

Response to the consultation on CQC's next phase of regulation

New models of care, assessment frameworks, registering services for people with a learning disability and/or autism, and changes to our regulation of NHS trusts

June 2017

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

Our purpose

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

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can.

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Introduction

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 supports improvement and sustainability, and that continues to make sure people have access to safe, effective, compassionate, high-quality care.

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

This document is the response to the first of our consultations on our next phase of regulation. The consultation asked for views on how we should develop and evolve our approach as we move into the next phase of our regulatory model. It focused on our principles for regulating new models of care; changes to our assessment frameworks; strengthening our guidance on registering services for people with a learning disability and/or autism; and changes to the way we regulate NHS trusts.

Since we started to develop our five-year strategy we have held continuous conversations around our next phase of regulation. To help shape this consultation and its proposals we sought feedback through co-production workshops and online reviews with providers and professionals, events with members of the public and those who represent them, and internal discussions with our own staff.

The consultation ran from 20 December 2016 to 14 February 2017. We were pleased to receive 496 responses, which have been analysed by OPM Group, an independent research and consultancy organisation. This document summarises the feedback from the consultation and sets out what we will do. Thank you for your support and contributions.

You can find our updated guidance for providers on how we regulate services on our website: www.cqc.org.uk/nextphase1. We have also integrated this content into our provider web pages.

Developing our next phase of regulation – consultations 2 and 3

We will continue to consult on our next phase of regulation with our second and third consultations.

Consultation 2 (June 2017)

Alongside this consultation response, we have published our second consultation which seeks views on specific proposals for how we will:

- regulate primary medical care services and adult social care services
- improve the structure of registration, and clarify our definition of registered providers
- monitor, inspect and rate new models of care and large or complex providers
- use our unique knowledge and capability to encourage improvements in the quality of care in local areas
- carry out our role in relation to the fit and proper persons requirement.

Our proposals explain how we will combine our approaches and work together where providers are delivering services across the hospital, primary care or adult social care sectors. We will also continue to work and learn with services as they change and adopt innovative ways of providing care. The consultation is available on our website:

www.cqc.org.uk/nextphase.

Consultation 3

Later in 2017/18, we will publish our third consultation. This will include specific proposals for how we will regulate and rate independent healthcare services starting during 2018/19. In developing our proposals, we will take account of the decisions we have made about the next phase approach for NHS trusts – which we have set out in this consultation response – as well as the feedback we received from independent healthcare providers and stakeholders to our first consultation.

Summary

Overall, respondents to the consultation were supportive of our proposals. There was general confidence that our proposed changes could improve the regulation of care services, and ultimately the quality of care. However respondents did make a variety of helpful comments and suggestions and asked for further clarity on elements of our proposals. There was some disagreement with particular proposals. However, in most cases this was from a relatively small number of respondents.

The feedback from respondents produced a number of themes across the consultation.

Clarity, consistency and transparency in implementing the changes

Respondents discussed the clarity, consistency and transparency of our proposals. In some instances they welcomed improvements which will make our regulatory approach clearer, more consistent and easier to understand for the public, but they also wanted further details on our plans for how we will implement the changes. In particular, respondents were keen for us to share further detail about how we will work with complex providers. This included how the new assessment frameworks will address cross-sector working and working across geographical boundaries, as well as detail on how we will aggregate ratings. Some warned about the risk of over-simplification in trying to improve clarity and transparency.

Flexibility in our approach

Many respondents highlighted the complexity and variety of health and adult social care providers, and warned against a one-size-fits-all approach in our processes and methods. However others recognised that alignment between settings and sectors was important for a shared view of quality. Respondents stressed the importance of an approach that is stable, efficient, and flexible enough to respond to the rapid pace of change in the health and social care sector.

The changes we are making will mean improved consistency in our approach for all providers. We also recognise the value of having expert-led inspections, with inspectors who specialise in specific sectors, supported by specialist advisors and Experts by Experience. We will need to be flexible with this approach as providers increasingly work across traditional sectors, but our regulation will continue to be based on specialised assessments, in the context of how providers deliver services.

Proportionate regulation

Respondents commented on whether our proposals would increase or reduce the administrative requirements on providers. While there were mixed views, overall respondents were optimistic about a reduction in administration. Respondents asked for reassurance that we will continue to inspect and rate providers robustly without being unnecessarily intrusive or imposing undue administrative requirements on providers.

We recognise that some of our proposed changes may cause some short-term administrative work for providers, for example those who base their quality monitoring

systems on our assessment frameworks. However, in the longer term, the changes are intended to reduce administration and duplication of effort, through more straightforward assessments of complex providers, improved alignment with other organisations, better coordination and scheduling of our inspections, and having appropriate, expert inspection teams.

Closer and more collaborative working with other organisations at local and national level

Many respondents called for CQC to work closely with other organisations across health and adult social care. They highlighted the benefits of sharing information and expertise with commissioners in particular, and also with national bodies, local authorities and voluntary organisations. Respondents were clear that it is important that the public are involved in holding services to account, including through our partners such as the Healthwatch network.

The changes we are making mean that we will do more to work closely with our partners at all levels, both locally and nationally. We are committed to working with a wide range of stakeholders to inform our regulation, including people who use services, to inform our understanding of the quality of care. We will work with national partner organisations to ensure we share information appropriately and avoid duplication or overlap wherever possible.

In response to our joint consultation with NHS Improvement, respondents welcomed our alignment and the drive to reduce duplicating work. We will work collaboratively as we continue to develop our joint approach to the use of resources assessment process and the joint well-led framework.

Issues outside of CQC's scope

Respondents raised concerns about providers being held to account for issues over which they have little control, for example funding or commissioning. While we understand the pressures that providers face, CQC's focus is on the quality of care for people who use services, and we cannot, and will not, compromise our standards on this. By using our independent voice and information gained from our regulatory work, we can highlight specific issues of concern, and all parts of the local health and care system, including commissioners and funders, can use our findings to inform their decision-making.

In response to the continued pressures in the health and social care system, the government has asked CQC to carry out targeted place-based reviews across 20 areas. The reviews will look at how health and social care work together, and what improvements could be made to benefit people who use services. We will start these reviews later this year.

Our consultation

Who we engaged with and who we heard from

Responses

We received a total of 496 responses during the consultation period. Some were from individuals and others were representative of a team or whole organisation. These comprised:

- 204 from health and social care providers or professionals
- 86 from the public, carers and people who use services (this also included Experts by Experience, a response on behalf of a foundation trust council of governors, and a response on behalf of an overview and scrutiny committee)
- 51 from CQC staff members/teams
- 38 from trade bodies or organisations representing health and care providers
- 36 from the voluntary and community sector
- 29 from local authorities, health and social care commissioners and parliamentarians
- 15 from other regulators or arms-length bodies
- 14 from members of a local Healthwatch or local Healthwatch staff
- 23 from a range of other backgrounds including researchers and representatives from the banking and legal sectors.

We used an online webform as the main way to gather consultation feedback, together with a dedicated email address. We also ran, and participated in, a number of events and webinars during the consultation period to encourage debate, discussion and feedback on the consultation. These events comprised:

- five webinars for providers and professionals
- three roundtable events with health and social care provider membership bodies
- four focus groups with community groups whose voices are seldom heard (including people with a learning disability and a group of women from Black and minority ethnic backgrounds)
- a meeting with Experts by Experience who have a learning disability
- a meeting with CQC's Children and Young People's Advisory Group
- a webinar with local Healthwatch.

We received feedback from our public online community on our question on registering services for people with a learning disability and/or autism. We produced an easy to read

version of this question and received two group responses and one individual response to this, which we reviewed internally.

Just before the start of the consultation, we held seven stakeholder events covering areas of the consultation. We also tested many of the proposals in our consultation in meetings with our national stakeholders to discuss common areas of focus.

Joint consultation with NHS Improvement

At the same time as our own consultation, we consulted jointly with NHS Improvement on our approach to assessing leadership and use of resources in NHS trusts. There were 117 responses to the joint consultation, and where relevant, we have considered them alongside the feedback to our consultation. The NHS Improvement/CQC joint response will be published later in summer 2017.

How we analysed the feedback

OPM Group, an independent research and consultancy organisation, analysed the consultation responses. The full set of consultation responses, a summary report of the analysis, detailed information about who responded to the consultation, and the methods used for the analysis can be found in the OPM Group consultation analysis report on our website: www.cqc.org.uk/nextphase1.

Section 1: Regulating new models of care and complex providers

Consultation question

1a, 1b Do you think our set of principles will enable the development of new models of care and complex providers? Please tell us the reasons for your answer.

“The principles are sound and should improve the quality and safety of care whilst enhancing the regulatory experience for some providers, particularly those who provide a variety of service types/regulated activities.”

Provider/professional,
Adult social care

“... Different ways of organising the provision of health and social care will require careful consideration of how they can be regulated so that the needs and preferences of patients, the public and service users are still central.”

Member of local Healthwatch

What you said

The majority of respondents to this question (59%) agreed or strongly agreed with CQC's proposed set of principles. Twenty eight per cent neither agreed nor disagreed, and 14% disagreed or strongly disagreed.

Overall, respondents thought that the principles were clear, useful and detailed; supported person-centred care; and were proportionate and flexible enough to deal with complex providers and a variety of contexts. Some thought they would reduce administrative requirements by simplifying regulatory processes and reducing duplication. However, some respondents expressed the view that the principles were too vague and not flexible enough. We have published our final principles, amended in light of the responses we received, as part of consultation 2: www.cqc.org.uk/nextphase.

1. Respondents welcomed the emphasis on **accountability of leadership** to help protect people from poor care. The importance of effective leadership in ensuring quality in complex organisations was highlighted, and respondents asked for further explanation of how CQC would encourage this.
2. Respondents also welcomed **considering an organisation's track record** to help CQC determine how and when to inspect. However, there were concerns that track record is not always an indicator of current performance.
3. Respondents were positive about CQC **aligning its inspection processes** to minimise complexity and increase efficiency for providers delivering different types of

services across different locations. Some respondents stated that closer alignment with NHS Improvement should be the highest priority.

4. Healthcare respondents agreed with the proposal **not to penalise providers that take over a poor service**, so we can support them and encourage improvement. However, some respondents were concerned that this could allow persistent poor care and accountability could be unclear, requesting a clear timeframe for improvement.

What we will do

1. We will hold the right people to account.

- We are consulting on proposals to extend the scope of registration to make sure that organisations are registered at the level of ultimate accountability. This will enable CQC to ensure that leaders drive up quality across their range of services. It is important that there is clear accountability for the quality of care in any type of organisation, no matter how it is set up.
- We are also consulting on proposals for a new approach to provider-level assessments (something that currently only happens in NHS trusts). This recognises the importance of leadership in driving quality, and that we may need to adapt our approach to reflect the changing landscape.

2. We will make use of up-to-date information, not just past performance.

While an organisation's track record will help us to determine when and how to inspect, we will never rely on past performance alone. We will continue to make use of information, including through CQC Insight, and local feedback (for example, from people who use services) to help make decisions on when and how we inspect, and we will always take action to protect people from harm.

3. We will align our inspection processes with our partners.

We have added a further principle that signals our intention to work closely with our partners so that we take a more coordinated approach to quality assessment, assurance and improvement. This reflects that these relationships – at a national and local level – are an important factor in ensuring that providers experience a joined-up approach from us and the partners we work with.

4. We will be fair to providers who take over poorly performing services, but will always take action when necessary.

We will always take action to protect and promote the health and wellbeing of people using services. However we recognise that we must look to strike a balance between the provider's need for time to embed improvements, and CQC's need for a regulatory intervention where there is a risk of poor care. We want to be fair to providers who feel they can take over and improve poorly performing services. By developing the relationship we have with providers and our partners, we can work together so that our regulatory activity supports rather than penalises providers. We know that providers that are given overall ratings, such as NHS trusts, are concerned about their overall rating being impacted by taking over poorly performing services. We will explore whether this can be protected while they work to improve the services they take over.

Section 2: Our assessment framework

Consultation questions

2a, 2b 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)? 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)?

“The proposed changes for moving certain KLOEs will not have a significant impact but will better reflect the principles of each key question and will serve to clarify what is expected under each of the five. It will also make it easier for the public to understand what it means to them.”

Provider/professional, NHS trust

“There is a danger, however, that having only two frameworks may have to be too simplified to enable them to be suitable across the whole of the two sectors.”

Local authority

What you said

The majority of respondents to this question (71%) agreed or strongly agreed with our proposal to move to two assessment frameworks. Sixteen per cent neither agreed nor disagreed, and 13% disagreed or strongly disagreed

Many respondents stated that reducing the number of assessment frameworks would improve the clarity and transparency of inspections and ratings. They said this would help:

- providers to understand how they are being assessed
- the public to compare services
- CQC inspectors to make assessments in a consistent way.

Many respondents said they were pleased that the five key questions remained as the basis of the assessment frameworks. Some said that the changes made the key lines of enquiry (KLOEs) more relevant, bringing them in line with changes and innovations in care and national policy, and would encourage providers to focus on the needs of people who use services as a whole. Some respondents thought the changes would encourage greater accountability from providers.

1. Respondents commented on **the administrative implications** – some were positive about the potential reduction in administrative requirements and bureaucracy for providers. However, a few respondents, particularly from the GP and adult social care sectors, were concerned about the transition period and the need to **amend their own quality monitoring systems**, where these are based on CQC's current frameworks.
2. Many respondents emphasised **the importance of clarity in wording, so that CQC's judgements are consistent** and providers are clear about what is expected of them. Some respondents requested specific wording revisions to make certain prompts or ratings characteristics less open to interpretation. In particular, more clarity was requested about the difference between the characteristics of the good and the outstanding ratings.
3. Respondents highlighted **the complexity and diversity of services**.
 - Some were concerned that using only two assessment frameworks would not reflect the differences in the type of service provided, the size or the setting.
 - The importance of being flexible with the frameworks was emphasised, along with the need for more detailed guidance to enable providers to see how the revised frameworks would work for specific services.
 - Respondents from the hospice sector were broadly supportive of including hospices within the healthcare framework, but were concerned that they should not be assessed in an overly 'medical' way.
 - Some requested further detail about how services that span health and social care would be assessed, and asked how having two frameworks fits with the alignment principle set out in the new models of care section of the consultation.
 - There were requests for CQC to improve the consistency of both content and structure between the healthcare and adult social care frameworks.
4. There was broad agreement that the proposed changes could **help improve the quality of care**, and there were some **suggestions to further develop some areas of assessment**.
 - There were positive comments around some of the additional prompts, including the introduction of information governance and assurance of data security; social action and active recruitment and training of volunteers; technology; supporting people to live healthier lives; and the increased focus on leadership.
 - Many respondents made detailed suggestions for improving or clarifying specific KLOEs and prompts, in particular around person-centred language; medicines;

end of life care; equality, diversity and human rights; autonomy, authority and consent; and the accessible information standard.

- Respondents were broadly supportive of moving the questions around consent and the Mental Capacity Act from the effective to the responsive key question, though a sizable minority felt it should stay under effective.
5. Some respondents expressed concern about the **overall effect of the changes**.
- The changes resulted in more KLOEs overall, and some duplication across themes.
 - The changes would make it harder to compare providers' progress over time.
 - The new KLOEs should be monitored and reviewed regularly to measure their success, and should be adapted if necessary to ensure that they have a positive impact and reflect the most current methods and issues in care.

What we will do

1. We recognise that some providers and stakeholders will **need to update their monitoring systems** and we will do what we can to help.
 - Some providers and stakeholders have developed internal quality assurance or monitoring processes based on our assessment frameworks that will need to be updated. There are three additional adult social care KLOEs and three (different) additional healthcare KLOEs. To help providers and stakeholders update any aligned systems or processes we have published two PDF versions of each assessment framework: one final version, and one that makes clear where we have introduced new KLOEs or prompts, made significant changes to wording of existing KLOEs or prompts, or made minor changes and merged prompts. All content has also been integrated in our provider web pages and we will show where some elements of the framework do not apply to particular providers.
 - We have set out a preliminary plan for implementation of the new frameworks, which begins with NHS trusts in June 2017; other providers will follow after consultations 2 and 3. Although this is a short timescale for implementation, we do not believe the revisions should make a significant difference to how providers are already delivering care. Our assessments will always be about the impact on people, and where we find services that are performing poorly we will hold providers to account.
2. We have **revised the wording of some KLOEs and prompts to improve their clarity**. We have already published examples of outstanding care for GP practices, and we are exploring options for providing similar examples for other healthcare and adult social care services.
3. We recognise the **complexity and diversity** that exists across health and social care.
 - We will continue to develop and publish additional sector- and service-specific materials that clearly link to the overarching assessment frameworks, and provide more detailed information about how they will apply in the context of a particular service.

- Some KLOEs, prompts and ratings characteristics will not necessarily need to be applied in all settings, and we have amended the applicability of some of them to reflect this. We will continue to amend these as we consult with different healthcare and adult social care settings. The KLOEs, prompts or ratings characteristics should only be applied where they are relevant and proportionate to the type of provider that is being inspected.
 - We have revised, as much as possible, a number of KLOEs, prompts and ratings characteristics to further align the two assessment frameworks, including making sure that the wording is the same where we are looking at the same aspect of care.
4. We have taken on board feedback about where we could **further develop some areas of assessment**.
- We are pleased that respondents agreed with our proposed changes and we have further strengthened some prompts to reflect the specific suggestions received.
 - Some suggestions were not appropriate for our assessment framework as they were too sector-specific or had the potential to go out of date too quickly. However, we will consider these proposals further for inclusion in sector-specific material.
 - In line with the requirements of the Department for Business, Energy and Industrial Strategy we will be reporting whistleblowing disclosures from April 2017 onwards with the first disclosures being reported in CQC's *Annual report and accounts 2017/18*. This will provide transparency and more detailed data on how whistleblowing needs are being responded to by CQC.
5. We appreciate the concerns expressed about the **overall effect of changes to the assessment frameworks**, however:
- We believe the revised KLOEs strike the right balance between substantial continuity with our previous frameworks and reflecting the most current methods and issues. The vast majority of content is very similar to the frameworks we introduced in 2014, and very few themes have moved between key questions, although we have included some new content to strengthen specific areas. We have made further amendments in response to the feedback, and reduced duplication of themes across KLOEs. This has slightly reduced the number of prompts overall from the number we consulted on.
 - The KLOEs on consent and mental capacity have not been moved from the effective to the responsive key question. The consultation response highlighted good arguments both for and against the proposal. There were also concerns about how this would impact on comparing key questions over time and a wish to keep changes to a minimum. Careful consideration of these views led to a decision not to make this change.
 - We recognise that for the few themes that have moved between key questions, these will no longer be directly comparable over time and this will be acknowledged in our assessments.

- We agree with respondents that we need to monitor the effectiveness of our assessment frameworks and supporting sector-specific guidance. However, we also appreciate the importance of continuity, and therefore do not intend to make any changes to the assessment frameworks for at least two years. We will then review whether any changes are needed.

Introduction of the revised frameworks

Sector	Implementation date
NHS trusts: NHS acute hospitals, NHS acute and specialist mental health, NHS substance misuse services, NHS community and ambulance trusts	June 2017
Community adult social care services Residential adult social care services	November 2017
NHS GP practices and GP out-of-hours services NHS 111 services Independent doctor services (primary medical services)	November 2017
Primary care dental services	From April 2018
Independent healthcare services: Acute hospitals Single specialty acute services Independent ambulances Hospice services Specialist substance misuse services Independent doctor services (non-hospital acute services)	Starting during 2018/19 – to be confirmed in consultation 3

We have finished the first round of comprehensive inspections for independent healthcare providers in acute and mental health hospitals, independent standalone substance misuse services, independent community health care, hospices and the majority of independent ambulance services. Inspections we carry out for these services during 2017/18 are likely to be in response to new concerns raised, or to follow up issues identified at the first inspection. We will continue to use the existing inspection approach for these services and other independent acute single speciality services during the next year, and consult later in 2017/18 on proposals for their next phase of regulation which will start during 2018/19.

Section 3: Registering services for people with learning disabilities

Consultation question

4 We have revised our guidance *Registering the right support* to help make sure that services for people with a learning disability 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.

“It is vital that services for people with LD [learning disabilities] and ASD [autistic spectrum disorder] are consistent and based on the persons needs and preferences in a way that is meaningful to them.”

Carer

“We support the CQC’s approach to ensuring that ‘Building the right support’ and the national service model are embedded into its regulatory framework, ensuring that models of care reflect best practice, values and policy.”

Local authority

What you said

The majority of respondents who expressed a sentiment were either positive about the proposed revisions to our guidance and said that the guidance could help to improve services for people with a learning disability and/or autism; or they agreed with the guidance but were constructively critical, discussing issues and suggesting changes to improve the guidance. People who use services, their carers and families were overwhelmingly positive about the guidance. Of those who were in support, people often said that the proposed revisions were appropriate and fair. Some also welcomed the alignment with national policy and some believed the guidance would result in improved services for people with a learning disability and/or autism. There was also support for the clarity of the guidance in delivering a bespoke registration process for the sector. People also mentioned that the guidance would support person-centred care.

Some respondents raised objections to the proposed revisions to our guidance and commented on the following issues.

1. The **application of the national service model to all services for people with a learning disability and/or autism**, given that the model specifically relates to people with a learning disability and/or autism who have “behaviour that challenges”.

2. **Whether there would be a degree of flexibility in regards to the location of services and “congregate settings”** (definition set out in our guidance), which would enable providers to tailor services according to the preferences of the people who use them.
3. That CQC had **adopted the definition of small-scale housing** to mean, “usually accommodating six or less”, which was considered to be a prescriptive requirement. Some suggested this measure would hinder innovation and result in a reduction of available community services for people with a learning disability and/or autism.
4. **Financial constraints on commissioners** that would prevail over good intentions and could result in the aims of the revised guidance suffering. The ability of the health and social care sector to secure funds to develop new services would be reduced as a result of our policy.
5. The potential negative impact of the amended guidance on providers, and **what this could mean for people using existing services that may not meet the requirements of the new guidance.**
6. The need for the **guidance on supported living services to be clarified**, and the need for assurance that there is not a potential loophole, specifically care homes being able to re-register as supported living services.
7. How the application of the revised guidance would **support innovation and new models of care.** Particularly, if the guidance is too prescriptive, providers could be discouraged from attempting to develop innovative services. There was concern that providers might develop models of care and then discover after significant investment, that they may not be granted registration.

What we will do

We have reviewed our guidance in response to the concerns raised. We respond as follows to particular points that have been raised:

1. Although we believe that the underpinning principles of choice and the promotion of independence and inclusion for individuals are fundamental to what a good service looks like for every person with a learning disability and/or autism, the service model within *Building the right support*¹ refers specifically to “people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition”. We will take the position that the principles of this guidance and accompanying service model should **apply to any service that provides care, or that might provide care in the future, to a person who meets this description.**

Our position has the support of the national Transforming Care Delivery Board and is aligned with current national policy and the long-held expectation that people with a learning disability and/or autism are as entitled to live an ‘ordinary’ life, as any other citizen. We know that the needs of people who use services change over time, and that new services are needed to support a range of people with varied needs.

2. We will assess each registration application on its merits against the statutory requirements, which includes our consideration of how the underpinning principles are applied.

¹ NHS England/LGA/ADASS, *Building the Right Support: A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition*, 2015, www.england.nhs.uk/learningdisabilities/care/

Our **general policy is not to support the development of new campus-style or congregate settings that do not promote the underpinning principles of the guidance.** Where proposed models depart from the underpinning principles, providers will need to demonstrate the evidence that supports their new model proposals.

3. We will **rely on national guidance on best practice, including *Building the right support*, for the definition of small-scale services** as those “usually accommodating six or less” for providers of services for people who have a learning disability, and/or autism and behaviour that challenges. We may register providers who have services that are small scale, but accommodate more than six people, where providers are able to demonstrate that they accord with all of the principles and values in *Building the right support* and other relevant guidance, and comply with all of the requirements of the Health and Social Care Act 2008 including the fundamental standards, and any enactments that apply.

We are mindful of the strong views expressed by people who use services and people who speak on their behalf, that smaller services are generally better in terms of meeting their needs and supporting them to be inclusive members of their chosen communities.

The evidence underpinning the national model is that smaller services are better able to provide personalised care than larger services. Therefore, smaller units are likely to be preferable for people with a learning disability and/or autism because they promote the underpinning principles set out in *Building the right support*. We are aware, however, that there are some larger services currently registered that are meeting regulatory standards in terms of being rated as providing good care. In accordance with the existing guidance, **we recognise the need to have a measure of flexibility in regards to the size of services.** We are likely to register new entrants that are small-scale, but we may not register existing providers that make changes to their services that cause them to increase in size if they are unable to demonstrate that their model accords with evidence-based best practice.

4. **We will continue to meet with financial institutions to ensure they are informed of any changes we make to our guidance.** We met with a number of financial institutions as part of this consultation, all of whom were concerned that our guidance would mean that economies of scale could not be achieved. This, they said, would increase the risk of providers not being granted registration, meaning banks would be less likely to lend. We have further revised our guidance to make our position clearer, specifically in relation to the size of services.

Commissioning authorities have signed up to implement this model at a national level. Where commissioners are failing to follow the national model, this is a matter for the national Transforming Care Delivery Board. We will continue to build relationships with commissioners to ensure there is an understanding about the services we will register.

5. We will gain assurance about good quality care and outcomes for people through our inspection programme. **We understand that the interests of some people may be best served, and this will be their choice, by remaining in their current service or home even though it does not meet the standards set out in the guidance.** We do not want to disrupt the lives of people who are currently residing in a service that is not small-scale, provided that the care is person-centred. We will encourage services to improve with respect to the guidance. Where people’s needs are not being

met, we will take the necessary appropriate regulatory action to improve the quality and safety of these services.

6. **We have further revised our guidance to clarify our regulatory position in relation to the registration of supported living services.** Although the accommodation in which personal or nursing care is provided is not part of the registration for supported living services, the regulated activity of personal care is part of the registration. We will therefore expect providers to ensure that the service provided is underpinned by the principles in *Building the right support* and *Building the right home*.²
7. We will be prepared to approve **genuinely innovative models of care**, where providers are able to demonstrate that their model aligns with the national model and is underpinned by evidence-based best practice. We support and encourage genuine innovation in new models of care for people with a learning disability and/or autism. It is not our intention to create a one-size-fits-all approach. We will implement systems to enable providers to discuss their proposals or development ideas before they submit them.

² NHS England/LGA/ADASS, *Building the right home: Guidance for commissioners of health and care services for children, young people and adults with learning disabilities and/or autism who display behaviour that challenges* 2016, <https://www.england.nhs.uk/learningdisabilities/wp-content/uploads/sites/34/2015/11/building-right-home-guidance-housing.pdf>

Section 4: Next phase of regulation – NHS trusts

This section covers our response to feedback on our regulatory approach for NHS trusts which covers the following elements of our operating model:

- Monitor
- Inspect
- Rate

We set out the detail of our approach in the updated guidance for NHS hospitals on our website: www.cqc.org.uk/nextphase1. This replaces the previous 11 separate provider handbooks.

Monitor

“We welcome the introduction of CQC’s new Insight model, and its strengthened relationship management, as part of its shift to a more targeted and intelligence-driven approach to inspection.”

Arm’s length body

“However it will be important to ensure that a ‘cosy’ club between the regulator and the Trusts don’t develop and to ensure that the patients voice doesn’t get drowned out by the strength of CQC/Trust relationships.”

Member of the public

CQC Insight

Consultation question – CQC Insight

5. (part 1) What should we consider in our new CQC Insight approach?

What you said

1. There were mixed views about the **requirements on providers**. Some respondents were positive about the prospect of reduced administration and less duplication of effort, for example collecting data from existing sources (such as commissioners), data-sharing with partners, and alignment with NHS Improvement. However, others (particularly NHS trusts) were concerned that CQC Insight might increase administrative requirements and asked for confirmation that there would not be duplication and existing data would be used as much as possible.

2. Respondents emphasised the importance of **working collaboratively** with providers, people who use services, and stakeholders in order to:
 - share findings and data as soon as possible
 - develop and clarify a process for CQC Insight that shows what data would be collected and how; how data sharing would work; and how concerns would be addressed
 - gather qualitative data from the public, people who use services and providers' staff. Respondents emphasised the need for this to come from people from a wide range of groups, such as people living with dementia, people who are Lesbian, gay, bisexual and transgender (LGBT) and, children and young people.
3. There were requests for **transparency, clarity and consistency**:
 - about data sources, the weighting given and context of data, particularly in relation to information from staff and people who use services
 - about how CQC Insight will work for trusts operating from multiple locations or providing multiple services, as well as how it would work for independent healthcare providers, and also for new models of care
 - about our approach to CQC Insight for mental health services.
4. Respondents emphasised the importance of **accurate, up-to-date and robust data**.

What we will do

1. We will aim to **minimise the costs for providers**. The content of CQC Insight will initially focus on **existing data collections** that are available nationally. Over time this will be supplemented with more qualitative analysis of information gathered directly from staff and people who use services. We will work with and share information with NHS Improvement, and we are participating in discussions with providers, national partners and the Department of Health about where we can further align or reduce the cost of information collections. We will only request additional monitoring information from providers where no other source is available.
2. We will **work collaboratively** with providers, people who use services, and stakeholders.
 - In developing all of our CQC Insight products, we will seek to work with providers, people who use services and our partners through our regular reference groups and co-production activities. Once ready, we will share our Insight products with all relevant providers and we will ask for feedback about them to continuously improve them. Furthermore, we will pilot each of our Insight products with providers and our partners before releasing them to ensure that they are clear in terms of the data used, how it is analysed and how we share it with others. For example, NHS acute Insight was piloted earlier this year and NHS mental health Insight will be piloted during the first quarter of 2017/18.
 - As part of the work to deliver our five-year strategy, we will be seeking ways to improve how we use qualitative information in our monitoring activities, particularly

the views from the public, staff and people who use services. In line with our wider engagement work, we will be drawing on views from a wide range of audiences to achieve this.

3. We recognise the importance of **transparency, clarity and consistency** of approach.
 - We will clearly state the sources of data for our Insight products and supporting documentation, and explain how we have analysed them, including any weighting applied. We will share full Insight reports directly with providers and the partners we work with. Information of interest to the public will be available on our website in different formats, for example in evidence appendices alongside our inspection reports. We will work with the public to define what this information should be and the most appropriate format for presenting it.
 - We will aim to align and simplify the way we monitor providers that deliver more than one type of service.
 - We will start developing Insight for independent healthcare providers in 2017.
4. We will work to ensure the **timeliness and robustness of the data** we use.
 - We will refresh the data in our Insight products as soon as possible when new data become available, including any new collections from NHS Digital.
 - We will ensure that we have strong governance processes to assess the robustness of all data and indicators before we include them in Insight.

Relationship management

Consultation question – relationship management

5. (part 2) What should we consider in strengthening our relationship management?

What you said

Respondents had positive comments about the importance of strengthening the way we manage relationships, for example, with the advent of new care models and integration in a challenging health and social care environment. Positive comments included the benefits of open conversations between CQC and NHS trusts, and sharing best practice. While several respondents raised concerns that there could be an increase in time spent on relationship management, as well as cost for providers, generally respondents were positive and thought that the proposal had the potential for reducing administrative requirements, including by aligning with NHS Improvement.

1. Many comments **requested transparency, clarity and consistency** in our approach.

- There were requests (particularly from NHS trusts) for a clearer, more formal and consistent approach to relationship management. There was also support for consistent engagement with one member of inspection staff, with respondents keen on a named contact who is experienced in the type of service provided.
 - Some respondents emphasised the importance of being transparent when sharing information from CQC Insight with providers as part of our relationship management. Respondents wanted CQC to be clear about what information we will take from relationship management meetings, how we will share it, and whether we will use it to inform decisions about a provider's rating.
2. Some respondents mentioned the importance of **working collaboratively with different groups**.
 - Respondents suggested partners and stakeholders they thought CQC could work with to strengthen relationship management, such as commissioners, the Healthwatch network, patient groups and voluntary organisations.

What we will do

1. We will improve the **consistency of engagement with providers**.
 - Relationship management meetings with providers will be quarterly, with an improved structure and format. The relationship owner will develop an understanding of the organisation and we aim to avoid changing the relationship owner, unless we have to.
 - We agree that it is important to be **transparent** when sharing information and that an effective relationship is built on open dialogue. We will share information with providers, in a proportionate way, where it will not breach confidentiality or prejudice the functions of CQC. While relationship management meetings do not constitute an inspection and will not directly inform a provider's ratings, they will inform our regulatory planning. We are also considering our processes for sharing and acting on any concerns that may arise in our provider engagement.
2. We are committed to **working collaboratively with a wide range of stakeholders** to inform our regulation.
 - Strengthening our relationships with partners and stakeholders will be increasingly important as we move towards an intelligence-driven model of regulation. We will improve how we manage relationships with local and regional stakeholders, for example with the Healthwatch network and with voluntary and community sector organisations that represent the public. We will develop our relationship management approach by working with national partner organisations, such as NHS Improvement and NHS England, to avoid duplication or confusion.

Provider information requests

Consultation question

6. What do you think of our proposed new approach for the provider information request for NHS trusts?

What you said

Respondents were generally positive about our proposals for the provider information request (PIR) for NHS trusts. There were positive comments around the more streamlined approach, reduced administrative requirements, and that it would take less time to complete once a year.

1. We received requests for further information about the PIR, particularly on:

- the **information** to be collected
- the **timing** of PIRs within the new annual process
- what **IT systems** providers need to use to submit the PIR.

2. There were also concerns from respondents about:

- the potential for PIR data to be **outdated** by the time of the inspection
- the **potential subjectivity of a provider's self-assessment**, and that issues might not be noticed, which could put people at risk of poor care
- **duplication of data** already submitted to other stakeholders or partners.

What we will do

1. Our new PIR is designed to improve the process:

- It is a **standardised template**, with supporting guidance to help providers submit consistent information. It is significantly shorter than our old-style PIR and comprises a combination of data requests, the trust's self-assessment against the five key questions and evidence from the trust to support its assessment. The new PIR is published on our website – the template shows the content required, and will be updated over time based on feedback and what we learn from experience.
- Providers will receive their **first new PIR between June 2017 and autumn 2018**. The PIR marks the start of the annual inspection cycle – with targeted inspections expected within the following six months. Thereafter they will be requested approximately once a year.
- As part of the work to move to a single online collection, we will **test in advance the IT systems** that providers need to use, to ensure that we make the process as streamlined as possible. Initially, providers will be asked to submit PIRs through

the current system while we test and develop our new system during the second half of 2017/18. We plan to move all provider information collections to the new system by April 2018.

2. In response to the concerns raised:

- While we recognise that **some data may not be up-to-date by the time of inspection, we do not see this as a significant issue**. This is because trusts have welcomed the single annual trust-wide return rather than repeat requests, and the self-assessment is unlikely to have changed considerably between PIR submission and inspection. Also, when inspectors are on site, they may ask for further information about the service, and this would be up-to-date.
- **Self-reported information will always be tested and corroborated** with other information sources, including information from people who use services and those organisations that represent them, as well as through our inspection activities, before it contributes to any judgements and ratings. The PIR will focus on asking the provider to evidence how they understand the views of people using their service and have made improvements as a result of that feedback. It is important that providers have a chance to share their view of the quality of care they provide and are able to tell us where they have made improvements or where they know challenges remain.
- We will continue to work with commissioners and the other partners, to share more information and **streamline information requests** to help reduce administrative requirements for providers.

Inspect

“A tailored approach is welcomed, based on risk rating and previous inspections. The move away from periodic comprehensive inspections involving all core services is supported – the burden in preparing for this for providers is significant.”

Provider/professional, NHS trust

“Inspecting across a range of providers and sectors provides the opportunity to examine the lateral connections that ensure that services are well-led and properly coordinated in the interests of the client, to produce efficient and effective services.”

Voluntary/community sector individual

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?

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,10b 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? Please tell us the reasons for your answer.

11a, 11b Do you agree with our proposals for using accreditation schemes to both inform and reduce CQC inspections? Please tell us the reasons for your answer.

Well-led at trust level

What you said

We asked about our approach to the frequency of inspecting core services and the well-led key question at trust level. The majority of respondents were positive about these proposals or suggested refinements. Responses were similarly positive on our proposal for assessing the well-led key question in our joint consultation with NHS Improvement. A joint response to that consultation will be published later in summer 2017.

The main issues about inspecting the well-led key question at the trust level, were that:

1. It might prove challenging to assess well-led at the trust level in a **consistent and effective way**, particularly across large providers with different types of services.
2. Inspections of the well-led key question could be **too frequent, could increase administration**, or might **duplicate** the work of NHS Improvement.

What we will do

1. We recognise the potential challenge around **consistency and effectiveness**, and are confident that we can address this in the following ways:
 - We will always collect evidence against all KLOEs in the strengthened well-led section of the assessment framework, and make consistent judgements against the corresponding characteristics. There will be a **consistent core approach** to assessing the well-led question, which we will apply to all providers. This will be supplemented with additional, more detailed assessment activity where we have concerns or need to investigate a particular area.
 - We will combine this consistent core assessment with **the right expertise to ensure our approach is effective**. The trust-level inspection of well-led will be conducted by a small, senior team of inspectors and specialist advisors with expertise in the relevant areas. This will enable us to explore key issues in organisational leadership, governance and culture.
2. We intend to **roll out our new approach** to allow us to evaluate, improve and refine it. We will then further assess the appropriate frequency and approach to future inspections of well-led at trust level. During the roll-out, we will:
 - ensure our approach to assessing the well-led key question at trust level is **proportionate and avoids unnecessary administrative requirements**, by varying the scope and depth of our trust-level inspections according to the nature of the individual trust.
 - work closely with NHS Improvement to align our planning, assessment and follow-up activity, to ensure our roles and work are clear and **duplication is avoided**, both in CQC's trust-level, well-led inspections and in NHS Improvement's work to support trusts to improve, including through leadership and governance developmental reviews, and other work. We will set out the principles and details of our working relationships with NHS Improvement in a new memorandum of understanding and associated operational protocols.

Core service inspections

What you said – core service inspections

Respondents highlighted the potential benefits of more targeted inspections. However, they also wanted more clarity on how we would implement them, including asking:

1. for reassurance that the approach is **not too 'light touch'** to truly assess quality and also whether **inspections are frequent enough**, especially for core services rated outstanding
2. how we will **select core services** and what role providers may have in influencing that decision
3. how the proposals would **apply to trusts of different sizes** and whether the scope of inspections will be appropriate to the size of a provider.

What we will do – core service inspections

We are aiming to achieve the right balance to ensure we appropriately assess quality, manage the administrative requirements on providers, and deliver within our resources. The roll-out of our new approach over two years allows us to evaluate its implementation and refine it if concerns emerge. In response to the requests for clarity on implementation:

1. Our new approach to monitoring, relationship management and the PIR is designed to ensure that we have sufficient information to target our inspections and that we are confident that we will be able to reach the **right balance of information gathered throughout the year and during the targeted inspections**. We will have the flexibility to inspect core services across all rating levels in response to information that points to emerging concerns or potential improvement. An important aspect of our current inspection methodology, gathering the views of people using services, will remain and will be embedded in our ongoing monitoring across our approach.
2. The **selection of core services will be guided by our frequency principles**. Every year we will inspect all core services rated inadequate; half of those rated requires improvement; a third that are rated good; and a fifth that are rated outstanding. Our selection of core services to inspect will also reflect areas where we or the trust have identified new risks or improvements.
3. The next phase of inspection approach gives us flexibility to change the scope of the inspection to take account of **trusts of different sizes**. Our ongoing evaluation will identify any concerns resulting from trusts of different sizes which we will use to refine our approach as we go forward.

What you said – unannounced core service inspections

Respondents were mostly positive about unannounced core service inspections, and no trusts opposed the proposal.

1. They raised some concerns about **the logistical issues** of an unannounced inspection. For example, increased workloads; providing cover for staff when speaking with inspectors; the potential for senior managers to be unavailable; the

impact on people using services (particularly vulnerable groups such as people with dementia); and inspecting geographically dispersed services, stating that these could affect the overall accuracy of the picture of care and effectiveness of the inspection. There were also some practical suggestions to address these issues.

2. There was concern that unannounced inspections could lead to **high levels of anxiety** amongst staff.

What we will do – unannounced core service inspections

1. To **address the logistical issues raised** we are refining our approach to be flexible enough to suit the range of NHS trusts that we inspect and the breadth of the planned inspection. This may include short notice periods for those trusts where it would be logistically challenging for an inspection to be unannounced. Whilst we may decide to defer an inspection in exceptional circumstances, this will not include the unavailability of senior staff at core service level. We would expect the service to operate in a similar manner regardless of whether a senior staff member is on duty.

As we currently do, our inspection teams will ensure that the impact on staff delivering the service, as well as to the people who are using services, is kept to a minimum.

2. We recognise there is the potential for unannounced inspections to be stressful for staff. However, our experience in inspections so far also highlights that an announced inspection can cause anxiety over the notification period. Therefore there is a balance to be struck and we believe **unannounced inspections will be more conducive to the staff experience overall.**

What you said – maternity and gynaecology, and outpatient and diagnostic core services

The majority of respondents were positive about our proposals or suggested refinements for these two services which does not mean an increase in core services.

1. There were concerns about **duplication** of effort and requests for **CQC to clarify** and justify the benefits of separating the two services. For outpatients and diagnostics there was concern about the possible **impact on waiting times** for related service areas, and **standards of diagnostic imaging.**
2. Suggestions **for improving the proposal** included:
 - reporting termination of pregnancy under gynaecology rather than maternity
 - reporting outpatient services as part of the surgery core service.

What we will do – maternity and gynaecology, and outpatients and diagnostic core services

1. Our experience to date and feedback from the sector supports the view that both maternity and gynaecology, and outpatients and diagnostic imaging are **distinct specialities, largely delivered by different staff.** We appreciate that in smaller providers the services may be managed and delivered by the same team but are confident that the proposed split better reflects the most common approach to the way services are delivered. **Waiting times** and other indicators of the quality of standards

in diagnostic imaging will be an **indicator within CQC Insight** and will be continuously monitored by the relationship owner.

2. In response to the feedback for improving the proposals:

- We will report **termination of pregnancy under the gynaecology core service**. This change means that it will be increasingly important to ensure that inspection teams consider onward referral and coordination with related services. We will ensure that the framework reflects this need.
- We acknowledge the case for inspecting outpatients as part of the surgery or medicine core services. However, on balance, we felt that **such a proposal would not generally reflect the management arrangements for outpatients** and it would remain difficult to adequately reflect outpatient services in the wider medicine or surgery core services.

What you said – additional services

The majority of respondents to this question (64%) agreed or strongly agreed with our proposed approach to inspecting additional services. Twenty five per cent neither agreed nor disagreed, and 10% disagreed or strongly disagreed.

1. There were requests for clarity around:

- the **size and frequency** of inspections and re-inspections, as well as the particular **methodology** inspectors will be using
- which services would be **categorised** as additional services, how the proposals would be **consistently applied**, and how we would **avoid duplication**.

2. There was concern about the proposed lack of **aggregation** and that additional service inspections would not affect trust overall ratings.

What we will do – additional services

1. In response to feedback, we are further refining our approach:

- We will inspect an additional service selected for an individual provider in the same way as for core services. We will **tailor our approach to the methodology** for inspecting additional services across providers (for example looking at pathways or location-based places of care) to the specific service being inspected.
- We have developed key criteria to ensure a **consistent approach** to selecting additional core services for an individual provider. We will select additional services across providers based on national priorities and concerns.

2. When we select an additional service for an individual provider, we will inspect, report and rate in a similar way to the core services, unless it is disproportionate to do so. When we inspect an additional service across many providers, we may not inspect it in every provider and it may be a number of years before that additional service is chosen for re-inspection. For these reasons, although we will rate the service and take enforcement action as necessary, **we will not aggregate to provider level**.

What you said – accreditation schemes

The majority of respondents to this question (61%) agreed or strongly agreed with our proposals for using accreditation schemes to both inform and reduce CQC inspections. Twenty three per cent neither agreed nor disagreed, and 16% disagreed or strongly disagreed.

Respondents were positive about the potential for the use of accreditation schemes to reduce duplication of effort and save time and resources. However there were also requests for clarity around:

1. **Which accreditation schemes** would be considered by CQC and why.
2. How accreditation schemes would **align with our assessment frameworks**.
3. The **role and value of accreditation schemes** within CQC's overall assessment, specifically asking:
 - how important are they in terms of informing our ratings?
 - will CQC enforce accreditation schemes?
4. Whether there will be any implication for **CQC fees**.

What we will do – accreditation schemes

In response to the requests for clarity:

1. We will only **use an accreditation scheme as an information source if it meets key quality standards** to assure us that it is of sufficient quality and rigour. We will only use accreditation schemes to reduce our inspection activity in a particular core service if there is adequate uptake among NHS providers of relevant approved schemes, to allow for benchmarking. We are working with the Health Quality Improvement Partnership to further define what this means.
2. Any accreditation scheme that we use will need to be able to **map its standards to our assessment framework**.
3. We will not enforce the use of accreditation schemes by providers. Rather, we will **reflect participation in accreditation schemes under the well-led and effective key questions** and this is reflected in the ratings characteristics. Participation in accreditation schemes will be an indicator of a good or outstanding service, but it is not the only indicator. The absence of accreditation would not therefore necessarily limit a rating.
4. There are no plans at present to reduce **CQC fees**. However, providers who participate in accreditation schemes report a number of benefits, including improved efficiency.

Rate

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)?

“We believe the most important aspect around the ratings is clarity in the reasons for the rating and for this to be included in a succinct, easy to read report format.”

Member of local Healthwatch

“... overall trust ratings will be reviewed and updated following a trust-level well-led assessment and planned core service inspections. This will need significant work and judgement to get right, as new care models are developed.”

Provider/professional, NHS trust

What you said

There was some support for our current approach to rating. Respondents recognised the importance of ratings for encouraging improvements in performance and our ability to hold providers to account.

1. Many respondents commented on the importance of **transparency, clarity and communication** of ratings, including:
 - suggesting we improve transparency about how we reach decisions and the rationale behind them and clearly communicate this to the public and to providers
 - the need for clearer and more succinct inspection reports that are presented in an accessible way.
2. Some respondents were concerned that the long intervals between inspecting some core services would prevent an NHS trust from **demonstrating the improvements** it has made, especially where improvements have been made over a short period.
3. Some respondents expressed concerns about **ratings in an evolving landscape**, including:
 - how we would incorporate the ratings of new services following a merger and whether this would be recognised in their provider-level rating
 - how aggregation takes account of complex providers, services that span different geographical locations or that comprise services of different sizes

- if and how use of resources will be aggregated.

What we will do

1. We will improve the **transparency, clarity and communication of ratings** by:
 - Setting out clearly in our inspection report how we reached our decision on trust-level ratings for each key question to ensure transparency in our decision-making. This will include the factors that the inspection team considered and how these influenced the overall rating. Being clearer about how we made our judgements will help encourage and support providers to improve.
 - Producing shorter, more accessible reports that summarise our findings and clearly present our ratings. We will include evidence that presents the facts and figures in a separate report which anyone can access when required.
2. We will plan our inspection activity to reflect what we know about changes to quality of care, and will **include inspection of some core services where the available information suggests that the quality of care may have improved**. Our trust-level inspection of the well-led key question will always consider improvements since the previous inspection, and this will be reflected in the rating for this key question.
3. We **recognise the challenges raised about ratings in an evolving landscape, and our accompanying consultation explores these in more detail**
 - We will continue to rate NHS trusts at provider level during 2017/18 based on our assessment of the well-led key question and use our aggregation principles and the professional judgement of our inspection teams to rate the other four key questions. There will be a stronger role for professional judgement in agreeing trust-level ratings for trusts that combine different types of health and care services. We will also rate acute hospitals at location level using our aggregation principles and professional judgement. Our accompanying provider guidance for NHS trusts explains how professional judgement might be used.
 - We recognise that there is increasing complexity and diversity among the services that trusts provide, and that in the future we will need a consistent approach across different types of provider. Our consultation proposes developing a new provider-level assessment for a wider range of providers.
 - When a trust acquires or merges with another service or provider in order to improve the quality and safety of care, we will not aggregate ratings from the previously separate services or providers at trust level for a period of two years. This will allow the newly-created trust time to address quality issues.
 - We are developing our approach to rating the use of resources in acute trusts, and plan to develop and test options for combining these ratings. We will consult on proposed options later this year.

Implementation for NHS trusts

We will introduce our new assessment framework and approach for NHS trusts from the second half of June 2017. This means that the first new PIRs will be sent at that point, the first regulatory planning meetings will take place from August, the first next phase inspections will take place between September and November 2017, and the first next phase ratings and inspection reports will be published in early 2018. The minimum inspection activity for an individual provider organisation will be one core service and assessment of the well-led key question (at provider level). After our internal regulatory planning meeting, we will inform the trust of the timing of the well-led inspection. We will roll out our approach slowly so that inspection staff can be fully trained; and to enable us to evaluate, improve and refine our approach. Our preliminary plans are to send PIRs to around a third of NHS trusts by the end of December 2017 and ensure that all NHS trusts receive a new PIR by autumn 2018. The early trusts will be identified on a risk basis and/or those that have not been inspected in the previous 12 months. We intend that the approach will be fully embedded by spring 2019, and at that point all trusts can expect to have an assessment of well-led and at least one core service inspection approximately once a year.

The level of inspection activity will be proportionate to the level of risk identified at each organisation and will reflect a trust's own view of areas of concern or improvement. Both the initial planning and the final review meetings will be chaired by either CQC's Chief Inspector of Hospitals or a Deputy Chief Inspector to ensure consistency.

Our plans allow CQC to retain flexibility to carry out a focused, responsive inspection if concerns arise during the year, where appropriate. Although we will inspect trusts approximately once a year, this will not be at the same time each year and will depend on the information that CQC holds and the level of risk based on the available evidence.

After we have completed the inspection activity, we will publish a shorter and more focused inspection report, together with an evidence appendix. These will be quality-assured and factually checked by the provider. After that we will hold an internal final review meeting to ratify the ratings and we will publish the report.

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