

## Consultation

# Our next phase of regulation

A more targeted, responsive  
and collaborative approach

Cross-sector and NHS trusts



# Contents

Foreword .....	3
Introduction.....	4
1. Regulating new models of care and complex providers .....	6
2. Our assessment framework.....	10
3. Registering services for people with learning disabilities .....	19
4. Next phase of regulation – NHS trusts .....	21
How to respond .....	35

## Separate annexes

Annex A1: CQC’s assessment frameworks for healthcare services – key lines of enquiry and characteristics of ratings

Annex A2: CQC’s assessment frameworks for adult social care services – key lines of enquiry and characteristics of ratings

Annex B: Registering the right support – updated guidance on registering learning disability services

# Foreword

Our strategy for 2016 to 2021, published in May 2016, set out an ambitious vision for a more targeted, responsive and collaborative approach to regulation, so that more people get high-quality care.

Demand for care has increased as more people live longer with more complex needs. Providers are meeting the challenges this creates by breaking down the traditional boundaries between hospital care, community-based services, primary medical services and adult social care services. They are turning to new ways to deliver care and using technology so that they can deliver person-centred care efficiently. CQC will respond to this changing environment in a way that facilitates and supports improvement and sustainability, and that continues to make sure people have access to safe, effective, compassionate, high-quality care.

We want your views on how we should develop our approach further as we implement our five-year strategy and move into the next phase of our regulatory model.

Some of our proposals apply to all regulated sectors, and include how we will regulate new and complex types of providers. We will evolve our assessment framework, which we use to make judgements about the quality of care. Our proposals aim to simplify our assessments, but also strengthen them using what we have learned over the last three years to make sure we continue to find out whether services are safe, effective, caring, responsive and well-led.

Our other proposals focus on how we will monitor, inspect, rate and report on NHS trusts from April 2017. These proposed changes are designed to enable CQC to be more responsive to risk and improvement, as well as to be more efficient and effective – by working more closely with our partners to increase alignment and reduce duplication. They also have a stronger focus on the importance of leadership to drive improvement.

Alongside this consultation, we are consulting jointly with NHS Improvement on our approach to leadership and use of resources in NHS trusts. CQC and NHS Improvement are committed to working together to recognise that effective use of resources is fundamental to enable health and social care providers to deliver and sustain high-quality care.

We will publish a second consultation in Spring 2017, which will focus on how we regulate adult social care and primary medical services.

As we update our approach, we want to keep the elements that we know people value and to improve what people tell us we can do better. We will continue to work with people who use services, providers, professionals and our other local and national partners to co-produce what we do.

We are grateful for your feedback to this consultation, which we will use to develop the next phase of our regulatory work.

**David Behan**  
**Chief Executive**

# Introduction

CQC's purpose is to make sure health and social care services provide people with safe, effective, compassionate high-quality care and we encourage care services to improve. Our strategy, *Shaping the future*, set out an ambitious vision for a more targeted, responsive and collaborative approach to regulation. We have four strategic priorities, which are to:

1. Encourage improvement, innovation and sustainability in care
2. Deliver an intelligence-driven approach to regulation
3. Promote a single shared view of quality
4. Improve our efficiency and effectiveness.

The accompanying 'sector by sector' [publication](#) to our strategy described how we would regulate and encourage improvement in each sector. In this consultation, we set out further detail about how we propose to update our approach and our assessment framework to reflect the changing provider landscape. We want to hear your views on these proposals, which are aimed at achieving:

- a more integrated approach that enables us to be flexible and responsive to changes in care provision
- a more targeted approach that focuses on areas of greatest concern, such as safety, and where there have been improvements in quality
- a greater emphasis on leadership, including at the level of overall accountability for quality of care
- closer working and alignment with NHS Improvement and other partners so that providers experience less duplication.

This year's State of Care [report](#) showed that, despite increasingly challenging circumstances, much good care is being delivered and many services have improved. However, it also painted a varied picture of quality, with some evidence of deterioration and some providers struggling to improve their rating beyond 'requires improvement'. Safety continued to be our biggest concern across all sectors – often influenced by the quality of leadership.

CQC has an important role to play in encouraging improvement and sustainability, and we will continue to highlight good and outstanding care and to share our unique insight. Where we have evidence of poor care, and the fundamental standards of care set out in our regulations are not met, we will take regulatory action. Again, we want to encourage improvement in the quality and safety of care, but we will take action to protect people where necessary.

We are considering what more we need to do when a provider has been unable to improve from a 'requires improvement' rating. We also want to explore how we might recognise a provider that has made improvements, but has not yet managed to move from a 'requires improvement' rating to a 'good' rating or from a 'good' to an 'outstanding' rating. We will include further details on this in our consultation in Spring 2017, which will also focus on how

we will regulate adult social care and primary medical services, and include further detail on the changes we want to make to how we register providers.

Alongside this current consultation, we are consulting jointly with NHS Improvement on our [approach to leadership and use of resources in trusts](#). We would encourage trusts to read both consultation documents before responding.

This consultation seeks your views on specific proposals for:

1. how we will regulate new models of care and complex providers
2. changes to our assessment frameworks across all sectors, and including an updated well-led key question for health services, which has been developed jointly with NHS Improvement
3. how we will register services for people with learning disabilities
4. how we will regulate NHS trusts and foundation trusts (referred to throughout as trusts) from April 2017, including how we might change our approach to rating.

Sections 1 and 2 of this consultation apply to all providers. Our Spring consultation will include the detail of how we propose to regulate adult social care and primary medical services.

When we publish our final assessment frameworks next year, we will make them available as online information, as well as documents. This will mean you can find the information you need by searching or navigating our website on whichever devices you use, as well as printing or saving the information to share with colleagues. The information will be in sections of the website for each type of service we regulate so that services and staff can easily access the information relevant to them. We will clearly show which information is generic to all services.

We are grateful for your feedback on this consultation, which closes on **14 February 2017**. See page 35 to find out how to respond.

# 1. Regulating new models of care and complex providers

Our inspections have found that many health and care services in England are providing good quality care despite a challenging environment, but that substantial variation remains. Maintaining quality while demand increases and budgets are under pressure is going to be challenging, even for the best-led services. Some local areas are responding by starting to shift towards new models of providing care.

National initiatives, such as the Sustainability and Transformation Plan process, devolution and the new care models programme, are supporting and enabling progress. However, we also know there are many commissioners and providers, beyond these national programmes, that are innovating and collaborating to improve care for the people they serve. CQC understands and supports these changes. We need to be flexible so that we continue to assure quality, encourage improvement and give people the information they expect from the regulator.

We know that innovation and change can lead to periods of uncertainty. We will support providers during this period, and make sure that regulation is not a barrier to innovation. In order to help us achieve that, we will expect providers to have clearly thought through how they will maintain quality through a period of transition, and how they will manage any identified risks to people who use services. In any new and complex models of care we will want to establish who is accountable for the provision of care. Our focus will continue to be on assessing the quality and safety of frontline services and providing information that is meaningful for the public.

CQC already regulates diverse and complex organisations, including trusts that provide services that span hospital care, community services, primary care and adult social care ('combined trusts') and corporate providers in health and adult social care – some of which provide diverse and geographically dispersed services across sectors. Our regulatory approach to combined trusts has been guided by six aims, outlined in our current sector provider handbooks. These aims continue to be relevant, and we have developed them further into a set of principles that will underpin our future approach to all types of complex providers, including new models.

## Our principles

We have developed a set of principles to guide our approach to regulating in a changing landscape of care provision:

1. We will always take action to protect and promote the health and well-being of people using services where we find poor care.
2. We will hold to account those responsible for the quality and safety of care.
3. We will be proportionate, and will take into account how each organisation is structured and its track record to determine when and how to inspect.
4. We will align our inspection process, where possible, to minimise complexity for providers that deliver more than one type of service.

5. We will be transparent about our approach and about how we make regulatory decisions.
6. We will not penalise providers that have taken over poor services because they want to improve them.
7. We will deliver a comparable assessment for each type of service, regardless of whether it is inspected on its own or as part of a complex provider.
8. We will rate and report in a way that is meaningful to the public, people using services and providers.
9. We will bring together inspectors who have specialist knowledge of different sectors to inspect jointly, where this is most appropriate for the provider.

Many of the changes we are consulting on in this document, and the consultation we have planned for Spring, are designed to support the changes we see providers making.

## Registration

Registration represents the start of the regulatory relationship and is the beginning of a process where providers commit to delivering care to defined quality and safety standards. If we do not register a provider correctly, it will affect our ability to monitor, inspect and rate a service and take regulatory action in the future.

Since starting our new approach to inspection across health and social care in 2014, we have seen that good leadership is critical in ensuring that people receive safe, high-quality care in a way that is sustainable. Apart from our assessments of trusts, we have focused our attention on leadership at the individual service level. But if we are to truly encourage improvement, innovation and sustainability in care in a way that maximises our efficiency and effectiveness, we need to consider whether this is always the right approach.

Some of the emerging models of integrated care and existing large and complex organisations present challenges for our current approach to registration. We therefore need to make sure that providers are clear about who has accountability for quality and that, where relevant, we adequately reflect the role of head office or board-level leadership when registering these types of organisation.

We will be working with stakeholders to develop proposals for consultation in Spring 2017 about how we can change the way we register providers at the level of the organisation's 'guiding mind' to better reflect new and more complex organisational structures. Currently the way we register providers is not always flexible enough; for example, our use of physical locations is more relevant for care homes than online providers.

We encourage any provider who is thinking through a change to let us know early in the process so we can offer support where it is needed. We want to build and maintain ongoing relationships with providers so that we are able to provide advice where changes to registration status are needed. We also expect providers to ensure that their Statement of Purpose is up to date at all times, as this is a core document that enables CQC to offer a consistent and coordinated approach to regulation.

Some innovations will not require changes to a provider's registration status, but we want to encourage providers to tell us about any innovative practices they are adopting, including by

using an improved provider information return and better ways to provide and update information through our online portal. This will help CQC take account of these changes, for example in our schedule of inspections across sectors. We will encourage improvement by recognising and reporting the innovations we find, while making sure that care continues to be safe, effective, caring, responsive and well-led.

## Assessment framework

We have previously published ‘handbooks’ for providers that set out how we regulate and inspect each sector, which resulted in 11 separate handbooks and accompanying assessment frameworks (key lines of enquiry, prompts and ratings characteristics) for specific types of service.

To reflect the way providers are changing, we now propose to move from 11 separate assessment frameworks to just two – one for health care, and one for adult social care. We will continue to provide additional sector-specific material, such as core service inspection frameworks (currently used for acute hospitals) and brief guides (currently used for specialist mental health services).

We think this will reduce complexity and confusion for providers that deliver more than one type of service, for example, a trust that delivers acute or mental health care and community health services, and also runs several care homes. We want to ensure that our end-to-end approach from registration through monitoring and inspection to rating and reporting provides a single high-level process that can be tailored to individual providers.

## Inspection

Our inspection teams will continue to specialise in a particular type of service, and inspections will still involve professional advisers and, where appropriate, people who have personal experience of using services (Experts by Experience). When a provider delivers a wide range of services or a more integrated model of care, we need to be able to bring these specialist inspection teams together, and a single high-level process will enable us to do this.

We are also exploring how we can schedule our activity in a way that recognises where providers are working together in less formal partnerships or as an entire local health and care economy. This would enable us to offer a coordinated approach to inspections in a local area or to provide a broader assessment of the quality of care in a place. We are continuing to develop and test approaches to assessing the quality of care for specific population groups or areas, through our thematic inspection activity and our quality in a place pilots.

## Rating

As services become larger and more complex, with a mix of service types delivered at different scales, we need to consider how best to present our ratings at overall organisational level. We do not currently produce an organisational level rating for any provider other than trusts, but we may wish to in the future. The assessment of leadership, through our well-led key question, will be of particular interest to us for such new or complex models, given its

significance for the sustainability, quality and safety of services. At the same time, we have been clear in the principles we have set out that we will not penalise providers that have taken over poor services because they want to improve them. We therefore need to consider how to ensure that an overall organisational level rating does not act as a disincentive. We describe these challenges in the context of trusts in section 4 and ask for views.

Our consultation in Spring will seek further views on how we register and rate new models of care and complex types of providers, in line with the principles we have set out here.

### **Consultation questions**

1a Do you think our set of principles will enable the development of new models of care and complex providers?

[Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]

1b Please tell us the reasons for your answer.

## 2. Our assessment framework

This section describes the changes we are proposing to our assessment frameworks across all the health and adult social care services that we regulate. Our assessment frameworks include our five key questions, the key lines of enquiry (KLOEs) and prompts, and ratings characteristics.

Our proposals (set out in [Annex A1 for healthcare services](#) and [Annex A2 for adult social care services](#)) are intended to support the implementation of our strategic priorities by more closely aligning our assessment frameworks for all sectors, enabling providers to more easily understand what we expect of them. They are also intended to reflect new or emerging themes in health and social care, such as the increasing integration of care and the use of technology to enhance care delivery.

Where we have evidence of poor care and the fundamental standards of care set out in our regulations are not met, we will take regulatory action. We want to encourage improvement in the quality and safety of care, but we will take action to protect people where necessary.

### Why we propose changes to our assessment framework

Care providers and other oversight bodies welcomed the clear way that we assess quality by asking each service the same five key questions: Is it safe, effective, caring, responsive and well-led? Some providers have aligned their own governance processes around these questions. We are not proposing a significant shift in what we already ask of providers; rather, our proposals for change represent an evolution of our framework.

Our proposals are intended to **strengthen** our assessment by:

- reflecting changes in the sectors
- incorporating what we have learned over the past three years and from new good practice guidance
- using the feedback we have received from internal and external stakeholders.

Our proposed changes are not intended to 'raise the bar' or make it more difficult for providers to achieve a good or outstanding rating. The majority of content is very similar to the frameworks we introduced in 2014. However, CQC's role in encouraging improvement means that we will look to providers to be able to demonstrate how they are developing and adapting to new evidence of good practice as well as the changing care landscape to improve the quality of that care.

The proposals are also intended to **simplify** the process by more closely aligning the questions we ask of different sectors and the characteristics that reflect a rating. A simpler process will reduce the regulatory burden on providers that deliver care across traditional health and social care boundaries, by working better with shared governance systems. It should also make it more straightforward for providers to respond to our regulatory requests and for statutory and local groups to collect evidence to support our work.

Our assessments of combined providers and new care models, and thematic or place-based inspections will also be made simpler, and our internal systems and processes will be more efficient. The proposed changes will also support our strategic priority, shared by our stakeholders, to promote a single shared view of quality – a consistent approach to defining and measuring quality and to collecting information. Through greater alignment of our frameworks, we will move closer to agreeing a definition of quality based around our five key questions, which means we can be clear and consistent about how we assess the quality of care across different types of service.

In our strategy for 2016 to 2021 we also committed to improving our registration process by using a framework based around our five key questions. The revised framework will inform the evidence that we will look for when registering providers, making the links between registration and the rest of our operating model more explicit.

We recognise that some providers and other stakeholders may have developed internal quality assurance or monitoring processes that reflect our current assessment framework and that any change to our framework may require these to be updated.

We have made some minor wording changes across the frameworks for clarity of language, which are not explicitly highlighted in our consultations proposals. However, we have made clear where we have introduced new KLOEs or prompts, made significant changes to wording of existing KLOEs or prompts, or moved a prompt or KLOE between key questions. We will also make this clear when we publish the final versions, so that it will be straightforward to update any systems that providers may be using. The changes we have made to the ratings characteristics reflect the changes we have made to the KLOEs or prompts.

## The changes we propose

### One overarching framework for health care and one for adult social care

We have combined 11 sets of KLOEs, prompts and ratings characteristics that we have been using for each different type of health and social care service into two overarching frameworks: one for healthcare services, and one for adult social care services. We have retained these two separate frameworks to reflect that, while the types of care provided are not mutually exclusive, the purposes, settings and nature of care are sufficiently different to require a different focus in our assessments.

We have reviewed common themes across both the health and adult social care sectors to ensure that they are assessed under the same key question (unless there is a clear rationale for why they should be different). Where possible, we use common or similar wording. The majority of the KLOEs, prompts and ratings characteristics in each of the two frameworks will be relevant to all health or adult social care sectors<sup>1</sup> and we have made some wording more

---

1. **Healthcare** includes: NHS and independent acute hospitals, community health services, specialist mental health services, hospice services, NHS and independent ambulance services, specialist substance misuse services, NHS GP practices and GP out-of-hours services, NHS 111 services, primary care dental services, independent doctors (non-hospital acute services), independent doctors (primary medical services). **Adult social care** includes: community and residential adult social care services.

generic to achieve this. The only sectors that are not covered by the revised frameworks are those that we inspect jointly with other organisations.<sup>2</sup> We will continue to develop additional sector-specific material, such as core service inspection frameworks (currently used for acute hospitals and ambulance services) and brief guides (for specialist mental health services), which clearly link to the overarching frameworks.

There are some types of providers that we regulate but do not currently rate, including primary care dental services, independent doctor services, independent substance misuse services and some independent community services. For these services, our inspectors will use the KLOEs and prompts in the healthcare framework to ensure consistency in our judgements about the quality of care. We recognise that not all of the KLOEs and prompts will necessarily be applied in all settings. We will only use the ratings characteristics for services that we rate.

## Hospices assessed under the new healthcare framework

Since 2014, hospices for adults and children have been assessed using the adult social care methodology and assessment framework. However, feedback has suggested that this arrangement is not satisfactory because of the varying nature and complexity of the services, the care pathways involved and the extent of clinical knowledge and experience required to inspect them. A report by the former National Clinical Director for Children, Young People and Maternity at the Department of Health on CQC's new approach to inspection in 2014 recommended that children's hospices would sit better within the portfolio of the Chief Inspector of Hospitals or Chief Inspector of General Practice. However, as the new inspection approach had just started, we decided not to make any changes at that time.

In early 2016, CQC created a national team of inspectors with the specialist knowledge and understanding required to assess hospices. In 2017/18, after we have completed the first round of inspections under our current model, we will start assessing hospices under the healthcare assessment framework and they will become part of the responsibility of the Chief Inspector of Hospitals.

In moving hospices to the Hospitals portfolio, we propose to make a minor administrative change to the definition section of our fees scheme. The change is to describe hospice providers as providers of 'healthcare services' rather than as providers of 'care services'. Our proposal to make this simple, technical amendment to the scheme is to better reflect the changed emphasis of how we will assess hospices in future. This change will have no impact on the current hospice fee bands or charges. If you wish to make any comments about our proposal to amend the definition of hospices in our fees scheme, please send them to: [hospicefeesconsultation@cqc.org.uk](mailto:hospicefeesconsultation@cqc.org.uk)

---

2. This includes health and social care services provided in prisons and young offender institutions, and health care in immigration removal centres, police custody centres, secure training centres and youth offending teams in the community. We conduct this work with HMI Prisons, HMI Probation, HMI Constabulary and Ofsted.

## Our five key questions

We will continue to use the five key questions in our assessments of quality, and we will give each question equal weight. While our focus for all of the key questions will remain broadly the same, we have made particular changes to aspects of some key questions to improve and strengthen our focus on the provision of safe, high-quality care, based on the learning from our inspections so far.

### Safe

We are not proposing to make any changes to the focus of the safe key question, which looks at whether people are protected from abuse and avoidable harm. As the area where our inspections have highlighted the greatest concerns to date, safety will be an important focus of our future targeted approach. We have used the learning from our inspections to strengthen a number of elements of safety, including recruitment practices, safeguarding, discrimination, medicines management, information sharing and management, and responding to external alerts and reviews.

### Effective

We are not proposing to make any changes to the focus of the effective key question, which looks at whether people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence. We have strengthened some elements of effectiveness, as detailed in the section on new and strengthened themes below.

### Caring

In our current assessment frameworks, the caring key question focuses on compassion, kindness, involvement and emotional support, with interaction between staff and people using services tending to be a key factor. While the kindness of staff is a vital aspect of how caring the service is, we have also strengthened our assessments to look at how the service supports a caring culture. We have amended the KLOEs to reflect this, and in doing so have improved the alignment between health and adult social care. We now have three KLOEs in health and adult social care that cover:

- how staff treat people
- how the service supports people to express their views and be involved in decision-making
- how people's privacy and dignity is respected and promoted.

### Responsive

In our current healthcare frameworks, the responsive key question includes the assessment of both service planning for population needs and being responsive to individuals and groups of people with specific needs (such as people with complex needs or in vulnerable circumstances). We received feedback that this was confusing, so we have removed service planning for population needs and moved this into well-led. This means we are clear that a responsive health or adult social care provider is one that delivers services that meet people's individual needs (including those with specific needs). A well-led healthcare provider is one that is organised and that plans for the benefit of the population it serves.

## Well-led

We are proposing a new single framework for well-led for all healthcare providers, which we have developed jointly with NHS Improvement as part of our commitment to promoting a single shared view of quality. In strengthening our assessment of well-led, we are clear that there is a demonstrable link between leadership, culture and the delivery of safe, high-quality care, and our focus on well-led is intended to support and reinforce this link.

The well-led framework for healthcare providers includes changes to the structure of KLOEs, increasing the number from five to eight. The changes are intended to allow us to support a clearer and more detailed assessment of well-led, especially for larger organisations, and to better align with NHS Improvement's approach. We intend the KLOEs to apply across all healthcare services, but recognise that not all of the prompts will necessarily be applied in all settings, for example small GP practices.

We have included a number of new prompts within the well-led framework for all healthcare providers, and made changes to the wording of existing prompts. The changes have been made to align our approach across the health sectors, to make our assessment approach clearer, and to reflect developments in policy and practice. In addition to the themes highlighted below, the updated framework reflects recent research on culture, improvement systems and leadership behaviour. The framework has also been aligned to the principles articulated in *Developing People – Improving Care: a national framework for action on improvement and leadership development in NHS-funded services* published on 1 December 2016.

The well-led framework for healthcare providers now also includes a clearer emphasis on ensuring the sustainability of services, reflecting the approach set out by the National Quality Board in its forthcoming Shared Commitment to Quality.

We have also updated the well-led framework for adult social care providers, aligning this where possible with the healthcare framework. The majority of adult social care providers will require a different approach to that for a healthcare service and so, while we have largely aligned the adult social care framework at the KLOE level with the healthcare framework, the underlying prompts draw out what each KLOE means across the breadth of the adult social care sector.

Furthermore, in our strategy for 2016 to 2021, *Shaping the future*, we said we want to improve our local activity by better understanding leadership at the head office or 'guiding mind' across more complex services, and how this affects quality where providers operate across multiple sites. Aligning the adult social care well-led framework with the healthcare framework is an important first step towards achieving this, especially as many of the larger providers span the traditional boundaries of health and social care in the services they deliver.

## Greater alignment of the adult social care KLOEs, prompts and characteristics

The characteristics that inform adult social care ratings have been revised to clarify how they relate to each of the KLOEs and associated prompts and to reflect what we have learned over the last two years of inspections under the new approach. This does not represent a shift in terms of the 'bar' that providers must reach for each rating. But it does mean we can be much

clearer on what good and outstanding practice looks like, based on evidence from our inspections and on what people have told us through engagement and co-production. Providers, commissioners, inspectors, people who use and want to choose services, and the wider public should find that the revised characteristics bring greater clarity to our expectations of what good-quality care looks like.

## The introduction of new and strengthened themes

We considered a range of proposals on new themes that we could include in the assessment framework, or themes that could be strengthened. We used the following principles to decide which proposals to include in our overarching assessment framework:

- High level and generic: our frameworks should be relevant to the majority of sectors in health or social care, have longevity and reflect the broad health and social care landscape. They should not be so specific that innovation is stifled or they go out of date too quickly.
- Proportionate: we should avoid duplicating themes over several key questions.
- Mandatory: all KLOEs should be mandatory to be assessed in an inspection of the relevant key question unless they are not applicable, for example because of the type of service being provided, or the context or premises care is provided in.

We will further consider the proposals that did not meet these principles for inclusion in sector-specific material, such as core service inspection frameworks (currently used to support our assessments of acute hospital services).

We have introduced six new and strengthened themes in our assessment framework (the codes provided refer to KLOEs or prompts in Annex A1 and A2):

### **System leadership, integration and information-sharing**

As the Five Year Forward View sets out, better outcomes for patients will be delivered by sustainable organisations operating as part of successful health economies. Providers need to collaborate with each other and work across their local system to find ways to improve the quality and sustainability of services. It is increasingly vital that organisations are well-led within the context of local systems.

Providers are also changing the way they deliver services, breaking down the boundaries between hospital care, community and primary care services, and adult social care services, and developing new models to deliver person-centred care. A central focus for many of these new models is working collaboratively with external partners to understand and plan for the needs of people who use services and to integrate services to improve how people experience care.

To reflect these developments and to encourage information-sharing and coordinated care, both within and across services, organisations and local health economies, we have strengthened and added several KLOEs and prompts as follows:

- safe (healthcare S4.3, S6.2)
- effective (healthcare E4 and adult social care E5 – new prompt)

- responsive (healthcare R2.6 – new prompt)
- well-led (healthcare W2.5 – new prompt, W4.4, W7.4 – new prompt, and adult social care W5.1 and W5.2 – new prompt).

## Information governance and data security

Having secure access to valid, robust and relevant information underpins the efficiency and effectiveness of all health and social care organisations. While there is widespread commitment across providers to keep data secure, we know there are areas where more can be done to protect against potential risks. In July 2016 we published the [report](#) on whether personal health and care information is being used safely and is appropriately protected in the NHS, and we committed to strengthening our assessment framework in relation to information governance. We have made changes as follows:

- safe (healthcare S4 – existing prompts from safe and effective have been merged into a single KLOE, and adult social care S1.6 – new prompt)
- well-led (healthcare W6.7 – new prompt, and adult social care W2.8).

## Technology

Services are increasingly innovating, using technology and digital services to deliver care that is efficient, accessible and more person-centred. We have widened the applicability of some prompts to other service types, and added prompts as follows:

- effective (healthcare E1.3 – new prompt also now applicable to GPs and NHS 111, and adult social care E4.5 – new prompt)
- responsive (healthcare R3.8 – new prompt, and adult social care R1.6 – new prompt)
- well-led (healthcare W6.5 – new prompt, and adult social care W4.6 – new prompt).

## Medicines

Medicines are the most common form of healthcare intervention in all care settings and are crucial to almost all care pathways. We have found through our inspections across different types of services that where services have problems with safety, we often find problems with how they manage medicines. We have therefore strengthened our assessment of a provider's systems, processes and practices to ensure proper and safe handling of medicines as follows:

- safe (healthcare S3 – new KLOE and prompts, and adult social care S4.6 – new prompt added to the pre-existing KLOE).

## End of life care

Delivering good quality care at the end of life is integral to many services that CQC regulates across health and adult social care settings, including hospitals, community health services, GPs, hospices and care homes. In May 2016, we published our [thematic review](#) of inequalities in end of life care, which found that many people face continuing inequalities at the end of their life. We committed to strengthening our regulatory approach across sectors to encourage improvement in the quality of care at the end of life for everyone, including people from equality groups and people whose circumstances may make them vulnerable. In July 2016, the Government published its [commitment](#) that every person approaching the end of

their life receives care that is personalised and focused on their individual needs and preferences. We have reflected the importance of good end of life care as a key component of good quality health and social care through changes to our assessment framework. End of life care continues to be a core service in our inspection approach for acute hospitals and community health services. We have strengthened our assessment in this area as follows:

- responsive (healthcare R2.9, R2.10 and R2.11 – new prompts, and adult social care R3 – KLOE moved from caring and added three new prompts).

## **Personalisation, social action and the use of volunteers**

Personalisation, social action and the use of volunteers can improve the quality of care and overall outcomes for people who use services. Healthcare systems that are organised around supporting people's lives and involving families, carers and social networks, can release the full potential of communities in supporting people's health and well-being. Reflecting the focus already present in our adult social care assessments, we have strengthened our assessment in healthcare settings of community and advocacy, and how services are coordinated to support this as follows:

- effective (healthcare E3.7 – new prompt)
- caring (healthcare C2.3, C2.4)
- responsive (healthcare R2.7, R2.8 – new prompt).

## **Change to the key question for consent and the Mental Capacity Act**

The Mental Capacity Act (2005) (MCA) is a crucial safeguard for the human rights of adults who might (or may be assumed to) lack mental capacity to make decisions, such as whether to consent to proposed care or treatment. We have retained a specific KLOE on consent, which takes account of the requirements of the MCA and other relevant legislation. This KLOE has been part of the effective key question in all sectors since the introduction of the assessment frameworks in 2014. The legal authority for intervening in someone's life in a health or care setting is consent, or if the person lacks the mental capacity to make the relevant decision, a best interests decision. Effective practice in this area is linked to good outcomes for people in this regard. However, it may fit better with the responsive key question, to reflect the importance of services being responsive to each person's capacity, wishes and interests. We have made this change in our proposals, but acknowledge that a case could be made for either key question and there are disadvantages to moving this KLOE in terms of comparability of ratings over time. We welcome views on this potential change.

## **Other new priorities**

As well as the themes above, we have also strengthened, or made more explicit, our assessments in a number of other areas. We have increased our emphasis on equality for staff as an important issue relating to the quality of care across the well-led key question. We have expanded the relevance to all health sectors of a KLOE that was previously only in the assessment framework for GPs, which asks how the provider supports people to live healthier lives and improve the health of their population (E5). For acute hospital services only, we have added a prompt on the availability of seven day services, to support this national priority (E4.5).

## When will we introduce the revised frameworks?

We will introduce the revised assessment frameworks over a phased period, to align with the introduction of our next phase inspection methodology:

Sector	Implementation date
NHS and independent acute hospitals Community health services Specialist mental health services Hospice services NHS and independent ambulance services Specialist substance misuse services Independent doctor services (non-hospital acute services)	from April 2017
Community adult social care services Residential adult social care services	from July 2017
NHS GP practices and GP out-of-hours services NHS 111 services Independent doctor services (primary medical services)	from October 2017
Primary care dental services	from April 2018

### Consultation questions

- 2a Do you agree with our proposal that we should have only two assessment frameworks: one for health care and one for adult social care (with sector-specific material where necessary)?  
[Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]
- 2b Please tell us the reasons for your answer.
- 3a What do you think about our proposed changes to the key lines of enquiry, prompts and ratings characteristics?
- 3b What impact do you think these changes will have (for example the impact of moving the key line of enquiry on consent and the Mental Capacity Act from the effective to the responsive key question)?

### 3. Registering services for people with learning disabilities

In October 2015, NHS England, the Local Government Association and the Association of Directors of Adult Social Care Services published a national plan (*Building the Right Support*) that stated the intention to develop community services and to close inappropriate inpatient facilities for people with a learning disability and/or autism. The plan also contained a service model for health and social care commissioners.

In our 2015 reports, *A Fresh Start for Registration* and *State of Health and Adult Social Care in England 2014/15*, we made a commitment to take a firmer approach to the registration and variation of registration for providers who support people with learning disabilities. In February 2016, we published *Registering the right support* to set out our expectation that providers would have regard to the national plan and service model when developing services for people with learning disabilities. It also set out the factors that would make it more likely that we would refuse applications to register or vary registration.

We now have eight months' experience of applying the policies in this guidance and are using our experiences, legal advice, and some helpful challenge from providers to develop the guidance to ensure providers are clear about our expectations and our commitment to the national plan and service model.

A legal review of the guidance found that, while clearly intended to encourage providers to make the right choices when developing services in accordance with national policy, the language used in the guidance was open to interpretation. For example, providers were asked to "have regard to" *Building the Right Support* and accompanying service model. This opened up the possibility of CQC receiving applications from providers that had taken *Building the Right Support* into account in their decision-making processes, but did not design their services to reflect the guidance.

We have therefore revised our guidance to strengthen our policy position and make it clear that we expect providers to comply with the national plan and accompanying service model. We have done this by:

- Being clear that providers who apply to register services in new premises that do not comply with *Building the Right Support* and other key national policy or good practice guidance may find that registration is refused.
- Setting out our legal powers through which we will decide to refuse such registrations.
- Demonstrating that we understand the current challenges within commissioning in health and social care, but being clear that we will not compromise on what 'good' looks like (as defined by *Building the Right Support* and other national guidance).
- Strengthening the language used in the case studies to show where applications are likely to be refused and which regulations would apply.

- Defining ‘small-scale housing’ as housing for six or fewer people using services, therefore adopting the NICE Guidance, *Autism spectrum disorder in adults: diagnosis and management* (2012).

Our revised *Registering the right support* guidance can be found at the separate [Annex B](#) to this document.

### Consultation question

- 4 We have revised our guidance *Registering the right support* to help make sure that services for people with learning disabilities and/or autism are developed in line with national policy (including the national plan, *Building the right support*). Please tell us what you think about this.

## 4. Next phase of regulation – NHS trusts

This section describes our proposed changes to how we regulate and inspect NHS trusts and foundation trusts (referred to throughout as trusts), and how we propose to implement our new approach. This includes acute, mental health, community and ambulance NHS trusts. It builds on what we set out in our strategy and reflects what we have learned from our comprehensive inspections and the feedback we have had from the public, people using services, providers, other stakeholders and CQC staff over the last three years. Where possible, we have also trialled elements of our new approach in recent inspections to inform these proposals.

The changes we set out in May in *What our strategy means for the health and adult social care services that we regulate* represent an evolution of our approach, building on the information we now have about the quality of all trusts across England, a more comprehensive baseline of quality than we have ever had before. Our strategy set out our plans for a more responsive, collaborative, targeted approach. In NHS trusts we are proposing to focus our inspections on those core services where we have greatest concerns or where we believe quality might have improved. Our inspections will continue to look at all five key questions at core service level and, as the area where our inspections have so far highlighted the greatest concerns, safety will inevitably be an important focus. Where we find care that falls below fundamental standards we will always follow this up and take regulatory action where required.

In addition to the core services at a trust that we select to inspect (and we will inspect at least one core service approximately annually), we are also proposing to assess the overall leadership of the trust based on our learning of the importance of leadership for the delivery of safe, high-quality care. This will include an assessment of how well trusts assure themselves that basic systems underpinning safe care are in place, for example learning from incidents. These changes are designed to enable CQC to continue to make sure services provide people with safe, effective, compassionate, high-quality care and to encourage improvement by introducing:

- A more responsive, intelligence-driven approach to regulation, with improved monitoring and inspection activity focused where risk is greatest or quality is improving.
- An increased focus on leadership, based on the evidence that effective leadership and a positive, open culture are important drivers for improvement and the delivery of safe, high-quality care.
- Closer working with NHS Improvement to increase alignment and reduce duplication, and support trusts to meet the dual challenges of quality and efficiency.
- Improving our own efficiency and effectiveness by rationalising our processes.

We have now inspected every trust in England and will complete the first phase of our inspections of most independent healthcare providers during 2017. We intend to start inspections using our next phase approach for the majority of providers in the independent sector in 2018/19. We anticipate the main elements of our regulatory approach will be the same for all providers, regardless of whether they are NHS or independent. However, this

section of the consultation is solely for NHS trusts. We will continue to work closely with independent providers to agree the timing and nature of any changes, and will consult as appropriate during 2017/18.

## Working with NHS Improvement

We are working closely with NHS Improvement to support trusts to give patients consistently safe, effective and compassionate care within local health systems that are financially and clinically sustainable.

CQC and NHS Improvement are committed to working together to support strong leadership and governance, and to recognise that effective use of resources is fundamental to enable trusts to deliver and sustain high-quality services for patients. A [joint consultation](#) being published in parallel describes in detail how we will work with NHS Improvement on these two aspects. Trusts should refer to that document when considering the proposals in this consultation.

## Summary of proposed changes

The nature and timing of our interactions with trusts is evolving, and the changes to our monitoring and inspection activity are intended to reduce the overall time required from trusts in their interactions with us. In particular, we are shifting our emphasis by strengthening our ongoing monitoring and relationship management, and adopting a more targeted approach to inspections – carrying out far fewer comprehensive inspections. Figure 1 summarises our new approach.

## Provider information request

Our new provider information request (PIR) will not be as detailed as the current one, to reduce the reporting requirements on trusts. For example, we are unlikely to request provider policies, or information that is available from other sources, such as Hospital Episode Statistics (HES) data or national audits. This will reduce the number of information items we request overall, in line with our more targeted and tailored approach. We will hold an internal planning meeting using the PIR information to determine our inspection activity.

## Inspection and reporting

We will inspect every trust regularly, and are moving to a more targeted and tailored approach to inspection where we focus on core services and the leadership of a trust. Our regular scheduled inspections will include at least one core service – assessed against all five key questions. In addition, we will always include an assessment of well-led at trust level approximately annually. As the area where our inspections so far have revealed the greatest concerns, safety will inevitably be an important focus.

This means we will only carry out comprehensive inspections (where we simultaneously inspect all core services with a large inspection team) for newly registered providers or where we have significant concerns. Our inspections will be built on previous inspection findings and ratings, or using wider intelligence about the quality of care defined in our new CQC Insight model (see below) and information gathered through our relationship management activities.

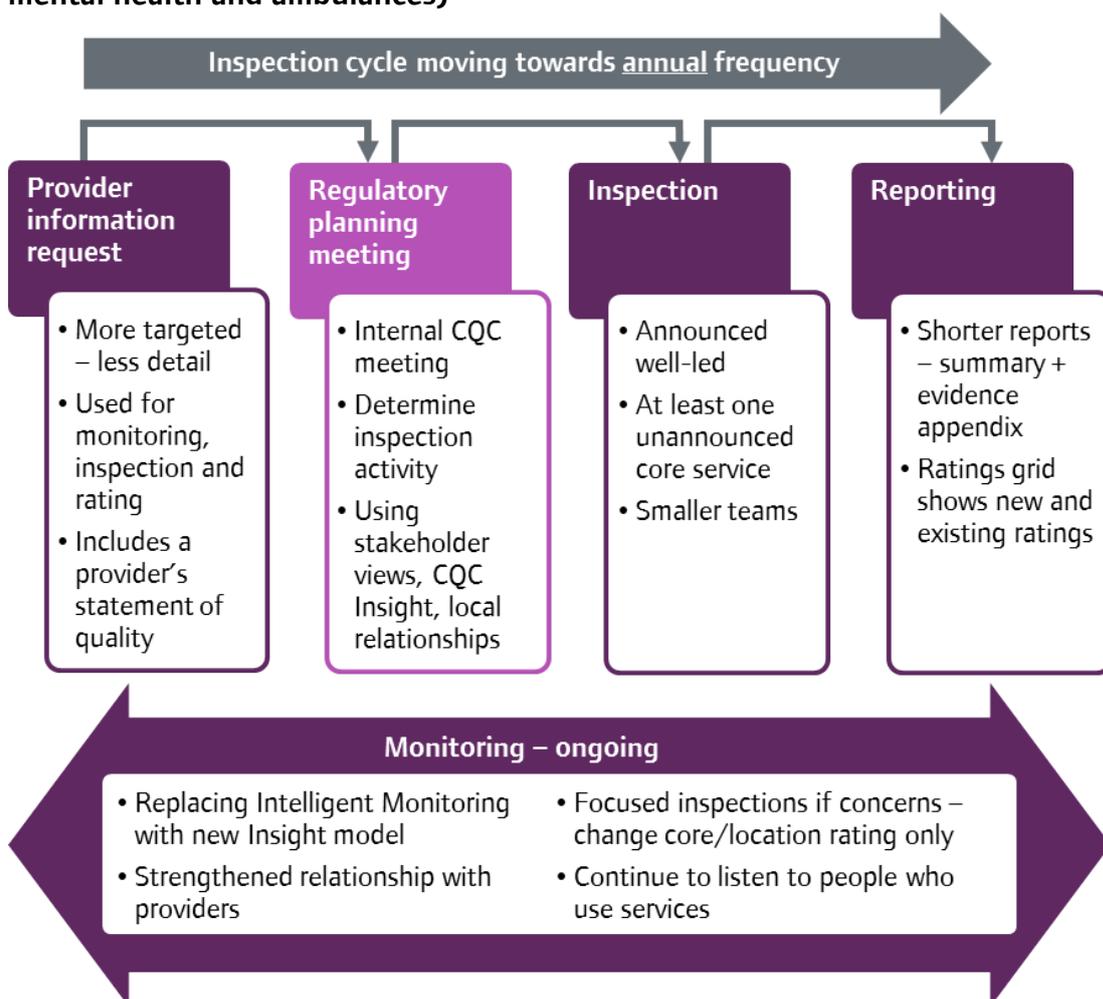
Once our new approach is fully embedded we will move to an approximately annual cycle, although the time of inspection will vary for a trust year-on-year.

Our inspection teams will continue to include specialist advisers and, where appropriate, Experts by Experience. Unless we are carrying out a comprehensive inspection, our focus on one or more core services and the trust’s leadership means that the overall team involved in inspection will be smaller. We will produce timely, shorter, more succinct reports that will be quality assured and published with a revised rating grid consisting of new and existing ratings, and supported by a separate evidence appendix.

## Monitoring

Our ongoing monitoring activity<sup>3</sup> will inform inspection activity as well as reports and ratings. It will also be used to identify new concerns and improvement. Where we take enforcement action or need to respond to a new concern we will continue to carry out a focused inspection that looks at the specific concern.

**Figure 1: Our approach to monitoring and inspecting NHS trusts (acute, community, mental health and ambulances)**



3. Including regular Mental Health Act monitoring visits to places where people are detained under the Mental Health Act 1983. Such visits are a requirement of CQC’s duties under the Mental Health Act itself and as a part of the UK’s National Preventive Mechanism against torture, inhuman or degrading treatment.

## The changes we propose

### Monitor

#### Introduction of CQC Insight

We are replacing our Intelligent Monitoring with the introduction of a new Insight model. The model has been designed to identify potential changes to quality since the previous inspection and will look at different organisational levels of data – for example, at trust level, and service location, core service and key question level. The Insight model builds on what we have learned from the Intelligent Monitoring model. It will include a number of the indicators that were used in Intelligent Monitoring but also use a wider range of data sources. For example, in addition to national datasets we will build in qualitative information from people who use services, from relationship management, from national partners and from the new style provider information request, which is described below. It will be updated regularly and will provide our inspectors with more timely information about a provider’s performance.

CQC will use this information to support how we monitor services, to highlight improvements in outcomes or risks to quality of care. We will use the intelligence to inform our decisions about when and what to inspect, as well as to support our findings and ratings when we report. Providers will be able to access their own Insight dashboard and we will also share outputs with key system partners, including NHS Improvement and NHS England.

Current approach to monitoring	New approach to monitoring
<b>Intelligent Monitoring</b> <ul style="list-style-type: none"><li>• Focused set of indicators</li><li>• Updated 2-3 times a year</li><li>• Used to decide when to schedule inspections only</li></ul>	<b>CQC Insight</b> <ul style="list-style-type: none"><li>• Wider set of information sources and indicators including more qualitative information</li><li>• Updated regularly</li><li>• Presents information at trust, location, core service and key question level</li><li>• Focuses on changes since the previous rating – improvements and areas of risk</li></ul>

#### Strengthened relationship management

Strengthening how we manage our relationships with providers is key to reaching a single shared view of quality. We will have more regular contact with trusts and key partners, such as NHS Improvement, NHS England and Healthwatch, throughout the year. Our approach will be developed in collaboration with them to ensure we avoid duplication, share appropriate information and minimise the requirements we make of providers where possible.

This is largely a shift of emphasis; rather than focusing all our activity around a single comprehensive inspection, this regular contact will be an opportunity to share information in a more timely and manageable way. Equally, activities that previously formed part of inspections, such as focus groups with staff, will be arranged during the year, rather than at a single time during inspection. This should build on the relationships we have already

established with trusts and develop more mature relationships so that providers feel they can be open and highlight challenges or concerns as they occur. We will continue to ensure, however, that we maintain our independence and scrutiny as the regulator, on behalf of people using services.

Current approach to relationship management with providers	New approach to relationship management with providers
<ul style="list-style-type: none"> <li>• Regular engagement meetings</li> <li>• Additional focus on engagement around the point of comprehensive inspections</li> </ul>	<ul style="list-style-type: none"> <li>• Regular engagement meetings to continue building openness and transparency to enable providers to be open and highlight challenges or concerns as they occur</li> <li>• Evidence gathering throughout the year (e.g. focus groups with staff, observations of patient settings) in addition to engagement meetings</li> </ul>

### Provider information requests

We are replacing the two-part provider information request (PIR) initiated 20 weeks ahead of a comprehensive inspection with a more streamlined request for information that will be required, on average, once a year for each provider. It will enable providers to set out their view of the quality of care they provide, as well as to provide a focused set of information relating to well-led and for each of the core services we rate. The new PIR will not be as detailed as the current one, to reduce the reporting requirements on trusts. For example, we will not request data that is available from other sources, such as HES data or national audits. Only information that supports CQC’s monitoring, inspection and rating of services will be requested, and the information returned will be added as an important source to the Insight intelligence model described above. Additional items of information may still be required and collected as part of the inspection, but will be fewer in number in line with our more targeted and tailored approach.

Providers will be asked to set out their view of the quality of services against the five key questions, including changes in quality since their last inspection. Alongside the statement of quality, providers will be asked to supply a limited amount of key information not otherwise available through national datasets – for example, indicators of quality for location and core service levels.

To support CQC’s assessment of well-led, trusts will also be asked to use the PIR to report information about their leadership, governance and organisational culture, against the new well-led KLOEs.

We aim to keep additional information requests from providers to a minimum, although we anticipate some additional requirements are likely to occur following inspection activity, led by our observations and findings. In addition, we plan to move to a single online collection mechanism. Providers will use this to submit and update information needed for both CQC monitoring and inspection and to help NHS Improvement identify support needs under its Single Oversight Framework.

Current approach to PIRs	New approach to PIRs
<p><b>Provider information request before a comprehensive inspection</b></p> <ul style="list-style-type: none"> <li>• Two-part request</li> <li>• Sent 20 weeks before inspection</li> <li>• Detailed, large request with significant number of documents required</li> </ul>	<p><b>Routine provider information request</b></p> <ul style="list-style-type: none"> <li>• On average, an annual request</li> <li>• Focused on key information for well-led and each of the core services</li> <li>• Providers to describe their own quality against our five key questions</li> </ul>

## Consultation questions

- 5 What should we consider in strengthening our relationship management, and in our new CQC Insight approach?
- 6 What do you think of our proposed new approach for the provider information request for NHS trusts?

## Inspect

Our future inspections will be more intelligence-driven and targeted. They will include at least one core service and an inspection of the well-led key question at trust level approximately annually. We will only carry out comprehensive inspections (where we simultaneously inspect all core services) for newly-registered providers or where we have significant concerns. We will use the most recent ratings for a trust to inform the number of core services that would be inspected during the yearly inspection programme. This will mean that the number of core services inspected in addition to well-led will vary for each organisation. Overall, we expect our contact with trusts to be more frequent, but far more targeted, so that the overall requirement on trusts as a result of our regulation will be less.

We will hold an internal regulatory planning meeting to review the available information and to plan our inspection activity. Core service inspections will be very similar to our current approach (which will reflect refinements to our assessment framework being consulted on in Annex A1 and A2). However, they may happen at different times and will mostly be unannounced to enable us to observe routine activity. The well-led inspection will be announced to ensure that the appropriate interviews can be scheduled.

## Core service inspections

### Core services

Our experience from comprehensive inspections suggests that the core services we have inspected for acute, community, mental health and ambulance services, are largely the right ones. We are therefore not proposing any changes to the core services we assess in

community, mental health or ambulance services, and only proposing two minor changes to acute core services to ensure that the focus of the inspection is appropriate. We will continue to assess against all five key questions.

**Change 1: Separating diagnostic imaging from the core service of outpatients**, with outpatients remaining as a core service. We may inspect diagnostic imaging as an additional service, depending on the individual provider and on the level of risk. We will use relevant diagnostic accreditation schemes where possible to reduce or replace regulatory review. If a provider is not accredited under an appropriate scheme, we will consider this as a factor when deciding whether to include diagnostic imaging as an additional service in our inspection.

**Change 2: Separating maternity and gynaecology.** Maternity will remain a core service and will include, where carried out, termination of pregnancy. However, gynaecology will be a separate additional service, which we may inspect on a provider-by-provider basis.

The purpose of both these changes is to enable us to take a more balanced and proportionate approach to inspecting gynaecology and diagnostic imaging services. We have often found it challenging to fully and clearly inspect and report on each of these services when combined into a single core service. Under our proposals, we will be able to provide a clearer and more focused report of our findings for outpatients and maternity services as part of our core service inspections, while taking a proportionate risk-based approach to inspecting gynaecology and diagnostic imaging services as additional services (see section below).

### Frequency of core service inspections

Once our new approach is embedded, we will inspect at least one core service in each trust approximately annually alongside the well-led assessment. We will decide which core services to inspect based on previous inspection findings and ratings, wider intelligence about the quality of care captured in CQC Insight, information from the provider, and information gathered through our relationship management. By targeting our inspections, we are aiming to focus on protecting people from poor care where there are greatest concerns, and to assess where improvements have been made.

For planning purposes, we will use previous ratings as a guide to setting maximum intervals for re-inspecting core services as follows:

- one year for ratings of inadequate
- two years for ratings of requires improvement
- 3.5 years for ratings of good
- five years for ratings of outstanding.

This could mean that in a single year we inspect areas where we have identified new risks, all core services rated inadequate, and a proportion of core services that are rated requires improvement, good, or outstanding. The following table gives an illustrative example.

**Figure 2: Illustrative example of how we could use the information we hold about core services to plan our inspections**

Information we hold about core services	Inspection plans
<b>Inadequate:</b> urgent and emergency care; surgery	<b>This year:</b> inspect urgent and emergency care; surgery
<b>Requires improvement:</b> medical care; critical care	<b>This year:</b> inspect medical care <b>Next year:</b> inspect critical care
<b>Good, but new risks identified:</b> maternity	<b>This year:</b> inspect maternity
<b>Good:</b> end of life care	<b>Within following 2.5 years:</b> inspect end of life care
<b>Outstanding:</b> services for children and young people; outpatients	<b>Within following 4 years:</b> inspect services for children and young people; outpatients
	<b>Overall plans:</b> inspect four core services this year

We will continue to test and confirm the maximum intervals as we implement our new approach.

The majority of core service inspections will be carried out unannounced or at short notice. The inspections will be planned using the information collected in the routine PIR but there may be additional requests for information generated by our findings at inspection, although we will aim to minimise such requests.

### Additional services

An ‘additional service’ is a service that we do not inspect routinely for all providers as a core service, but which we may choose to inspect for an individual provider because it represents a significant part of the range of services delivered by that provider and/or it has been identified as potentially outstanding or high risk. As well as identifying additional services to inspect in individual providers, we are considering whether we could select additional services for inspection across a range of providers or sectors, to provide a broader view of the quality of services. The chosen additional service would be inspected either within or across service sectors, or among a selection of providers (for instance on a place-based approach).

We propose that where we conduct an inspection across a range of providers, we would report and provide a rating of the service where appropriate. We are proposing that our aggregation rules would not be applied to these ratings, meaning that the ratings for additional services inspected under this approach would not affect the overall trust-level ratings. We would always take appropriate enforcement action where required.

For example, we are currently developing our approach to inspecting cancer services, and intend to inspect them in 2018/19. We are also exploring how we can assess mental health services in NHS acute trusts and will be piloting our approach in early 2017. Other possible additional services might include stroke or diabetes care.

Current approach to core services	New approach to core and additional services
<p><b>Core services in acute services</b></p> <ul style="list-style-type: none"> <li>• Maternity and gynaecology</li> <li>• Outpatients and diagnostic imaging</li> <li>• No separate framework for assessing mental health in acute settings</li> </ul>	<p><b>Separating core and additional services in acute services</b></p> <ul style="list-style-type: none"> <li>• Maternity</li> <li>• Outpatients</li> <li>• Gynaecology becomes an additional service (included in inspection when it meets specific criteria)</li> <li>• Diagnostic imaging becomes an additional service (included in inspection when it meets specific criteria)</li> </ul> <p><b>Possible additional services in acute</b></p> <ul style="list-style-type: none"> <li>• Cancer</li> <li>• Mental health services in acute settings</li> </ul>

### Effective use of accreditation schemes

As with our proposed approach to outpatients and diagnostic imaging, we are keen to make better use of relevant accreditation schemes across all core and additional services. We propose to reflect participation in accreditation schemes in the provider well-led key question, as evidence of a commitment to quality improvement and assurance. The achievement of accreditation under a specific scheme would be reflected in the effective key question of the relevant core service.

Where an accreditation scheme itself meets key quality standards and has a good level of uptake among NHS providers, we propose to move towards using accreditation under that scheme to reduce, or over time in some areas potentially replace, CQC inspection of the accredited service.

The intention of this approach would be to support our overall aim to adopt a more targeted and proportionate approach to regulation, to assist in avoiding duplication across the health and social care system and to reduce requirements on providers where appropriate.

### Trust well-led inspection

The well-led framework for healthcare providers now also includes a clearer emphasis on ensuring the sustainability of services, reflecting the approach set out by the National Quality Board in its forthcoming Shared Commitment to Quality.

The trust-level inspection of well-led will be an evolution of our current approach to assessing and reporting on our key questions at the overall provider level. It will also support our commitment to ensuring that we are holding complex organisations to account for the quality of care they provide at the right level. In any new or complex models of care we will want to establish who is accountable for the provision of care.

Our provider-level reports for trusts currently include a report on what we found through assessment and inspection of trust-wide leadership under the well-led key question. This assessment is used to corroborate and, where necessary, modify the trust-level rating of well-led that would be generated through aggregation from the location-level ratings. In future, our assessment of trust-wide leadership, governance, management and culture will be the starting point for the trust-level rating of well-led. This will consider improvements and changes since the last inspection. It will take into account the findings for well-led at location level, but will not be a simple aggregation of these.

In strengthening our assessment of well-led, we are clear that there is a demonstrable link between leadership, culture and the delivery of safe, high-quality care and our focus on well-led is intended to support this link. The proposed updated framework (see [Annex A1](#) and [Annex A2](#)) has been jointly agreed between CQC and NHS Improvement, and both organisations will use it to assess well-led. We will also work closely with NHS Improvement to coordinate our respective uses of the well-led framework and ensure we do not duplicate information requests or activity. As with our existing approach, the trust-level inspection of well-led will be conducted by a small, senior team of inspectors and specialist advisors. This team will draw on a range of evidence applicable at the overall trust board level, including interviews with board members and senior staff, focus groups, analysis of data, review of strategic and trust-level policy documents, and information from external partners.

The scope and depth of our regular trust-level well-led inspections will vary according to the individual provider. In deciding on the nature of the inspection approach, we will consider factors such as the size of the trust, the findings of previous inspections, and information gathered from the provider, external partners and other sources on performance and risks in the trust. We will be developing and further piloting our approach to inspecting well-led at trust level in the coming months, in collaboration with trusts and NHS Improvement.

Current approach to inspecting well-led	New approach to inspecting well-led
<p><b>A dedicated team within the comprehensive inspection to look at well-led</b></p> <ul style="list-style-type: none"> <li>A small trust-wide team responsible for corroboration of all ratings from service to trust-wide level, with a focus on well-led at trust level</li> </ul>	<p><b>An assessment of well-led at trust level</b></p> <ul style="list-style-type: none"> <li>An assessment focusing solely on well-led at trust level, which will draw on our wider knowledge of quality in the trust at all levels</li> </ul>

### Consultation questions

- 7 What do you think about our proposal that our regular trust inspections will include at least one core service and an assessment of the well-led key question at trust level approximately annually?
- 8 What do you think about our proposal that the majority of our inspections of core services will be unannounced?

## Consultation questions (contd)

- 9a What do you think about the changes we have proposed to inspecting the maternity and gynaecology core service?
- 9b What do you think about the changes we have proposed to inspecting the outpatients and diagnostic imaging core service?
- 10a Do you agree with our proposed approach to inspecting additional services (services that we do not inspect routinely) across a range of providers or sectors?  
[Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree]
- 10b Please tell us the reasons for your answer.
- 11a Do you agree with our proposals for using accreditation schemes to both inform and reduce CQC inspections?  
[Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree]
- 11b Please tell us the reasons for your answer.

## Reporting

We will introduce a shorter, more succinct report, which will be more accessible and user friendly. It will provide the information that the public and people who use services want, including a summary of our findings, ratings, contextual information and any enforcement activity we have taken. We will explore how we can better present information for large community, mental health and ambulance services that provide care across a large geographical area.

We will continue to follow current factual accuracy processes to ensure that providers have the opportunity to check the evidence that informs our reports. We will have a peer review process and will quality assure our findings at a national level. We plan to publish an appendix of all the evidence that supports the findings and the ratings. This will make the evidence available in a structured way and help our inspectors to gather the evidence they need to reach a robust judgement.

Current approach to reporting	New approach to reporting
<p><b>Report</b> Includes all evidence, findings, ratings, contextual information and any enforcement action we have taken</p> <p>Presented in a narrative style</p>	<p><b>Separate report and evidence appendix</b> Report includes a summary of findings , contextual information and ratings</p> <p>Evidence appendix includes all the evidence presented factually</p>

## Rating

In its 2013 report *Rating providers for quality: a policy worth pursuing?*, the Nuffield Trust reviewed the role of ratings in health and social care. This review recommended that any approach to ratings should allow complex organisations to be assessed and rated at different levels, with organisational and service-specific ratings. Building on the findings of the review, it is our view that the key purposes of any quality rating should be to:

- inform choice for people using services
- incentivise improved performance in delivering safe, high-quality care
- increase accountability and transparency.

Quality ratings should also enable comparisons of performance over time and enable comparisons across organisations. We recognise that different audiences use our reports and ratings differently – for example to a patient, the core service or location report is more meaningful than a provider-level report. Meeting the needs of different audiences will be a key consideration for any refinements to our trust-level assessments and ratings. We are not proposing any changes to how we rate at core service and location level.

This section describes:

- how we will update ratings in future
- our separate consultation about introducing a use of resources assessment
- issues we need to consider for the future as the trust landscape changes.

### How we will update ratings

Overall trust ratings will only be reviewed and updated following a trust-level well-led assessment and planned core service inspections. Where we have not carried out an on-site inspection the previous rating will stand. Reports will make clear whether a rating is based on the most recent or a previous inspection. Aggregated ratings will be a combination of previously allocated and new ratings from recent on-site inspection activity. Providers will then be required to display an updated grid. Focused inspections that look at a specific concern may result in a change to a core service or location-level rating.

### Use of resources assessment

NHS Improvement and CQC are working together to develop an assessment and rating of use of resources. This will enable a comprehensive view of trusts' performance, reflecting the fact

that effective use of resources is an important determinant of high-quality and sustainable care. Our joint consultation sets out the process and indicative metrics for future use of resource assessments. We will be further testing and refining that approach in 2017. If you would like to offer views on this, please see the [joint consultation](#).

## Future considerations

Although our current rating approach has worked well in the majority of cases, there are two situations in which we are aware of issues with our approach to aggregating ratings to determine an overall trust rating. These are:

1. Where trusts provide more than one service type
2. Where trusts take over other providers to improve their quality.

### 1. Where trusts provide more than one service type

Many trusts already provide a complex set of services that cross traditional care boundaries, and we expect to see this increase. For example, trusts may provide a combination of acute or mental health care and community health services, and also run care homes or provide GP services. We have found that, in larger and more complex organisations, it is challenging to show how we have balanced the scale and quality of different services in our aggregated ratings at provider level. For example, where a trust delivers a wide range of community health services, as well as two GP practices, our aggregation rules do not take account of the relative size of these different service types. Future trust-level assessments of well-led are intended to be more comprehensive and capture organisation-wide leadership – we will continue to review and refine this approach as organisations evolve.

### 2. Where trusts take over other providers to improve their quality

There are already examples of trusts taking over other trusts or other types of services in order to improve their quality – for example, Frimley Health NHS Foundation Trust's acquisition of Heatherwood and Wexham Park Foundation Trust. The Acute Care Collaborations new care model programme is intended to drive more of this activity to improve care for patients. We have been clear in the principles set out on page 6 that we do not want trusts to be disincentivised from taking on providers with poorer quality because this could impact on their overall CQC rating.

We expect to see more of both of the situations given above. As we introduce the use of resources assessment and rating (for acute trusts initially, and then all trusts), we will also consider how we might address these issues. Potential options include:

- Introducing greater professional judgement to moderate aggregated ratings at the trust level, for example to take account of the relative size of different services and the duration of ownership.
- Being flexible about the best level at which to provide an overall aggregated rating, for example at overall trust-level or site/location-level.
- Continuing to rate recently acquired or merged providers separately for a period of time, for example two to three years to allow the trust time to address quality issues.

The changes we make should be sufficiently flexible to accommodate any organisational form where we wanted to rate at provider level now and in the future, including combined

providers with rated and unrated services, independent sector providers, corporate providers, chains and federations, and new models of care.

We do not currently produce an organisational-level rating for any provider other than trusts, which are also unique in that they will have a use of resources rating as well. We want to introduce this new use of resources rating and test how to combine it with our quality ratings before making any further changes to respond to the issues raised above.

We welcome general views and suggestions for changes we should consider to provider-level ratings, and we will continue to engage with providers and people who use services to determine any changes.

### **Consultation question**

12 What do you think about our current approach to trust-level ratings and how do you think it could be improved (taking into account the new use of resources rating)?

## **Introducing our new approach**

We will introduce our new assessment framework and approach for NHS trusts from April 2017. This means that the first new provider information requests will be sent out from April 2017, and the associated inspections will take place within the following two to six months and be informed by CQC Insight. We will roll out the new approach over two years to allow us to evaluate, improve and refine it. We expect the approach to be fully embedded by April 2019, and at that point all trusts will have a well-led inspection and at least one core service inspection approximately annually.

# How to respond

You can respond through our online form at: [www.cqc.org.uk/nextphase](http://www.cqc.org.uk/nextphase) or by email: [nextphase@cqc.org.uk](mailto:nextphase@cqc.org.uk)

You can write to us at:  
Freepost RTTE-JTBT-ZTHH  
Next Phase Consultation  
Care Quality Commission  
151 Buckingham Palace Road  
LONDON  
SW1W 9SZ

You can also tweet us your thoughts at: [#CQCNextPhase](https://twitter.com/CQCNextPhase)

**Please reply by 14 February 2017.**

Thank you for taking the time to contribute to the development of our future work. Your feedback and comments are important to getting this right.

## Summary of consultation questions

- 1a Do you think our set of principles will enable the development of new models of care and complex providers?  
[Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]
- 1b Please tell us the reasons for your answer.
- 2a Do you agree with our proposal that we should have only two assessment frameworks: one for health care and one for adult social care (with sector-specific material where necessary)?  
[Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]
- 2b Please tell us the reasons for your answer.
- 3a What do you think about our proposed changes to the key lines of enquiry, prompts and ratings characteristics?
- 3b What impact do you think these changes will have (for example the impact of moving the key line of enquiry on consent and the Mental Capacity Act from the effective to the responsive key question)?
- 4 We have revised our guidance *Registering the right support* to help make sure that services for people with learning disabilities and/or autism are developed in line with national policy (including the national plan, *Building the right support*). Please tell us what you think about this.

- 5 What should we consider in strengthening our relationship management, and in our new CQC Insight approach?
- 6 What do you think of our proposed new approach for the provider information request for NHS trusts?
- 7 What do you think about our proposal that our regular trust inspections will include at least one core service and an assessment of the well-led key question at trust level approximately annually?
- 8 What do you think about our proposal that the majority of our inspections of care services will be unannounced?
- 9a What do you think about the changes we have proposed to inspecting the maternity and gynaecology core service?
- 9b What do you think about the changes we have proposed to inspecting the outpatients and diagnostic imaging core service?
- 10a Do you agree with our proposed approach to inspecting additional services (services that we do not inspect routinely) across a range of providers or sectors?  
[Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]
- 10b Please tell us the reasons for your answer.
- 11a Do you agree with our proposals for using accreditation schemes to both inform and reduce CQC inspections?  
[Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]
- 11b Please tell us the reasons for your answer.
- 12 What do you think about our current approach to trust-level ratings and how do you think it could be improved (taking into account the new use of resources rating)?

## How to respond to this consultation

### Online

Use our online form at:

[www.cqc.org.uk/nextphase](http://www.cqc.org.uk/nextphase)

### By email

Email your response to:

[nextphase@cqc.org.uk](mailto:nextphase@cqc.org.uk)

### By post

Send your response to:

Freepost RTTE-JTBT-ZTHH

Next Phase Consultation

Care Quality Commission

151 Buckingham Palace Road

LONDON

SW1W 9SZ

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

If you have general queries about CQC, you can:

Phone us on: 03000 616161

Email us at: [enquiries@cqc.org.uk](mailto:enquiries@cqc.org.uk)

Write to us at:

Care Quality Commission

Citygate

Gallowgate

Newcastle upon Tyne

NE1 4PA

[www.cqc.org.uk](http://www.cqc.org.uk)

CQC-359