a single shared view of quality. Some of these comments were about how CQC could or should work with providers, emphasising the value of a collaborative approach to developing a single shared view and how this would empower providers to further improve the quality of their services.

"The key to making this a success will be to develop it in close partnership with providers. Many of our members would welcome a move to a model that more closely mirrors how boards currently assure themselves of quality." (Member of a foundation trust council of governors)

In other instances, comments about collaboration involved responding organisations expressing an interest to work with CQC on this theme, or respondents emphasising who else CQC should work with and how. As in responses to other questions, respondents were keen for CQC to work with local authorities, commissioners, local Healthwatch organisations and national bodies. Specific suggestions included to work with a broader range of organisations specialising in adult social care and to consult with regulators operating in Scotland and Wales to ensure cross-country consistency.

"An important forum that could support the shared view of quality would be the Quality Surveillance Groups as this where issues of quality can be discussed locally." (Member of an arm's length body)

Respondents also highlighted in various comments their desire for CQC to consider or prioritise views from people who use services when they develop a single shared view of quality.

"You must have ongoing consultation with the public - with groups like ours who are not comfortable with going to large open meetings. Language, communication confidence are key barriers issue for us." (A member of the public)

There were a range of other suggestions about how CQC could implement the proposal, many of which focussed on the wider practice of inspections and ratings. A few respondents recommended the use of NICE (National Institute for Health and Care Excellence) and SCIE (Social Care Institute for Excellence) guidelines as a basis for developing a single shared view of quality. There were a few suggestions highlighting a need for the approach to acknowledge differences between provider organisations and how these differences require flexibility in the implementation of quality standards, so that comparisons between providers are fair and

meaningful. A few respondents thought that peer reviews would usefully complement a system of self-assessment.

> ***"Some element of peer review would help to mitigate the risk of "cosy relationships" or complacency." (Provider/professional – acute healthcare)***

A few suggestions were made to broaden the scope to include access to services, commissioning, safeguarding, or staff morale. There were a small number of comments emphasising the importance of clearly communicating the single shared view of quality to the public and suggesting ways to increase public involvement in its development. Finally, some respondents made general suggestions about providing greater clarity on what CQC means by quality.

> ***"There should be a clear indicator of what people should expect of words such as outstanding, good, requires improvement etc. and what the implications of such ratings are." (Provider/professional – adult social care)***

3.3. Feedback from consultation events

3.3.1. Opportunities and benefits

In general comments, participants described the proposals for implementing a single shared view of quality as 'useful', 'essential' and 'a great idea', as well as an 'opportunity'. In some instances participants expressed a positive view along with a caveat, saying for instance that it would take time to make this work, or highlighting differences in people's interpretations.

Participants associated a range of positive potential **outcomes** with the proposals for implementing a single shared view of quality. They thought that the approach would foster improvement, stating that it would be a consistent way of improving or that it would lead to a culture of improvement. To fully achieve this, participants emphasised the need for CQC to focus on continuous quality improvement and to effectively communicate good practice.

According to participants, **communication and transparency** would benefit from the proposed approach. They suggested it could help improve engagement and challenge, prevent providers from blaming each other and support whistleblowing. Participants emphasised the potential of a single shared view of quality in helping **build relationships** across the sector, helped by everyone speaking the same language.

There were suggestions from participants that the proposals would help the **public trust** services and build **provider confidence**. They also thought that a single shared view of quality could result in the public knowing and understanding CQC better, looking to CQC rather than to local authorities for reassurance. Furthermore, participants mentioned that it would **empower patients** to make a more informed choice on care or help people who use services in knowing their rights. They highlighted the importance of input from people who use services

and their carers and families, saying that the proposals could improve how their views were captured.

Participants thought a single shared view of quality would enable progress in terms of **integrating services**, improving patient journeys by developing better pathways. Another potential positive outcome identified by participants was a greater degree of **consistency** across services, or a reduction in variance across the country. Participants also thought the proposals could result in criteria for judging quality accounts, help authorities deliver their scrutiny function, and highlight pressure points in the system.

Participants thought the proposals would bring **greater alignment** between regulators, reducing duplication between CQC, CCG and local authority activities or generally improving efficiency and reducing bureaucracy. **Cost savings** were highlighted too. They thought it would reduce conflicting views and/or guidance and make CQC inspectors' and local authorities' jobs easier. This would also bring advantages for providers, participants said.

Participants believed these advantages would include a **reduced burden for providers** of all sizes, as well as greater stability and assurance, with inspections becoming less fearsome and burdensome. Providers would experience fewer inspections and reporting requirements as CQC would achieve a shared understanding with other bodies, participants said. They also highlighted the potential for a single shared view of quality to make the registration process more streamlined. Participants said that the proposals could **enhance partnership** among relevant providers and encourage co-production. Furthermore, there was a mention of the proposals supporting greater links with staff.

In their specific comments on how a single shared view of quality could be **implemented**, participants mentioned the opportunity to use a single monitoring system. Participants also saw opportunities for quicker and slicker **reporting**. There were suggestions that the approach would help CQC's work in looking at provider locations and that it would work well for big care homes with independent quality monitoring. Other comments included that the proposals were positive in terms of learning from mistakes and that it was positive that Experts by Experience were used.

Participants' comments about the **key lines of enquiry** (KLOEs) included general support as well as specific mentions of their ability to help shape provider training and their value to Healthwatch. It was suggested that all five key questions were equally important. Participants expressed a desire for the KLOEs to remain as they are and emphasised that the KLOEs could help organisations' quality assurance. They also commended the KLOEs for being consistent with a person-centred approach.

Participants thought that the implementation of a single shared view of quality would bring opportunities for the way CQC and **Healthwatch** work together, saying it could grant Healthwatch a bigger role and that it could help Healthwatch in their assessments.

3.3.2. Challenges and barriers

General challenges and barriers to a successful implementation of a single shared view of quality, according to participants, included suggestions that there is **no need for change** or that a single view of quality would not be worth pursuing, as well as remarks that the **timing** of the proposal was difficult, with a mention that CQC should focus on improving the current model. Participants also highlighted that the differences between people's and organisations' **interpretations of quality** would present a challenge in achieving a single shared view.

Participants frequently emphasised **practical difficulties** around establishing a single shared view of quality. They thought that it would be challenging to deliver this generally, and said it would take time to achieve alignment. With regards to the view itself, participants argued that it would need **simplification**, while also stating that a broad definition of quality would be meaningless. Where they discussed specific aspects of the view, participants questioned the definition of safety and suggested that equality strands should be included in the shared view of quality.

The different outlooks that different people and organisations might have on quality were mentioned in multiple conversations, usually to emphasise how this would hamper efforts to achieve a single shared view of quality. Participants highlighted the diversity of the care landscape and the **differences between sectors** and providers in particular. They thought this would make it difficult to define and measure quality in a meaningful way across services and called for the quality framework to be **flexible** and/or tailored to sectors. Specifically, participants argued that quality markers and/or KLOEs could be used in a different way per sector or provider.

Participants also noted that **providers** are 'stuck in the middle' having to comply with quality requirements from commissioners and CQC, which are not the same. In similar vein, there was a comment challenging the requirements for achieving an 'outstanding' rating, which participants thought were demoralising for general practitioners (GPs).

There were various questions from participants about the collection and publication of **information**. Participants wondered what a framework would look like and emphasised a need to broaden the scope of information gathering, saying there would need to be different sources and specific questions or criteria to make it robust. With regard to providers' self-assessment, participants highlighted that it was important to have assurances about **accuracy and transparency**.

Participants questioned how a single shared view of quality would work for **particular sectors** and organisations, mentioning integrated organisations and care homes without local authority contracts. They also said that sharing good practice is not common practice in the independent sector. A further question was about how the proposals would cover commissioning of services, which participants thought should be included in their scope.

Local authorities were singled out by participants as a possible obstacle in achieving a single shared view of quality. Participants suggested that it would be difficult to match CQC's quality view with that of local authorities, or that local authorities would be less than keen. They also

mentioned that political bias in local authorities could hamper a joined-up approach. However, Sunderland City Council was mentioned as having adopted a shared quality framework already.

The **public's understanding** of the shared view of quality and associated terminology was questioned by participants. For example, they wondered about the meaning of 'compassionate' and 'safety', and generally argued that there should be greater clarity on the key lines of enquiry. Participants emphasised the need to have **clear, easy-to-understand definitions** to communicate to the public, as well as the need to encourage the public to raise concerns. They worried that the patients' view of quality might come last, and stated that it was important for all population groups to feed in.

Other issues mentioned by participants in relation to the implementation of a single shared view of quality included: comments about what information could **trigger** an inspection, concerns that a single shared view of quality would stifle **innovation**, a concern that providers are not sufficiently **flexible** to adapt to public needs, the need for providers and their staff to be more aware of the **KLOEs**, and concern about the impact of **funding cuts** on providers' ability to meet quality expectations.

3.3.3. Suggestions

Participants' made various suggestions for implementing a single shared view of quality. They emphasised a need for clearly identified **fundamental standards** of care, and added that the same standards should apply to public and private providers. They also said that the single shared view should establish a **common expectation** of quality across a place, agreed with providers, local authorities and commissioners. Participants thought the single shared view should set the bar high and keep raising it.

Participants said that the view should consist of **high-level definitions** with tailored examples that would be relevant to different communities and different types of care. Similarly, they argued that a single shared view of quality should be **flexible** to allow for ongoing refinement and to adapt to learning.

In its implementation, participants thought that a single shared view of quality should assist **ongoing relationships or conversations with providers**. They suggested that CQC asks the key questions regularly and that action plans, in order to be sustainable, are sent in periodically. They also expressed a preference for ongoing conversations over 'snapshot' inspections. Another suggestion from participants was for a more collaborative relationship with providers, including open and transparent communications, with greater emphasis on **CQC's support role**, advising providers on how to improve.

A specific suggestion from participants in relation to how a single shared view of quality might be supported in practice was the use of a local area quality dashboard owned by providers and coordinated by CQC. Other suggestions included an increased role for peer review, the use of Experts by Experience to gain a better understanding of specific services, and for CQC to attend provider board meetings to establish whether they were well-led.

General implementation suggestions included for CQC to engage with **provider staff** and to be more approachable, a need for safe **whistleblowing** mechanisms, and a need for more **training**.

Participants spoke about communication frequently, mostly making suggestions for how CQC and others should **communicate with the public** about care quality. Participants argued that the public needs to know and understand what a single shared view of quality looks like and emphasised that information should be provided in **the right language** to accommodate this. They suggested that the message to the public should be about caring about outcomes for them and improving expectations of what good looks like. Another suggestion was to provide clear and concise **definitions** for the public, accompanied by qualitative information to bring it to life.

In related suggestions, participants argued that the **public profile of CQC** needed to be increased and that CQC reports should be more accessible to the public. Similarly, they requested that good practice case studies are communicated to the public as well as findings from inspections and information on what will be done in response to those findings. In addition, participants said they would like to see **evidence** of what has been done made available publicly.

Similar to comments reported above, participants' suggestions often highlighted the importance of seeking the views of **people who use services**. For example, they thought that the public should be involved in defining quality and that the overall focus should be on patient outcomes. Participants proposed the setup of a representative citizens' panel, stating concern that otherwise the single shared view might not be supported by the public view.

Other specific comments on **seeking public views** included the need to consider real experiences of care, greater involvement of families of people who use services, and ensuring that the views of particular groups are heard. Groups that were mentioned included people who have a diagnosis of dementia and people who are not represented by family members.

Further suggestions from participants on implementing a single shared view of quality included: looking at providers' **approach to risk** and financial triggers when monitoring them, greater clarity on the evidence requirements for an **'outstanding' rating, s**peaking to **locums** as a source of information about providers, making better use of the **CQC website** alongside other tools of communication, and using Advocacy North as a **pilot site**.

Chapter 4: Targeting and tailoring CQC's inspection activity

This chapter gives an overview of respondents' views on CQC's proposal for targeting and tailoring its inspection activity as set out in the consultation document. First, it shows to what extent respondents indicated they agreed with the proposal (responses to consultation question 4a), then it summarises respondents' comments relevant to the proposal (responses to consultation question 4b). The final section of the chapter summarises feedback on the proposal expressed at consultation events.

4.1. Responses to question 4a

4a. Do you agree with our proposal for targeting and tailoring our inspection activity, including reducing the frequency of some inspections so we target our resources on the greatest risk?

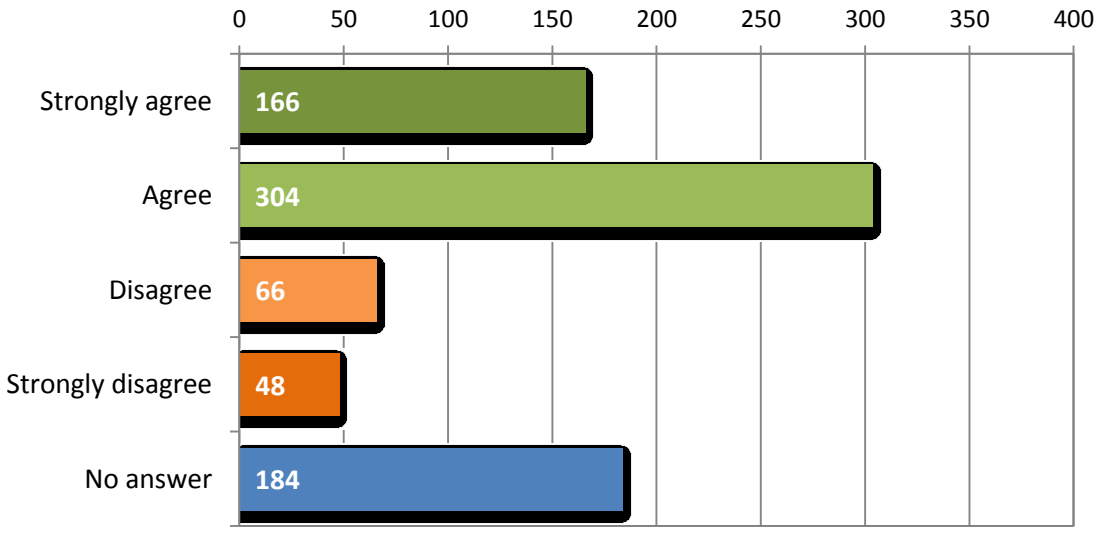

Figure 4 Overview of responses to consultation question 4a.

Of the 768 consultation respondents, 584 answered question 4a, which asked: *Do you agree with our proposal for targeting and tailoring our inspection activity, including reducing the frequency of some inspections so we target our resources on the greatest risk?* A clear majority of these respondents agreed or strongly agreed with the proposal, while a small minority expressed disagreement.

- The picture for most groups of respondents, including primary medical care providers or professionals, was roughly in accordance with the distribution as shown in Figure 4 above.
- Providers or professionals in the adult social care sector or in mental health were very supportive of the proposal: only a small proportion of these respondents said they disagreed.

- While a majority of respondents who identified themselves as members of the public or members of CQC staff said they agreed with the proposal, overall these groups were not as supportive as others. For example, 21 members of the public indicated that they strongly disagreed.

4.2. Responses to question 4b

Question 4b asked respondents: *What do you agree with, or not agree with, about targeting and tailoring our inspection activity?* Approximately 420 respondents made comments in response to this question. Additionally, some 120 respondents commented on this proposal as part of a general response.

4.2.1. Opportunities and benefits

A large number of respondents made general positive comments about the proposal for targeting and tailoring CQC's inspection activity, in most cases without any reservation. Several respondents expressed caveated support, stating that they agreed with the idea of the proposal but had some degree of hesitation about how it would succeed in practice.

"The [respondent] is pleased to see the CQC consider a more targeted and tailored approach to inspection activity. The [respondent] has previously highlighted that the majority of practices provide a standard of care well above the minimum standard and as a result there is a little need to take a heavy handed, audit focused approach when conducting inspections." (No respondent information provided)

Respondents who made supportive comments about the proposal often said they expected the approach to lead to improvements in care quality, a better experience for people who use services, or increased confidence in providers among people who use services. One specific positive outcome that some respondents mentioned was the potential for the proposed inspection approach to focus on monitoring and supporting struggling providers to drive improvements in their services. A few respondents highlighted the prospect of providers taking greater ownership of their quality performance.

"I think the idea of co-regulation in this respect is very helpful, particularly to allow providers greater accountability and ownership of their own strategic approach to quality." (Provider/professional – adult social care)

Several respondents thought the proposal would allow CQC to use its resources more efficiently, as fewer inspectors would be needed to carry out comprehensive inspections. They agreed that if CQC's overall resources were to be reduced, it was sensible to focus on providers that were more likely to require inspection and/or support.

"In order to work within confined budgets it is important to use resources wisely. Targeting those that require improvement is both prudent and important to raise the quality of care." (A member of the public)

Similarly, some respondents thought that (good or compliant) providers would benefit from having fewer inspections, sometimes emphasising the amount of time currently involved with preparing for and undergoing CQC inspections.

"We welcome the commitment to working with NHS England and us to reduce the burden of inspections on primary care." (Worker for another regulator)

In other positive comments, respondents mentioned the potential of a targeted and tailored approach to inspection to work well in conjunction with greater use of data and information, and emphasised their agreement with CQC's proposal to regulate large providers at a corporate level.

4.2.2. Challenges and barriers

Several respondents made general negative comments about the proposal for targeting and tailoring CQC's inspection activity. A common criticism was that the proposal provided in the consultation document was insufficiently clear and that detail about the proposed risk-based approach was lacking.

"We would also like to see more information on the frequency of inspections for those providers which are rated good and outstanding, and more detail on how incidences of service deterioration would be managed in this approach." (Member of an arm's length body)

Various respondents were concerned about the implied reduction in the extent and frequency of provider inspections. Respondents argued that providers' quality performance can deteriorate rapidly and that regular inspection visits helped ensure that providers remained focused on improving quality. They also highlighted the importance of regular provider inspections as a way of instilling public confidence in the care sector. Some respondents suggested that every provider should receive a visit from CQC inspectors at least every two years.

"As someone who works in a variety of care providers settings I see good, not so good, indifferent and poor practice. Inspections do not pick up things now and reducing them will only lead to increased abuse, neglect and poor practice." (Other)

Similarly, many respondents believed that the approach would limit CQC's ability to accurately identify situations where people who use services were put at risk by a failing care provider. Several respondents highlighted that risks could be mitigated by other elements of CQC's proposed strategy – greater use of data and information and a single shared view of quality –

but said that all processes would need to work well in order for a targeted and tailored approach to inspection activity to be safe.

"The CQC would need to use the processes outlined in this document effectively, including data, to ensure regular monitoring under the surface of organisations to pick up any potential emerging risks and monitor hotspot areas." (Provider/professional – mental health)

Several respondents expressed concern about the ability of CQC inspection teams to make an accurate assessment of providers' quality performance, stating that this would thwart CQC's ability to move to a model of targeted and tailored inspections successfully. Respondents highlighted the need for inspectors to have specialist knowledge and/or experience of the sector they were inspecting. A few respondents commented that CQC would be insufficiently equipped for cross-sector working, or that it would not be ready to change its approach to provider inspections.

"Those carrying out the inspection need to have a full understanding of the problems faced - they should look for solutions to those problems, but should understand the what works in a metropolitan area may not be appropriate elsewhere." (A member of the public)

Some respondents highlighted the importance of data in helping CQC identify risks and target its inspection activity. Some reiterated reservations expressed in response to the consultation question about a greater use of data and information, others specified that issues with data accuracy and reliability could undermine the proposed approach to inspection activity. A few respondents thought there would be particular risks in relation to data available about the quality of adult social care services.

"The success of this approach will depend to a large extent on the success of acquiring relevant quality data as a form of non-inspection surveillance." (Member of an arm's length body)

Although a relatively large number of respondents indicated that the proposal would reduce the regulatory burden for providers, this was not unanimous. A smaller number of respondents worried that the proposal would have the opposite outcome, creating a greater burden for providers by its reliance on self-assessment and data requests. A few respondents thought that it was inappropriate that CQC proposed to increase its fees for providers while also proposing that some of the quality monitoring tasks are transferred from the regulator to providers.

"Producing good quality and real-time information without considering the cost of providers creating such a comprehensive technological infrastructure will create a significant obstacle in achieving this aim." (Provider/professional – adult social care)

Other concerns respondents expressed in relation to the proposal included a question whether experiences from people who use services would be duly considered, requests for CQC to clarify that its approach to regulating at a corporate level would not affect its oversight of individual locations, reiterated concerns around the effectiveness of provider self-assessment, and a perception that the proposal benefits larger providers more than smaller providers.

4.2.3. Suggestions

A large number of respondents' suggestions about the proposal for targeting and tailoring CQC's inspection activity concentrated on the method and frequency of inspections. With regard to inspection methods, respondents made a wealth of suggestions, including points about the composition of inspection teams (including the use of Experts by Experience), the length and scope of inspections of particular types of providers, the timing of follow-up inspections, the need to adapt inspection methods to the context in which a provider operates, and the use of data and information to trigger inspection activity.

"However we believe it is important to have a more flexible arrangement for providers to be able to demonstrate the improvements they have made following visits by the CQC, and subsequently for ratings to be updated in a more timely manner than is currently the case (e.g. for those rated as requiring improvement)." (Provider/professional – acute healthcare)

Suggestions about inspection frequency included several requests for providers with a 'good' rating to be able to demonstrate their improvements to CQC in order to be upgraded to 'outstanding', with respondents expressing concern that this would be hampered by the proposals. Some respondents suggested that the inspection frequency for particular sectors (such as general practice) could be reduced, or expressed support for CQC's intention to inspect poorly performing providers more frequently. Other comments argued that CQC should not change the current frequency of inspections. Some respondents suggested a specific frequency that they thought would be appropriate for provider inspections.

"As CQC is saying it will only issue a rating following an inspection, good providers are likely to have to wait years before re-inspection." (Provider/professional – adult social care)

Furthermore, several respondents emphasised the merit of unannounced inspections compared to scheduled ones, or suggested complementing scheduled inspections with unannounced visits. They thought that provider visits without prior warning would be more effective in making sure that providers keep focussed on their quality performance and that inspectors would obtain a better impression of the actual delivery of services. Some respondents suggested that unannounced visits should be short and focussed.

"Maybe random checks should be made to get a clearer picture of the normal daily operation. My fear is that vulnerable people won't always be truthful about the standard of their care out of fear." (A member of the public)

Respondents also made a range of suggestions about the focus of CQC inspections. Several respondents expressed general support for a focus on providers or services that were considered to represent a risk. Others expressed a desire for CQC to focus inspections on care pathways. Some respondents suggested a focus on a particular type of service, with a great variety of services getting a mention in comments. Similarly, some comments suggested inspections should focus on a specific group, such as frail elderly people or people with dementia. A few respondents suggested that CQC focuses on positive findings in its inspections.

"Change the emphasis from one which seems to be 'let's find out what's bad about this Home' to one more like 'let's find out all the good things'. This is what Ofsted do. The fact that only 0.5% of Care Homes have been awarded Outstanding is a reflection of this." (Provider/professional, adult social care)

Respondents' comments included a variety of suggestions as to how CQC could or should collaborate with other organisations in the context of targeting and tailoring its inspection activity. Respondents emphasised opportunities around data sharing and improving the effectiveness of regulation through working with others. As in responses to other questions, respondents mentioned providers, commissioners, local authorities and other monitoring organisations as appropriate partners for CQC. Specific mentions were made of SCIE, Ofsted and the NHS England Vanguard programme.

"Relationships between CQC and scrutiny committees need to continue to develop - so that there are contacts between scrutiny and all inspection teams." (Member of an overview and scrutiny committee)

As in responses to other consultation questions, several respondents made suggestions emphasising a need to consider or prioritise gaining input on the experience of people who use services. There were specific suggestions on how to do this, including asking people who use services to complete surveys at the end of their care experience and considering feedback on social media.

"Furthermore, we would welcome an approach that takes into account the experience of the service user, rather than one which is driven purely by process." (Local government officer)

It was suggested in several comments that targeting and tailoring inspection activity needed to be paired with targeted and tailored support for providers. Respondents highlighted that underperforming providers are more likely to benefit from support than from an increased level of inspections. Respondents thought that by collecting good practice examples, CQC would be well-placed to help struggling providers improve.

"Targeted/tailored inspections are a good idea, assuming the support of the CQC is given to the provider. Specifically, the CQC could have greater involvement in assessing a provider's

progress against the actions it has taken to improve since the findings of its previous CQC inspection, report and rating." (Provider/professional – primary medical services)

Other suggestions included comments about inspection reports and suggestions on how to make these better as well as call to better inform the public about CQC's approach to inspections.

4.3. Feedback from consultation events

4.3.1. Opportunities and benefits

Participants talking about the proposals for targeted and tailored inspections made some general positive comments, stating that they thought a risk-based approach is appropriate or that they like the idea of targeting and focussing.

Participants thought that more detailed inspections would help the public feel more **confident** in CQC's findings. Another comment was that those who perceive regulation as a burden that impacts on care resources would welcome an approach with fewer comprehensive inspections.

The proposals for a targeted and tailored approach to inspection activity could result in **positive outcomes**, according to participants. They thought it would encourage providers to manage risk better, also saying that providers' fear of inspection could help drive improvement. Participants liked the idea of CQC focussing on areas where risk is highest for service users. They thought that fewer inspections would allow more resources to go into patient care and that joined-up inspections would improve the moral among providers.

In similar comments, participants expressed support for **efficiency gains** the proposed approach would deliver. They thought it would mean less stress for providers and result in a more efficient use of resources for both CQC and the providers they inspect. Participants mentioned a **reduction in duplication** between inspection activity by CQC and other regulators as another benefit.

4.3.2. Challenges and barriers

Participants worried that the proposed approach of targeting and tailoring inspection activity might represent an **increased risk to people who use services**, saying the quality of services that are not inspected frequently could fall. They thought that providers would be less inclined to drive improvement if their services are not targeted by CQC inspections. Participants said this would reflect negatively on CQC, as it might be perceived by the public to be complacent or not doing its job properly. Another issue raised by participants is that less frequent inspections would make it more difficult for providers to improve their rating.

In related comments, participants wondered how valid a **rating** would be if years go by before the service is inspected again. Participants were sceptical about the CQC's ability to monitor the quality of services on the basis of **data** alone, saying that data is easy to manipulate for

providers, while feedback from people who use services could be cynical. They would prefer CQC to ensure that the image of a provider is accurate by doing qualitative research or by 'crossing the threshold'.

Commenting on the implementation of the proposed approach, participants thought it would only work once CQC had a robust method for **defining and identifying risk**, as well as a shared view of quality. They said that the proposed approach would require markers to monitor changes, and mentioned **staff and leadership changes** as risk factors that CQC would need to focus on. Participants also wondered how the proposed approach would work with regard to integrated care – who would expect it and when?

Participants expressed some concern about how the views of **people who use services** would inform CQC's inspection activity under the proposals. They said that CQC needed to improve how it captures people's experiences of care as well as how it responds to concerns raised by people who use services and provider staff. Participants also thought there would be a risk of missing certain cohorts of people who use services.

4.3.3. Suggestions

Participants made many suggestions as to how the proposals for targeted and tailored inspection activity should be delivered. Various suggestions were made about the **focus of inspections**, with participants stating that CQC should inspect services or providers about which concerns are raised, or more generally focus inspection activity on providers with a poor track record.

Some of participants' suggestions were about what **aspect of a service** CQC should focus its inspections on. These suggestions included mentions of board-level activity, quality accounts, and integrated care pathways (e.g. for specific conditions). Participants also thought CQC could prioritise groups that were more at risk, such as older people.

Participants' suggestions as to what should **trigger** an inspection by CQC included changes in staff or leadership, concerns raised, and feedback from the Freedom to Speak Up Guardian. Participants thought that CQC should work with data from others to help identify risk. They mentioned data from other regulators, Healthwatch, patient groups, local quality surveillance groups, and people who use services.

In relation to the **method and frequency of inspections**, participants suggested that their preferred inspection regime would combine risk-based elements with a more generic strand of inspections. They thought that there could be a mix of scheduled inspections and risk-based inspections, adding that they would like some of the inspection activity to be **unannounced**. Participants suggested that the frequency of inspections could be linked to a provider's rating, but some emphasised that all providers should be inspected regularly; others suggested that those with a 'good' or 'outstanding' rating would only need inspecting if something triggers a need. Another suggestion was to carry out sufficient risk assessment (e.g. through a survey) in between inspections.

Participants also suggested that the inspection regime could be more **tailored** to the different sectors and thought this could involve a greater focus on adult social care. A specific suggestion for this sector was for CQC to provide a ranking of care homes per area. They also said that it should be clearer who is responsible for quality when providers contract out care to others.

Specific suggestions about **how inspections are carried out** included:

- The use of **peer review** groups in primary care and specialist centres
- Inspection teams being **proportionate** to the size of the service they are inspecting
- Recruiting and training **Experts by Experience** so they can assist inspections
- Involving **people who use services**, including young people.

More generally, participants thought that the proposed approach should accommodate for greater **input from people who use services**, stating that CQC should ensure better representation of this group by making it easier for them to raise concerns about services. Participants added that there was a need to make sure that the views of **vulnerable or marginalised groups of people** are sufficiently heard, emphasising that CQC should look to listen beyond the loudest voices. They also suggested that CQC uses existing user feedback data effectively for targeting inspection activity.

Participants thought that CQC's **communication to the public** was an important factor in encouraging feedback and involvement from people who use services. They recommended that CQC raises awareness of inspections and reports and that it holds well-advertised listening events. It was suggested that rating upgrades in response to improvements were important to ensure awareness among users of a service. They also said that CQC should be **open and transparent** about their risk-based approach to inspection activity, being transparent about criteria and methodology.

Greater **alignment with other organisations** was a theme alluded to in various suggestions. Participants proposed that CQC liaises more closely with local authorities, that it works more effectively with Healthwatch and that it aligns its inspection regime with CCGs and NHS England. Specific comments on the latter included a suggestion for CQC to effectively regulate **commissioners** and a suggestion for CQC to attend CCGs' regular quality meetings.

Chapter 5: Developing a more flexible approach to registration

This chapter gives an overview of respondents' views on CQC's proposal for developing a more flexible approach to registration as set out in the consultation document. First, it shows to what extent respondents indicated they agreed with the proposal (responses to consultation question 5a), then it summarises respondents' comments relevant to the proposal (responses to consultation question 5b). The final section of the chapter summarises feedback on the proposal expressed at consultation events.

5.1. Responses to question 5a

5a. Do you agree with our proposal for a more flexible approach to registration?

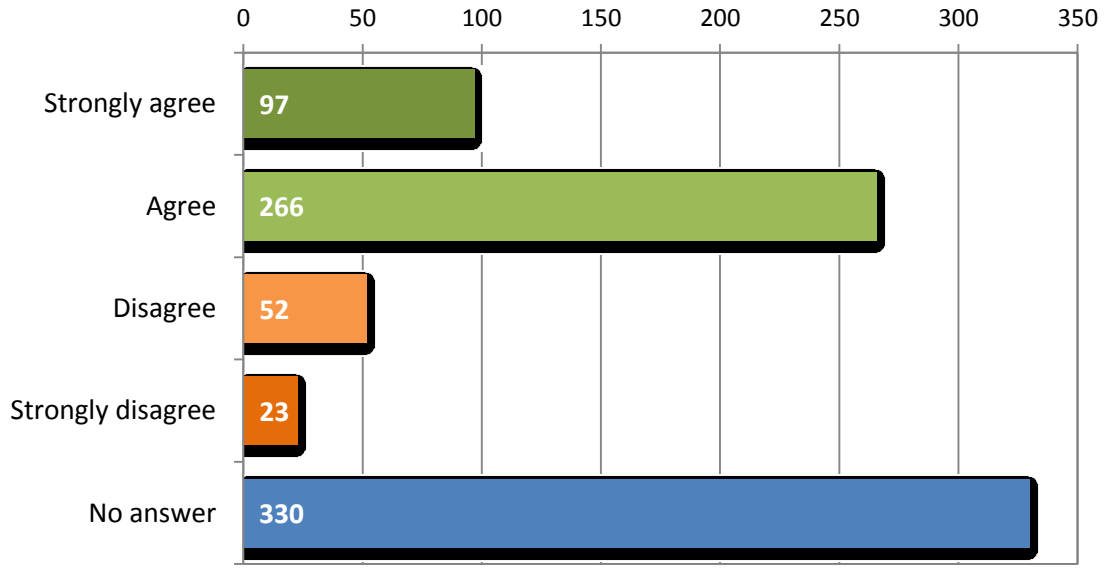

Figure 5 Overview of responses to consultation question 5a.

Of the 768 consultation respondents, 438 answered question 5a, which asked: *Do you agree with our proposal for a more flexible approach to registration?* A clear majority of these respondents agreed or strongly agreed with the proposal, while a small minority expressed disagreement.

- The picture for most groups of respondents, including providers or professionals in primary medical care, was roughly in accordance with the distribution as shown in Figure 5 above.
- Providers or professionals in the adult social care sector were very supportive of the proposal: only a small proportion of these respondents said they disagreed.

- Members of the public were less supportive overall: while most did not answer this question, of those who did, a substantial minority said they disagreed, most of them strongly.

5.2. Responses to question 5b

Question 5b asked respondents: *What do you agree with, or not agree with, about a more flexible approach to registration?* Approximately 400 respondents made comments in response to this question. Additionally, more than 100 respondents commented on the proposal as part of a general response.

5.2.1. Opportunities and benefits

Many respondents made general supportive comments about the proposal for a more flexible approach to registration. Approximately one-third of those who commented positively did so with a caveat, stating that they agreed with the principle or the theory, but had some level of reservations about the delivery of the proposal.

"Agree - it is important that registration requirements can accommodate the innovation in delivery which is increasingly being taken forward in local areas." (Member of a local Healthwatch or local Healthwatch staff)

Respondents who made supportive comments often concentrated on how the proposal would reduce the burden on providers. They welcomed the prospect of less bureaucracy and less duplication, and thought streamlined registration for providers with a good track record was appropriate, particularly for administrative changes such as an office move. Some respondents emphasised that reduced administrative burdens would enable providers to spend more time and money on delivering good care.

"Recognising that a historically good provider is likely to be both safe and effective should enhance relationships and ease the regulatory burden on services." (Provider/professional – adult social care)

In similar comments, several respondents highlighted the benefits of greater flexibility, agreeing that this would be necessary to support innovation in the sector and to facilitate CQC's regulation of new models of care. A few respondents also emphasised that smaller providers would particularly benefit from greater flexibility. Other respondents simply stated that greater flexibility would be positive, without specifying how.

"Agree with flexibility for different providers - recognises the changing integrated models that are being developed, it would recognise innovative approaches and smaller providers." (Other)

Respondents thought that a more flexible approach to registration would have beneficial outcomes, ultimately contributing to better care services through encouraging well-performing providers to register new services and preventing poor providers from re-registering. Some respondents added that the proposal would help providers to better understand their responsibility. Similar comments were made about how the approach would help CQC: giving it a better overview and clearer understanding of provider skills. A few respondents thought the proposal would allow CQC to better recognise the contribution different services make to the system.

"This will ensure that responsibility and accountability will be shared across all levels of an organisation from operational to management to a corporate level for the quality of the service provided." (Other)

Other benefits that respondents associated with CQC's proposal for a more flexible approach to registration included saving CQC time and resources to focus on other regulation aspects and benefits for corporate providers through registration at a corporate level.

5.2.2. Challenges and barriers

A relatively small number of respondents made general negative comments about the proposal for a more flexible approach to registration, including a few respondents who said that the proposal lacked detail.

"[Respondent] have some concerns about the proposal for a more flexible approach to registration, and would like to see more detail about how this will work in practice." (Local government officer)

Many respondents expressed concern about the impact of the proposed approach on CQC's ability to identify risk. They said that the proposed approach would not give enough assurance about the safety of new services and that it would increase chances of poor services slipping through the net and operating for a long time before they would be inspected by CQC. Some respondents simply stated a preference for the current registration process, arguing it is safer. Some respondents were particularly concerned about the potential lack of scrutiny regarding newly registered care homes.

"While our systems must be made simpler and easier for providers to use - we must not reduce the scrutiny applied to providers and managers - it is vital that we are reassured that new providers and managers are in a position with the knowledge and skills to provide good care - regardless of the model they are using." (Member of CQC staff)

Respondents also thought that a more flexible approach might lead to unwanted outcomes, most notably the risk that vulnerable people will be affected by sub-standard or even unsafe levels of care, as poor providers exploit the flexibility of the registration process to evade CQC

scrutiny. Again, a few respondents expressed particular concerns about providers in the care home sector.

"We have seen across a number of other sectors 'flexible' registration arrangements create loopholes and inconsistencies and in some cases the development of 3rd party professions assisting providers with the registration process." (Other)

Other challenges and barriers identified by respondents included a need for CQC to better equip its staff to carry out registration for a range of providers and specialisms, concerns that the approach would unfairly (seem to) favour private or corporate providers, and calls for the current categorisation of services to be simplified or abolished. There were questions about how the registration process would work for integrated care, caveats that the approach needs to be accompanied by robust monitoring and an element of inspection activity, and general concerns about implementation or feasibility.

"We recognise the need for a more proportionate, tailored and risk-based approach to registration but have concerns about where accountability for quality improvement would sit in systems that involve multiple agencies." (Member of an arm's length body)

5.2.3. Suggestions

Respondents made several suggestions in relation to CQC's proposal for a more flexible approach to registration. These included statements to stress that the registration process needed to be sufficiently robust. Some respondents added that this might involve particular checks, such as a visit to the premises where the provider proposes to perform its services, an assessment of providers' financial performance, or an investigation into past services a provider has been involved with.

"However, given that the registration stage is the gateway into being a regulated service, the process must be robust and consistent, and ensure that problems are identified and dealt with before a provider is able to start offering services. This is particularly pertinent for adult social care, and especially so in the case of 'lone providers' which can be isolated." (Member of an arm's length body)

Some respondents thought that CQC should also use the registration process to focus on positives, identifying and sharing best practice. A few respondents thought that this would be particularly appropriate for applications for innovative care.

"Particularly interested in the point on how innovative services are registered. Would suggest that this process is more transparent and widely shared across providers, if only to share best practice and stimulate further innovation in the sector." (Provider/professional – adult social care)

Other suggestions about a more flexible approach to registration included ensuring that all providers are treated in the same way, following a fixed process, a need for CQC to develop greater understanding of the structure of organisations, and calls for CQC to improve its responsiveness and the timescales for registration processes.

5.3. Feedback from consultation events

5.3.1. Opportunities and benefits

In general positive comments about CQC's proposals for a flexible approach to registration, participants said it was a very welcome idea. They thought it could contribute to improving the quality of care and that it would result in **increased confidence**. Participants believed that the proposed registration approach would ensure that providers' history was taken account of and that it would help to obtain a full picture of providers.

Participants identified various **benefits for providers**. They thought that an improved registration process would ensure that providers are clear about expectations. The approach would result in a **streamlined process**, according to participants, which they thought would improve applications and help recognise poor managers. Participants also thought a flexible approach to registration would be less tedious than the current process, and that it would be useful for providers with multiple locations.

For CQC, the approach could bring opportunities to start a **dialogue with providers** and build relationships, according to participants. They also thought it would help CQC to use their **resources** efficiently.

5.3.2. Challenges and barriers

Only a few challenges and barriers were mentioned by participants regarding the proposals for a flexible approach to registration. Participants said that providers would need **greater clarity** on what registration includes and what evidence is required, or made general remarks about **providers' support needs** throughout the registration process. Other concerns included a reflection on the risk that new managers represent and an observation that enforcement processes have a detrimental impact on provider practices, including recruitment.

5.3.3. Suggestions

Participants' suggestions for a flexible approach to registration included requests for the process to be **clearer and simpler** for providers. They recommended that CQC provides more support and guidance to providers, for instance through a flow chart that clarifies the registration process.

With regard to the registration activity itself, participants made suggestions for providers to be personally involved and for CQC to conduct face-to-face interviews so that **expectations and confidence** are more robust on both sides.

Participants thought that while there should be **flexibility** regarding types of services, the overall approach should remain **consistent**. They suggested that CQC should look at organisations as a whole and that providers should report to CQC at corporate level.

There were further suggestions stating that services should be inspected once they were registered and that the public should be assured that all evidence has been considered. Participants also mentioned that CQC could learn from the NHS approach.

Chapter 6: Developing methods to assess quality for populations and across local areas

This chapter gives an overview of respondents' views on CQC's proposal for developing methods to assess quality for populations and across local areas as set out in the consultation document. First, it shows to what extent respondents indicated they agreed with the proposal (responses to consultation question 6a), then it summarises respondents' comments relevant to the proposal (responses to consultation question 6b). The final section of the chapter summarises feedback on the proposal expressed at consultation events.

6.1. Responses to question 6a

6a. Do you agree with our proposal for assessing quality for populations and across local areas?

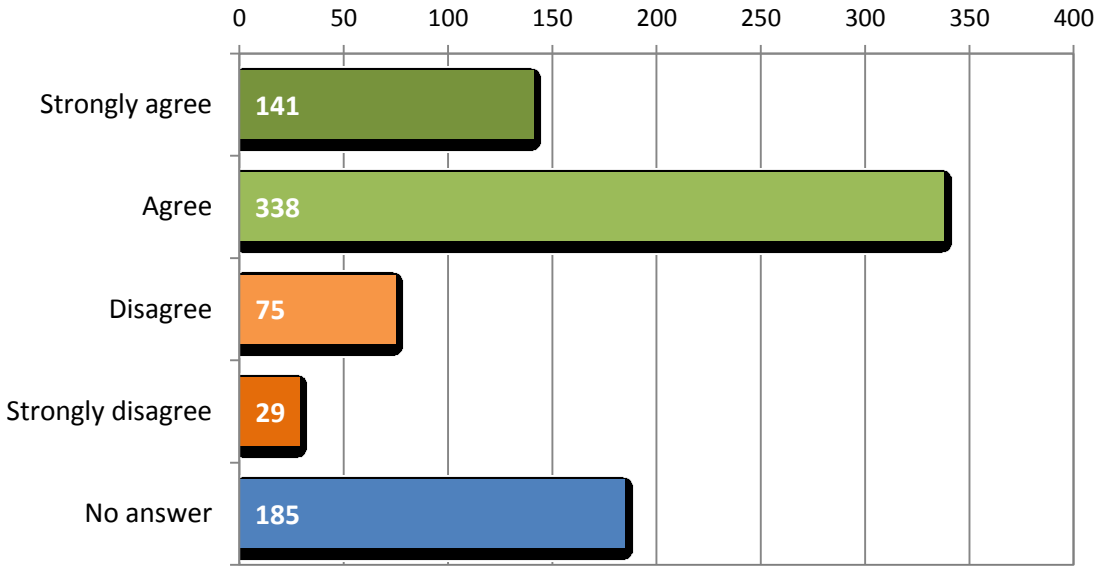

Figure 6 Overview of responses to consultation question 6a.

Of the 768 consultation respondents, 583 answered question 6a, which asked: *Do you agree with our proposal for assessing quality for populations and across local areas?* A clear majority of these respondents agreed or strongly agreed with the proposal, while a small minority expressed disagreement.

- The picture for most groups of respondents was roughly in accordance with the distribution as shown in Figure 6 above.
- Members of the public were very supportive of the proposal: only a small proportion of these respondents said they disagreed.
- Providers or professionals in primary medical care and members of CQC staff were less supportive than other groups. In the case of primary care providers and professionals a

substantial minority expressed disagreement; in the case of CQC staff members most did not answer the question, but those who did were fairly divided.

6.2. Responses to question 6b

Question 6b asked respondents: *What do you agree with, or not agree with, about assessing quality for populations and across local areas? When responding to this question, please indicate which part of the proposal your response relates to (populations or across local areas).* Approximately 380 respondents made comments in response to this question. Additionally, a small number of respondents commented on the proposal as part of a general response.

6.2.1. Opportunities and benefits

A large number of respondents indicated general support in their comments on CQC's proposal for assessing quality for populations and across local areas, although approximately half of the expressions of support came with a caveat, with respondents stating that they approved of the idea but had some level of doubt about how the proposal would be delivered.

"The Patients Association fully agrees with the CQC proposal for assessing quality for populations and across local areas." (Voluntary and community sector representative)

Respondents often suggested that the proposed approach would generate beneficial outcomes, saying for example that it would help ensure better provision of care across providers, supporting a patient-based view of care. They thought that a focus on populations and places would be an appropriate approach to regulating new models of care, supporting further partnership working and integration across the health and social care sectors.

"We also welcome the recognition that it is important to be able to assess quality in new models of care and care pathways and we would like to explore opportunities to work with CQC to ensure that doctors are working and being trained safely within these models." (Worker for another regulator)

In their comments, respondents identified various ways in which the proposal for assessing quality for populations and across local areas would benefit people who use services. In particular, they said that the assessments would assist in understanding local needs and meeting these, resulting in better access to care and more tailored care for local populations. Respondents also emphasised the potential for the assessments to highlight and help address local and regional variations in the quality of care.

"This proposal is an excellent approach for CQC to take and will help to check local health and care economies are really putting into practice what they are telling the public." (Member of a local Healthwatch or local Healthwatch staff)

One particular benefit of the approach, according to many respondents, was its potential to reveal information about the quality of care in a place or in relation to specific care pathways. Respondents highlighted that such information would be of great use, not only to CQC but also to local authorities, commissioners and the general public. They suggested that detailed information about the quality of care for local populations would help CQC to paint a national picture, understand trends and variations, and identify areas in need of targeted support. Respondents thought that on a local level, assessment findings might help local authorities and commissioners identify quality issues as well as good practice, supporting (joint) commissioning. They said that for the public, the information obtained from pathways assessments would be more meaningful than provider inspection reports, as the assessments would reflect how the public experience the care landscape. Respondents said that with this information, the public would be able to make more informed choices about their care.

"Being able to assess multiple services that a single patient may be using will give a broader view of health and social care as a whole." (Provider/professional – dental)

Some respondents spoke positively about CQC's approach to testing the proposed assessments through a number of pilots. Respondents agreed that this was appropriate and expressed their interest in finding out more about the results of the pilot schemes.

"The example on your website of North Lincolnshire provides a wealth of information and if detailed reports such as these can be produced for even each county area it would be beneficial." (Local councillor)

Other benefits that respondents associated with assessing quality for populations and across local areas included that the assessments would have a beneficial impact on equality and that the assessments could help clarify responsibilities for local issues.

6.2.2. Challenges and barriers

A relatively small number of respondents made general negative comments about the proposal for assessing quality for populations and across local areas. However, respondents expressed a range of specific concerns about the proposal, including several comments suggesting that CQC would not be able to deliver it successfully.

"Though we can see that there is considerable potential worth in this proposal we cannot support it given that it puts considerable extra burdens on a regulator already unable to deliver its primary objectives in a timely manner." (Provider/professional – adult social care)

Some respondents questioned the merit of assessing quality for populations and across local areas, stating for example that they were not convinced of the purpose of such activity, or saying that in doing this CQC would mostly be duplicating efforts already undertaken by other bodies.

"Governors raised issues around any overlap of this assessment with Monitor and TDA and external audit - recommend that duplication should be avoided." (Member of a foundation trust council of governors)

Several comments highlighted questions around accountability and enforcement, asking how CQC could address issues identified in the assessments, if for example a partnership of multiple providers was found to be inadequate. Similarly, respondents highlighted that CQC does not have powers to hold an entire care economy to account or to take regulatory action against, for example, commissioners or local authorities.

"We agree that this might be useful, but we remain unsure as to who would be liable should deficiencies in service provision be identified in an area. Where will the CCG fit in as they are not registered with CQC and CQC currently do not have jurisdiction over them?" (Provider/professional – adult social care)

Respondents also asked for greater detail on the proposal, stating that they were unsure about how CQC envisages implementing the proposal and what outputs would look like. They also requested greater clarity about the data, tools and systems that CQC would use to conduct the assessments, as well as how CQC would follow up on assessments. Some respondents specifically commented on the language of the proposal, complaining that there was too much jargon. There were various comments suggesting that clear definitions were needed as to what constitutes a 'population' or a 'local area'.

"However, it is not clear from the proposals entirely what this will mean in practice so it is hard to come to a clear view." (Member of an arm's length body)

Several respondents questioned whether assessing quality for populations and local areas was within CQC's remit, with some firmly stating that in their view it was not. Respondents suggested that CQC should concentrate on its core activity (looking after the quality or individual care providers) and/or that the task of assessing quality for places and populations should lie with a different organisation, for example Public Health England or local authorities.

[Respondent] believes this is the responsibility of others, such as the CCG's and NHS Strategic Clinical Networks. If CQC takes this on it will increase cost and may impact on CQC's ability to do what it is meant to do - act as public watchdog for monitoring provider services. (Provider/professional – adult social care)

In similar comments, several respondents expressed concern that if CQC were to concentrate on assessing quality for populations and across local areas, its commitment to carrying out provider inspections might suffer. Respondents emphasised that to them CQC's role in ensuring that individual care services are meeting quality standards was paramount. Some said that they would only support an expansion of the regulator's activity if it could guarantee it could keep provider inspections on track.

"This would be a great achievement but we would suggest that CQC should ensure that they have the right inspection processes and outcomes in place first." (Provider/professional – adult social care)

Several respondents said they were concerned about the potential impact of the proposal on CQC resources, either reiterating concerns about their diversion from CQC's current regulatory activity or more generally questioning whether the regulator would have sufficient staff to add assessing quality for populations and across local areas to its portfolio.

"We are concerned about the challenges to be overcome in making this stream of work meaningful and valuable given CQC's limited resources and capacity." (Voluntary and community sector representative)

Similarly, some respondents worried that the proposed assessments would be costly, reflecting that CQC's budget is expected to shrink over the next few years. A few respondents expressed disagreement with the prospect of provider fees being used on regulatory activity outside the scope of provider inspections.

"Who is going to fund you to expand into this new area?" (Provider/professional – primary care)

Some respondents highlighted issues around the data needed to assess quality for populations and across local areas. They thought, for example, that it would prove difficult to identify and collect accurate and reliable data that would allow the assessments. Others commented on the information that the assessments would produce, expressing doubt as to how the information could be used to improve the quality of care provision.

"The Council has further questions about how the data will be compared against other local areas; and how consistency in data will be achieved across all local authorities." (Local government officer)

Further comments on the implementation of CQC's proposal for assessing quality for populations and across local areas included a number of general observations that the task would be a difficult one, given the complexity of the care landscape. Several respondents warned against taking this too lightly, stating that the exercise would not be meaningful if it did not recognise the full range of relevant factors. Some respondents were particularly keen for CQC to take into account local-specific data, so that assessments acknowledge the particularities of specific locations.

"The care market is complex and is impacted by the economic and demographic environment. Equally, the differing natures of communities and their different health profiles also need to be taken into account." (Voluntary and community sector representative)

6.2.3. Suggestions

Respondents made a variety of suggestions in relation to the proposal for assessing quality for populations and across local areas. Many suggestions aimed to draw attention to particular places or populations that respondents envisaged would be relevant for CQC's proposed approach. In terms of places, a few respondents highlighted the need to assess care provision for (isolated) rural areas, while a few others thought that cities should take precedence. Respondents were keen for CQC to ensure that relevant background information is taken into account for assessments of places, so that comparisons are fair. In terms of populations, a range of specific groups were mentioned by participants, including carers, people with dementia, people requiring end-of-life care, people with mental health issues, people with treatable sight conditions, children and adults with learning disabilities, and children with complex needs. There was also a suggestion to concentrate on equalities and human rights and assess, for example, the quality of care for people by sexual orientation or gender identity.

"Those populations that need particular focus with regard to quality of service provision include learning disability, those with sensory impairments, carers, dementia, frailty and end of life." (Provider/professional – primary medical care)

Suggestions about the scope of CQC's quality assessments for populations or across local areas included several calls to broaden the assessments to include the quality of commissioning. Some respondents said they thought assessments should be specific to pathways. Particular elements that respondents would like CQC to consider included new models of care, support for carers, throughput in hospitals, GP triage and the integration of dentistry.

"We would be particularly interested to understand how CQC can make a more comprehensive assessment of the quality of commissioning processes in a local area." (Local government officer)

Other suggestions about the implementation of the proposal included several mentions of CQC's thematic analysis activity, generally stating support for this programme and highlighting how thematic assessments could play a role in establishing the quality of care for populations or across local areas. One respondent suggested that horizon scanning should be undertaken to identify which thematic reviews were needed.

"Could CQC use its powers and undertake thematic analysis to review and highlight areas where local services and systems need to work differently." (Provider/professional – mental health)

Some respondents suggested that CQC could make use of existing mechanisms and existing data to inform its assessments for populations and places. One example was to use feedback gathered during provider inspections.

"We have noted above that CQC might be able to generate information about service user pathways from collating information that is already held as a result of service inspections." (Voluntary and community sector representative)

As in responses to the other consultation questions, many suggestions were made as to other organisations that CQC could or should collaborate with to realise its aims for assessing quality for populations and across local areas. Some of those who responded on behalf of organisations offered to work with CQC within their particular area of expertise. Others emphasised the potential benefits of close involvement of providers or commissioners in the delivery of the proposal. Other specific organisations whose relevant expertise was highlighted included: Public Health England, Ofsted, NHS England, NHS Improvement, and local authority quality teams.

"Commissioners should be encouraged to find ways to reward great practice and to actively promote pathway meetings where successes are dissected and learnt from." (Provider/professional – adult social care)

Other suggestions included ensuring that there are sufficient and appropriate mechanisms to collect the views from people who use services, including those who need support expressing it, sharing evidence across the devolved nations, and better communication.

6.3. Feedback from consultation events

6.3.1. Opportunities and benefits

General comments from participants on CQC's proposals for developing methods to assess quality for population and across local areas included **expressions of qualified support** for the idea, stating that the theory is good.

Participants said that assessing quality across local areas would be important as it would help **identify health needs and gaps in provision**. Participants highlighted that no one currently takes responsibility for such assessments. They asserted that the proposed approach would help avoid a postcode lottery of care by uncovering differences between places.

Participants saw various **strategic benefits** in the proposals, which they thought could help achieve system-wide improvements. In particular, participants thought that the proposed methods could identify issues with **commissioning**, and put CQC in a position to influence this. They thought the assessments would help evaluate **the allocation of funding**, clarify how well services are used (and where resources are underused), whether the delivery of services meets what has been agreed at management level, and 'who is in charge in an area'. Participants also generally commented that the proposals had the ability to **hold local authorities and commissioners to account**, or to establish joint accountability through joint protocols.

Participants emphasised that the proposals could **expose barriers** to quality improvement and highlight pressure points within the system. Another thing participants said the proposals would identify was the variation in community and hospital service. They added that carrying out **thematic reviews** in good areas could encourage improvement elsewhere, or emphasised the potential of sharing good practice about pathways. It was mentioned that councils sometimes use CQC's thematic reports to decide what to review.

Participants thought that assessing quality for places and populations could assist CQC's efforts to **target and tailor inspection activity**, as it would reveal issues that CQC should look at. Participants thought the assessment findings would also help commissioners. They emphasised the potential of having population-specific information, and cited examples of populations whose health needs were important to know, such as homeless people.

The proposed approach could also support the **integration of services**, according to participants, who also said that it was important to have better information about the quality of pathways and about people's actual experiences. There was a suggestion that **assessing pathways** would enable looking at the 'softer' things that are important to people. Participants also mentioned new models of care, saying that the proposals would present an opportunity to regulate and assess new services.

Participants identified opportunities for the public to obtain better information about services in their area. They thought the findings from place-based and population specific assessments would **enable the public to make more informed choices** regarding the (specialist) services they use, which would also help people who are moving into new areas. It was suggested by participants that a place-based approach would be beneficial for the public's ability to understand, while some comments called for an accessible framework to aid this.

Participants said the proposals could push care to being individual-led and that they could **empower people** to take more responsibility for their health. They added that the proposals would raise expectations for people with care conditions and that they could help users focus on the quality of their services. Participants suggested there might be a role for CQC in explaining experiences impartially and standing up for people who use services.

Potential **benefits for providers**, according to participants, included that the proposals would encourage **healthy competition** and help providers benchmark their services. Participants also thought the assessments would foster **sharing information** between providers and the idea that all providers are 'in it together', as well as bringing their story to life, for instance the mental health pathway. Greater clarity about expectations was seen to benefit providers too and participants added that a clear framework would save providers time.

As with some of the other proposals, participants supported the idea that the proposal for assessing quality for populations and places would encourage **greater partnership working** between CQC, local authorities and commissioners, sometimes also citing the potential for partnerships to encompass providers or the public. There was a specific mention of the voluntary sector too.

6.3.2. Challenges and barriers

General challenges and barriers to assessing quality for places and populations raised by participants included questions about **whether such assessments would be useful** and observations that this should not be a **priority**. Participants expressed scepticism about the possibility to obtain meaningful information or uncover structural issues, pointing to the **complexity of the task** and the health and social care sector in general. Questions were also asked about whether the proposed assessments would be useful to the public, with participants highlighting that they would not describe specific services. Furthermore, participants wondered **how findings would result in improvements**, for instance who should be held to account for failing pathways.

There were comments from participants stating that they valued CQC's **provider-based approach** and would not support a departure from the current approach, as it would increase risk. Participants generally questioned whether assessing quality for specific populations and across local areas should be within **CQC's remit**, sometimes specifying that public health is not a target for CQC. Suggestions were made as to which other organisations should conduct these assessments instead and participants mentioned local authorities, Healthwatch and Public Health England.

If not the remit, some participants questioned **CQC's ability** to take on the proposed assessments, wondering whether it would fit in with the organisation's current activity and whether it would have **capacity** to address this task on its own. Participants thought it might be difficult for (specialist) inspectors to cover such a wide range of services. A specific comment was made about CQC's ability to assess and measure outcomes of preventative programmes. There were questions as to which part of CQC should lead these assessments.

Participants also reflected on **CQC's resources** and were sceptical about the organisation's ability to do a good job at assessing quality for populations and places as well as fulfilling its existing regulatory duty. They wondered whether implementing these proposals would see the number of provider inspections reduced and emphasised the need to get the current regulation right first. There was also a question about the funding of the proposed approach.

Comments about the **scope of the proposals** included concerns that they would not cover currently unregulated care services and unmet needs. There were also questions about how the approach would capture the experiences of hard-to-reach individuals and communities, or particular groups such as non-resident service users.

There were a range of comments and questions from participants on the **method** for the proposed assessments. Participants thought the proposed approach would require clear **definitions of populations and places**, finding solutions to deal with services that cross boundaries and recognising variation within population groups. General comments included observations about the difficulty to analyse assessment data as well as questions about what outputs would look like. Participants warned that **interpreting data** would require great care and that local variations might hamper the extent to which information is meaningful.

Participants identified various factors that might **complicate the task**, in particular the specifics of each local area, such as levels of deprivation, differences in funding, and devolution issues. Participants thought that the inspection team would need deep local knowledge in order to appreciate these issues. They also pointed to the difference in health and social care in an area as a potentially complicating element.

There were observations from participants about whether local partners would be ready to commit to the proposed assessments. Participants said **local authorities and commissioners** would be difficult to persuade to share information, or that they might not be keen to adapt the same priorities.

Other comments from participants included: a question about encouraging improvement in **health and wellbeing boards**, a concern about **providers' (financial) ability** to comply with CQC requirements, a question about the role of **carers**, and a concern that people would **move area** to receive better care.

6.3.3. Suggestions

Participants made various suggestions about the **focus** for CQC's assessments of quality for specific populations and across local areas. They thought that **place-based assessments** might be most appropriate for areas that show signs of poor quality, or deprived areas in general. However, they also indicated that CQC should take into account the local financial situation when it assesses the quality of care. Another suggestion was to use public health indicators to inform what to focus on in a specific area. Participants argued that **assessments for specific populations** could concentrate on particular vulnerable groups or on conditions including mental health issues, sensory impairment and dementia.

A few other suggestions with regard to the **scope** and focus of the assessments were:

- To assess the quality of **commissioning** with NHS England and Public Health England
- To include **public health** and preventative care
- To include **access to services**
- To include external services such as (public) **transport** and parking
- A suggestion that **population-specific assessments** would be more useful than place-specific assessments.

With regard to the implementation of the proposed assessments, participants suggested that CQC could review the approach so that the emphasis is on pulling together **existing data**, rather than CQC collecting and compiling. They said that CQC could use existing projects to generate data for thematic reviews. Potential sources of data mentioned by participants included provider forums and local authority plans.

More generally, participants made suggestions for CQC to develop an **easy-to-understand framework**, as well as a need to integrate thematic and/or pathway reviews within assessments of quality for a local area. Another suggestion was for the **equality impact assessment** to be embedded in the proposed quality assessments. There was a

recommendation from participants to share examples of integration working well, as well as a suggestion to make **partnership working** a key line of enquiry.

Participants made various suggestions about how CQC could deliver the **assessments together with others**. They included a request that CQC develops the right prompts and questions for the assessments and checks these with the sector. It was also suggested that universities could help develop a strategy, or that CQC could work with people who use services and Experts by Experience. Participants proposed that people who use services could keep diaries of their experience for CQC to review.

Suggestions were made about **communicating with the public**, with participants emphasising that CQC should use more communication channels, warning about technology that is not accessible to some groups of the population. There was a recommendation to engage through community groups and a plea for CQC reports to be relevant to the local population.

A few suggestions were made in relation to **how services could be improved** with a view to achieving better care for specific populations and across local areas: all aspects of the pathway to be managed from a **central hub** or care centre, **advocacy support** to be available within pathways, and **NHS numbers** to span health and social care.

Chapter 7: Impact on equality and human rights

This chapter give an overview of respondents' views on the impact of CQC's proposals on equality and human rights. It summarises responses to consultation question 7.

7.1. Responses to question 7

Question 7 asked respondents: *What impact do you think our proposals will have on equality and human rights?* Approximately 350 respondents made comments in response to this question. Additionally, a small number of respondents commented on the impact as part of a general response.

7.1.1. Overall views

Of the roughly 200 respondents who expressed an overall view about the proposals' impact on equality and human rights, approximately half said that they believed the impact of the proposals would be positive. A very small number of respondents thought that the proposals would have a negative impact on equality and human rights, while most others thought there would not be a discernible impact either way. A few other respondents said they were unsure.

"Ultimately improving and strengthening the way in which data is used and collected will enable CQC to identify risks and thus improve human rights." (Other)

7.1.2. Specific comments and suggestions

Many respondents did not expand on their comments expressing their overall views. However, respondents who did make specific comments highlighted a range of considerations. Those who thought the proposals would have a positive impact said, for example, that they thought the proposals would support the needs of vulnerable groups. Similarly, some respondents agreed with the proposals' emphasis on the perspective of people who use services.

"It is vital that vulnerable groups are being supported both because they are often the hardest to reach and the most likely to be in need of support." (Provider/professional – adult social care)

Some respondents referred to the potential outcomes of the proposals and regarded improvements in the way care is delivered and monitored as positive impacts on equality and human rights. Similar comments were made about better standards of care, better information and greater transparency.

"If there are the resources to fully implement these proposals I think a far better service would be provided for everyone within your local area. (A member of the public)

Several respondents, including some whose overall view was that the impact of the proposals would be positive, expressed reservations about particular aspects of the equality and human rights impacts. A common caveat was that the impact would depend on the implementation of the proposals, with some respondents expressing some degree of doubt as to whether CQC would be successful in this. A few comments emphasised the importance of embedding an equality and human rights approach into the delivery of the proposals.

"Anyone can write visions or mission statements but care providers need to feel it to understand the impact. Equality is essential as every human being is the same and if any provider fails on equality then it must be brought to account and lose its contract." (A member of the public)

Some respondents commented that specific vulnerable groups needed greater focus in the proposals or specific support to obtain the care they need. Sometimes, these comments reflected on issues or barriers within the care system which have a detrimental impact on groups or individuals. Specific mentions included: people in rural areas, people with dementia, people receiving end-of-life care, people with learning difficulties, ethnic minority populations, and homeless people.

"However, frail older people currently need all the protection they can get. Many frail older people are at risk in the community as the result of lack of resources leading to dangerous thresholds for care, poorly commissioned or poorly delivered services." (Provider/professional – adult social care)

Specific comments on the draft impact analysis included several expressions of agreement, usually simply stating the respondent's support for the impact analysis, or a mention that they broadly agreed with its content.

"The analysis identifies some important opportunities and risks, and factors to consider in terms of maximising opportunities and mitigating against risks." (Provider/professional – other)

Some respondents indicated that they thought the draft impact assessment lacked detail, or that it some of its themes were not clearly present in the consultation document. Specific elements that respondents thought were insufficiently detailed in the draft impact assessment included the implementation of the proposals in general and an approach to supporting individuals who may have difficulty expressing their views.

"The impact analysis clearly outlines how each of the 6 themes will be considered in terms of equality and human rights. It does not give specific detail of how some of the areas will be achieved so further information on this would be welcomed." (Local government officer)

Chapter 8: Other comments about CQC

8.1. Consultation responses

This chapter gives a very brief summary of respondents' comments about the Care Quality Commission. Across consultation questions, respondents made many comments reflecting on CQC's current practice. While these comments are not strictly speaking relevant to the consultation, as they do not address the proposed strategy, they may be useful in understanding respondents' hopes and concerns about CQC's regulatory activities.

In total respondents made some 350 comments about CQC. The bulk of these comments were made in response to consultation questions 1 and 8, and in responses that did not refer to the consultation questionnaire.

A large number of the comments about CQC were about its current inspection practice. Many respondents commented on the effectiveness of inspections, generally to state that they did not think that (elements of) inspections were currently effective. Another common theme in respondents' comments about inspections was consistency, stating that there was too much variation between CQC inspectors' judgements. Other concerns about inspections included the burden they represent for providers and their lack of efficiency and proportionality.

"You mention ongoing support and advice. From our recent inspection we felt very let down from the feedback we received and completely deflated professionally."
(Provider/professional – primary medical services)

Respondents also made several comments about the ratings system employed by CQC, often complaining that it is not effective. Some of these comments related to observations about inspections – notably the perceived inconsistency – and expressed a sentiment that the meaning and fairness of the ratings system was undermined by poor inspection practice. Respondents also questioned the ratings system more broadly, with comments including perceived barriers to achieving an 'outstanding' rating as well as concerns about public perceptions – especially regarding the boundary between 'good' and 'requires improvement'.

A further common theme in respondents' comments about CQC was that of provider fees. Several respondents commented on the proposed increase in provider fees – which was the subject of another recent consultation – or on the financial relationship between the regulator and providers more generally. Respondents sometimes reasoned that CQC should ensure that it uses its income from fees on activities that directly benefit providers.

There were also various general comments about CQC, many of them negative, including suggestions that CQC should be abolished or that it was not fit for purpose. A smaller number of general positive comments were made, including praise for CQC's work in general, its progress over recent years, and its efforts to consult with the public.

"We feel that the existence of the CQC does contribute to ensuring that children and their families receive high quality care." (Provider/professional – other)

8.2. Consultation events

Participants made a range of comments which were not specific to any of the vision themes, but rather a reflection on how CQC currently operates. Most of these comments were about participants' perception of CQC's inspection activity.

Commenting on **the scope of CQC's inspections**, participants thought that commissioning by local authorities and CCGs could be subject to CQC scrutiny as well. They thought that the current inspection regime could not sufficiently address quality issues that were outside providers' control. Another suggestion was for inspections to expand to carers who can be contracted by people on a personal budget.

Comments from participants included suggestions that there is currently **too much variation**, with different inspectors asking different things. They called for a shared framework to help the consistency of evidence used in inspections. Participants thought that feedback on provider information requests (PIRs) failed to specify whether it had satisfied inspectors' information needs, and cited an example of poor timing of an information request.

It was suggested by participants that inspectors should spend time within a provider setting so that they are better equipped to assess the quality of services. Participants also said that CQC should work more with **Experts by Experience**, and added that they should be properly trained, suggesting that current training is insufficient. Another comment was that the agreements that Experts by Experience need to sign should be streamlined.

Participants expressed concern about the time it takes for CQC to **produce feedback** and/or reports after inspections, while also suggesting that reports should be briefer and more consistent. They further suggested that some inspectors should receive training in giving feedback, and said that the 'mum test' was an appropriate tool for ensuring that feedback was clear enough. Another comment was that patients do not read inspection reports, and may not be bothered about provider ratings.

Participants said that inspections can have a disproportionate **impact on providers**. They also mentioned the impact of inspections by different bodies on care home residents. According to participants, there should be closer **collaboration** between inspectors and providers, and more communication in between inspections.

Participants made various comments about **CQC and the general public**, saying for instance that CQC should do more work in partnership with people who use services to obtain a more accurate picture. They were concerned that the public sees CQC as an organisation that takes away services, which may result in hostile views. Participants also questioned whether CQC was sufficiently equipped to address some key barriers for vulnerable groups. According to participants, the public primarily wants to be reassured that services are safe, and how to address issues that they encounter. They added that CQC needs to be clear that it is not tasked

with investigating individual complaints. Another suggestion was for CQC to raise more awareness about its thematic reviews.

On the topic of **registration**, participants expressed concerns about the process, saying that CQC's understanding of providers fell short or citing an example of a bad experience in trying to register a service with CQC. Participants mentioned a lack of connection between registration and inspectors. They suggested there should be a qualification requirement for registered managers.

There were a few comments on the topic of **equality, diversity and human rights**, with participants suggesting there should be a lead inspector for this topic area and stating concern about the quality of commissioning for particular groups, such as black and minority ethnicity people.

Appendix 1

Social media feedback

CQC invited public and stakeholders to engage in the consultation via social media and collected feedback it received on Twitter and Facebook. 57 tweets were collected. Most of the Twitter feedback was received as part of an online conversation that CQC publicised and hosted. A small number of other comments were tweeted during the consultation period, and collected by CQC.

Twitter comments on **CQC's vision** for quality regulation included calls for it to link more clearly to outcomes for patients or to demonstrate how these would be achieved. Other tweets highlighted the importance of continuous improvement, suggesting that this should be the focus, and warning that compliance breeds apathy.

Other **general comments** received via Twitter included a call for CQC to deal with the quality of commissioning, as this would impact on the quality of care services, and a suggestion to learn from the work of other regulators. Comments were also tweeted about NICE Quality Standards, the RightCare programme, and about encouraging sharing good practice between providers.

Users tweeting about better use of **data and information** commented that this would require good quality data from the public, or that CQC needed to look at joined-up data to see the whole picture. One tweet noted that monitoring risk had gone wrong in the past.

Twitter comments about the proposal for a **single shared view of quality** included a few voicing agreement, stating they saw the need for greater alignment. Users also suggested that CQC should develop criteria as to what information is acceptable from providers and emphasised the importance of the proposal for mental health and paramedics.

Several tweets expressed agreement with the proposal for **targeted and tailored inspections**. Users thought that targeted inspections would represent an overall improvement, a good way of prioritising CQC's resources and a better use of public money. Some other tweets expressed caution or disagreement, stating that inspection activity should not be reduced, or that targeted inspections would see CQC concentrating too much on poor performance. Other tweets included a comment that it would make sense for CQC to target offenders and an observation that the public are unaware of the size and scope of CQC's inspections.

A few users of Twitter commented positively on the proposal for **assessing quality for specific populations and across local areas**, stating support for a focus on pathways and systems, and saying for example that this would help drive improvement. Tweeted suggestions included that CQC should look at joined-up health and social care pathways, that specialist teams were needed for pathway assessments and that the assessments should only happen where risks have been identified, for instance around hospital discharge. A few tweets suggested that the proposal would be difficult to carry out, with one stating that it might delay reports and one questioning how CQC would define a place.

Some of the tweets collected during the consultation contained comments about **CQC's practice**, including a few comments encouraging CQC to improve its performance or to deliver more value for money. Some others tweeted their desire for CQC to stop operating altogether, saying this would free up time for providers to deliver care. Specific suggestions included calls for CQC to provide more support to struggling services and to focus on patients and frontline staff. One user asked how they could address inaccuracies in CQC reports. Another expressed dismay at changes to the contracts of Experts by Experience.

A total of eight comments were made in response to CQC's posts on **Facebook** with regard to the strategy consultation. These were mostly negative general comments on CQC, including a comment specifically questioning the objectivity of care home inspectors. One user encouraged CQC to use social media feedback in its regulation of social care providers.

Appendix 2

Consultation questionnaire

1a Do you agree with the vision we have set out for regulation of the quality of health and adult social care services in 2021?

- Strongly agree
- Agree
- Disagree
- Strongly disagree

1b What do you agree with, or not agree with, about the vision?

2a Do you agree with our proposal to make greater use of data and information to better guide us in how we identify risk, and how we register and inspect services?

- Strongly agree
- Agree
- Disagree
- Strongly disagree

2b What do you agree with, or not agree with, about greater use of data and information?

3a Do you agree with our proposal for implementing a single shared view of quality?

- Strongly agree
- Agree
- Disagree
- Strongly disagree

3b What do you agree with, or not agree with, about a single shared view of quality?

4a Do you agree with our proposal for targeting and tailoring our inspection activity, including reducing the frequency of some inspections so we target our resources on the greatest risk?

- Strongly agree
- Agree
- Disagree
- Strongly disagree

4b What do you agree with, or not agree with, about targeting and tailoring our inspection activity?

5a Do you agree with our proposal for a more flexible approach to registration?

- Strongly agree
- Agree
- Disagree
- Strongly disagree

5b What do you agree with, or not agree with, about a more flexible approach to registration?

6a Do you agree with our proposal for assessing quality for populations and across local areas?

- Strongly agree

- Agree
- Disagree
- Strongly disagree

6b What do you agree with, or not agree with, about assessing quality for populations and across local areas?

7 What impact do you think our proposals will have on equality and human rights?

8 Are there any other points that you want to make about any of the proposals in this document?