CQC's next phase of regulation consultation:

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

Summary analysis report

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1. Summary

1.1 Process

Having published a consultation on its five-year strategy in May 2016, the Care Quality Commission (CQC) consulted on the next phase of its regulatory model between December 2016 and February 2017. Members of the public, providers and stakeholders were invited to express their responses to 18 consultation questions, spanning a range of proposals focusing on CQC's principles for new models of care, changes to CQC's assessment frameworks, CQC's guidance for registering services for people with a learning disability and/or autism, and changes to CQC's regulation of NHS trusts.

There were 496 responses to the consultation from respondents including members of the public, carers, various representative organisations, local authorities, and members of CQC staff. Just over 200 respondents submitted responses on behalf of health or social care providers or in their capacity as health or social care professionals. An overview and count of all respondent types is provided in section 2.3.1.

The responses were collected by CQC and sent to OPM Group, a professional independent specialist agency, for analysis. This report summarises the findings of the analysis.

1.1 Findings

1.1.1 Recurring themes

Overall, many respondents are supportive of CQC's proposals for its next phase of regulation. Across the consultation questions, respondents express confidence that the changes CQC proposes could improve the regulation of care services, and ultimately improve the quality of care. Respondents also offer a variety of comments and suggestions asking CQC to further consider or clarify elements of its proposals. Some express fundamental disagreement with particular proposals; in most cases these are relatively small numbers of respondents.

Respondents to all consultation questions discuss the **clarity** of the proposals. In some instances, they praise CQC's proposals for being clear or for making the regulatory process clearer, in particular with regard to the proposals on CQC's assessment framework. However, some respondents think CQC could further improve the clarity of its key lines of enquiry (KLOEs) and ratings characteristics. On other themes, respondents request that CQC provides more detail about how it plans to implement changes. Respondents would like more clarity on proposals about regulating new models of care, CQC's new approach to Insight and provider information requests (PIRs), and registering services for people with a learning disability and/or autism.

Consistency within the regulation process is another prominent theme in consultation responses. Respondents often emphasise the importance of consistency for a robust and trustworthy regulatory regime. They welcome some of CQC's proposals for their potential to enhance consistency, including the proposals on assessment frameworks, inspections, and strengthening relationship management. Respondents utter some caution with regard to CQC's proposals on registering services for people with a learning disability and/or autism, and accreditation schemes, saying they might prevent consistency between services. Across themes, some respondents express concern that changing CQC's methods and metrics could undermine the consistency of findings and ratings over time.

Respondents regularly reflect on how CQC's proposals would affect **transparency**. There is praise for proposals that are considered to make CQC's work (including provider ratings) easier to understand for the public, including the reduction of the number of assessment frameworks, proposed changes to KLOEs and ratings characteristics, the regulation of new models of care, and the development of trust-level ratings. Some respondents warn about the risk of oversimplification in attempts to enhance clarity and transparency. Respondents also say that CQC must ensure its own processes, especially its data collection, weighting and rating, are transparent.

Many respondents highlight the complexity and variety of the care sector, calling for CQC to fully acknowledge this by building in sufficient **flexibility** in its processes and methods. Some respondents express concern about CQC's proposals to change its assessment frameworks and KLOEs, or its proposals for registering services for people with a learning disability and/or autism, arguing that CQC needs to be more flexible. Respondents perceive some proposals to be a move towards a one-size-fits-all approach, which they think might negatively affect some providers, such as smaller or complex organisations.

Those who respond on behalf of health and social care providers and professionals often evaluate whether CQC's proposals would increase or reduce the administrative **burden** perceived by providers. For each consultation theme, some respondents welcome an anticipated reduction in paperwork or duplication, whereas others say they are alarmed about potential increases. The latter group is usually smaller, and there is optimism about burden reductions prevails in responses to questions about the proposed new CQC Insight approach, PIRs, inspections and accreditation schemes. While this is also true for responses about assessment frameworks and new models of care, some respondents ask that CQC makes sure that it regulates in a flexible and proportionate way, preventing undue burden on providers.

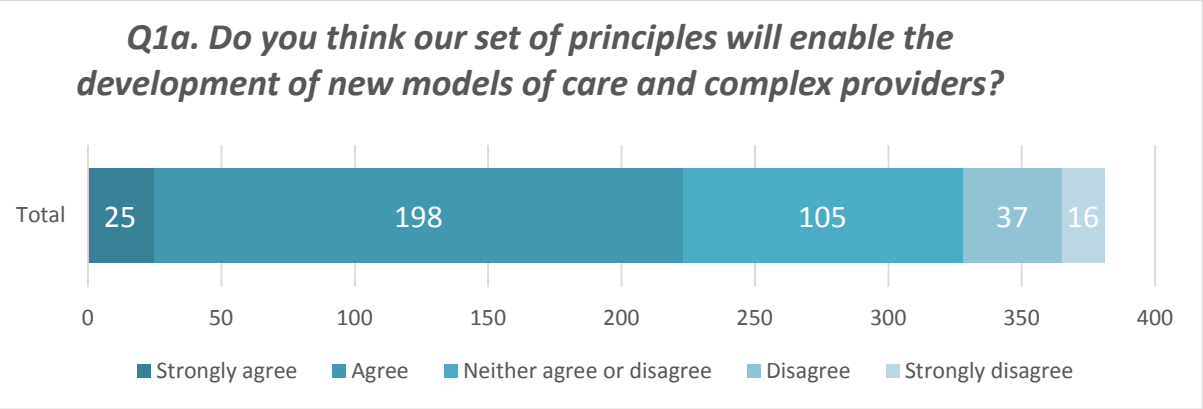
Respondents commonly recommend that CQC puts more emphasis on **working with others** in the sector. Respondents believe that closer collaboration holds benefits for CQC as well as (potential) partner organisations, including sharing data, exchanging knowledge, and influencing the quality of care within local areas. Suggestions of organisations that CQC could work more with include arm's length bodies, royal colleges, national representative organisations, voluntary and community organisations, and local Healthwatch. Above all, respondents urge CQC to increase its efforts to work with local authorities and their

commissioning groups, as they perceive the commissioning of health and social care to be instrumental to the sector's potential to improve care quality.

Consultation responses often mention the funding and commissioning context, which they argue affects providers' ability to improve. Respondents highlight the pressures experienced by local authorities and care providers to deliver sufficient care, while resources are often scarce, and ask CQC to be mindful of this when requiring providers to change. Some respondents emphasise that decisions about funding and commissioning are outside their control, as well as outside CQC's reach.

1.1.2 New models of care and complex providers

In **question 1** of the consultation questionnaire, CQC asked respondents to state their opinion about a set of nine principles aimed at enabling the development of new models of care and at complex providers.



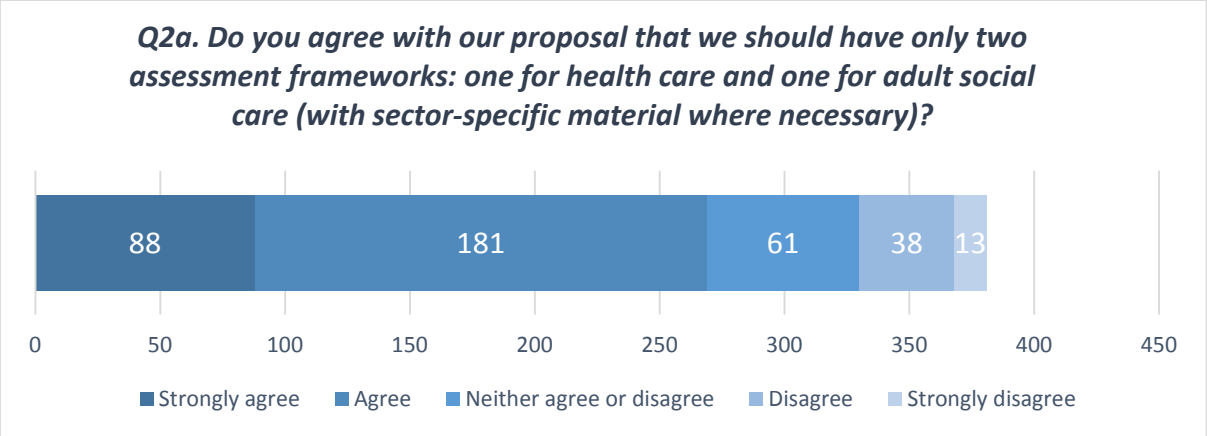
Most respondents express support for the proposed set of principles; a relatively small number of respondents explicitly oppose them.

Where respondents comment positively on the principles, they often praise their clarity and level of detail, which they think will contribute to their successful implementation. Respondents express particular support for the principles addressing accountability, proportionality, minimising complexity and bringing together specialist inspectors to inspect jointly.

Respondents who raise concerns about the principles often question whether and how they would support the desired developments in care provision, saying for instance that the principles are not clear enough or that their impact would be minimal. Some respondents say they are worried that the proposed principles might complicate CQC's regulatory activity or impact on providers' ratings.

1.1.3 CQC's assessment framework

In **questions 2 and 3** of the consultation questionnaire, CQC invited respondents to comment on changes it proposes to its assessment framework, including a reduction from 11 to two assessment frameworks and a revision of its key lines of enquiry (KLOEs).



A majority of those who responded to these questions expressed support for the proposed changes. Of the 300+ respondents to these questions, some 50 expressed disagreement and/or criticism.

Many respondents welcome the proposed changes, stating for example that they would improve the assessment framework's alignment with national policy and guidance, make regulation more transparent, or make it easier for providers to know what to concentrate on to improve their services.

However, other respondents highlight further changes they believe CQC should make to the assessment framework, so that it becomes more effective. Examples include making the health care and social care frameworks more similar and comparable, reducing duplication of KLOEs, clarifying where particular KLOEs are not applicable to certain services, and tightening the wording so that KLOEs are less open to interpretation. Several respondents express concern that the proposed assessment framework would lack flexibility, or that it might struggle to accommodate the complexity and variety of the care sector.

Numerous comments concentrate on CQC's proposal to move the KLOEs specific to the Mental Capacity Act (MCA) and consent from the 'effective' key question to the 'responsive' key question. Respondents are divided on the merits of such a change. A majority of those who comment on the proposal concur that the moving these KLOEs to responsive would encourage care providers to be more sensitive to applying the MCA appropriately; a minority say that the change would be unhelpful, as the current KLOEs seem to work well. Respondents also worry that the proposed change would affect providers' existing quality monitoring processes, and their ratings.

1.1.4 Registering the right support – guidance for people with a learning disability and/or autism

In **question 4** of the consultation questionnaire, CQC asked respondents to express their views about its revised guidance on registering providers supporting people with a learning disability and/or autism. Many respondents make positive comments about the revised guidance, while several others raise issues or express criticism. On balance, more respondents are supportive than critical.

Where respondents express support for the revised guidance, they often do so in a general manner, or adding that they agree with the alignment of the guidance with national policy or best practice. Several respondents emphasise the need for improvement in care for people with a learning disability and/or autism, and praise CQC for the aims of its revised guidance, including the proposed 'small-scale housing' requirement, which seeks to limit the size of residential facilities for people with a learning disability and/or autism.

The proposed small-scale housing requirement is the focus of many respondents' criticism on the revised guidance. They argue that the requirement would be too prescriptive, incompatible with pressures from commissioning and funding, or beyond CQC's remit. Respondents express concern that the proposed small-scale housing requirement would disrupt existing care provision, to the detriment of providers as well as people with a learning disability and/or autism who need adequate care.

Respondents also raise issues about the clarity and scope of the revised guidance, the impact and feasibility of its aim to ensure people with a learning disability and/or autism will have residential care in a community setting close to their families, the impact of the revised guidance on previously registered services, and how CQC plans to register services that offer supported living.

1.1.5 NHS trusts

The consultation included eight questions on CQC's regulation of NHS trusts. This section discusses comments to each question in turn.

In **question 5** of the consultation questionnaire, CQC asked respondents how it should strengthen its approach to relationship management and its new Insight approach. Regarding the proposed CQC Insight approach, respondents make positive comments about CQC's proposed alignment with NHS Improvement, which they believe will reduce the regulatory burden. Some respondents query how CQC will ensure that the data is accurate and emphasise the importance of transparency. Some respondents who comment on the proposed approach to relationship management and assert that this needs to be approached in a structured and organised way, to a specified schedule and with a clear agenda.

In **question 6** of the consultation questionnaire, CQC asked respondents to state their opinion on the proposed new approach to provider information requests (PIRs) for NHS trusts. Many respondents say they support these changes. Several respondents agree that obtaining data from other sources where possible could succeed in offering a more

'streamlined' approach to requesting information. However, some respondents request that CQC clarifies the detail of the implementation of the PIR approach.

Several respondents comment on CQC's use of available data and some express concern about data accuracy. Respondents stress the importance of information being up-to-date and shared with both providers and inspectors prior to inspection. Some respondents are generally concerned about providers carrying out a self-assessment, raising doubt about the reliability and objectivity of data obtained in this manner.

In **question 7** of the consultation questionnaire, CQC asked respondents to express their view on a proposal that trust inspections include at least one core service and an assessment of the well-led key question on an annual basis. Around half of respondents make positive comments about this proposal, describing the benefits of a more targeted approach and the reduced bureaucracy that would result. Many respondents make specific comments. Some query how the proposed approach would work across different settings and sectors. A smaller number of respondents identify potential issues such as CQC capacity to implement the changes, or the perceived infrequency of inspecting services rated 'outstanding'.

In **question 8** of the consultation questionnaire, CQC invited respondents to comment on its proposal that the majority of inspections of core services would be unannounced. A majority of those who responded to this question mark support for the proposal, stressing the potential to allow an accurate assessment of 'business as usual' and avoid providers giving inspectors false impressions of care quality. Several respondents support the proposal with caveats around its implementation, such as ensuring the appropriate management staff are available to provide information. A smaller number of respondents express opposition to, or scepticism of, the proposals, highlighting potential issues such as increasing staff stress.

In **question 9a** of the consultation questionnaire, CQC asked respondents about its proposed changes to inspecting the maternity and gynaecology core service. Most respondents who addressed this question express support for the proposed changes, arguing that as maternity and gynaecology are distinct specialities, it is appropriate that CQC separates them. In contrast, some respondents identify potential issues with the proposed changes. These include potential duplication in the inspection process or increased burden for providers.

Question 9b similarly asked respondents about CQC's proposed changes to inspecting the outpatients and diagnostic imaging core service. Most respondents who answered this question express support for the proposed changes, arguing that separating the two services makes sense as they are distinct specialities with separate quality assurance processes. A smaller number of respondents highlight potential issues, such as inspectors overlooking the impact of waiting times for digital imaging services on outpatient services, or the quality of patients' journeys through both core services.

In **question 10** of the consultation questionnaire, CQC invited respondents to comment on its proposal to inspect additional services (services that are not inspected routinely) across a range of providers or sectors. A majority of those who responded to this question express

support for the proposal, identifying the potential for increased consistency of standards across services. Several respondents discuss issues or suggestions specific to the proposals, querying for example the size and frequency of additional service inspections. A smaller number of respondents make negative comments, expressing concerns that additional service inspections would not affect overall trust-level ratings, and the potential ambiguity between core and additional services.

In **question 11** of the consultation questionnaire, CQC asked respondents for comments on the use by CQC of accreditation schemes to inform and reduce CQC inspections. While the majority of respondents are supportive of this idea, there are some suggestions for CQC to consider and requests for further detail.

Supportive comments focus on how using accreditation schemes to support CQC's ratings approach could reduce duplication of effort and support transparency, where the approach used by the accreditation scheme is clear.

Some respondents think paying for accreditation schemes would add to providers' costs, given they already pay a fee to CQC. Respondents also query the comparability of data used by CQC and accreditation schemes, as well as the role of accreditation and the extent to which it would 'replace' CQC's role.

In **question 12** of the consultation questionnaire, CQC asked respondents for their comments on the current approach to trust-level ratings, including the new use of resources rating. While some respondents praise the ratings system, saying that ratings are now well-understood and offer important information to the public as well as to providers, others are sceptical of their impact, or express concern that providers and staff might become overly preoccupied with ratings.

Many respondents make specific comments, with several requesting that CQC takes a flexible approach to ratings based on the context of each provider, taking into account provider size or local area needs. Respondents also comment on the timing of ratings and how this affects interpretation, how rating decisions are communicated to inform the public and patients, communicating decisions to providers, methodology including how ratings aggregate more specific metrics, and the role of the use of resources rating.

2. Introduction

2.1 The consultation process

CQC's strategy for 2016 to 2021 was 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.

CQC's consultation asked for views on how it should develop and evolve its approach as it implements its vision and moves into the next phase of its regulatory model.

The consultation ran from 20 December 2016 to 14 February 2017. The consultation document included 14 open consultation questions that invited respondents to comment on proposals for changes to various aspects of CQC's regulatory approach, specifically:

- Principles for regulating new models of care and complex providers;
- Changes to the assessment frameworks;
- Changes to guidance for registering services for people with a learning disability and/or autism;
- Changes to the regulation of NHS trusts.

It also included four closed questions that asked respondents for their agreement or disagreement with specific aspects of the proposals.

CQC used a mix of engagement methods to talk with the public, people who use services and those who represent them, health and social care providers and professionals, other stakeholder organisations and CQC staff. These methods included responses through a webform, email responses, public and provider events and online discussions. CQC also held focus groups to listen to people in communities whose voices are seldom heard, as well as internal meetings and events with staff.

CQC used this summary report alongside the full response data to get a full and detailed picture of all responses. CQC used the information to write its consultation response and make changes to its regulatory approach.

CQC published a second next phase consultation in June 2017 and a third consultation will publish later in 2017/18.

2.1.1 Joint consultation with NHS Improvement

At the same time as its own consultation, CQC consulted jointly with NHS Improvement on its approach to leadership and use of resources in NHS trusts. The NHS Improvement/CQC joint response will be available later in summer 2017.

2.2 Consultation and analysis of feedback

2.2.1 Consultation responses

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

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

The collection of responses was managed by CQC. The analysis of responses, of which this report is the output, was conducted by OPM Group, an independent specialist company formed of OPM and Dialogue by Design. Responses were transferred in weekly batches from CQC to OPM Group via a secure data link. CQC carried out data entry for responses submitted by email. OPM Group imported all response data into its analysis database. Note that chapter 8 summarises comments made at seven events and meetings CQC held with stakeholders before the consultation period commenced. These were not included in the respondent count, but notes from the event were analysed by OPM Group.

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

2.3 Consultation respondents

By the end of the consultation period, 496 responses had been received. A total of 381 respondents had used the webform to participate in the consultation (this included submission of event notes); the additional responses were received by email.

2.3.1 Respondent categories

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

Table 2-1: Count of overall respondents by "responding as"

	Count
Carer of someone who uses health or social care services	22
CQC Expert by Experience	7
CQC staff member	51
Health or social care commissioner	5
Local authority	21
Member of a foundation trust council of governors	1
Member of a local Healthwatch or local Healthwatch staff	14
Member of an overview and scrutiny committee	1

Member of the public/person who uses health or social care services	55
Other	21
Parliamentarian	3
Provider trade body or membership organisation	38
Provider/professional: I work at or am associated with a CQC-registered health or social care service	204
Researcher/student	2
Staff member of an arm's length body or other regulator	15
Voluntary or community sector representative	36
TOTAL	**496**

Table 2-2: Counts for sector and sub-sector if provider/professional as entered by respondents and if specified (respondents could tick more than one sector and more than one sub-sector)

Sector if Provider	Count
3rd Sector Air Ambulance	1
Adult social care	69
Adult social care, Independent healthcare	3
Adult social care, not specified	1
Adult social care, Specialist schools/colleges, Independent healthcare	1
CCG	2
Commissioned project	1
Community services CiC	1
Healthcare	1
Hospice services	6
Independent healthcare	12
Independent healthcare, Adult social care	4
NHS trust	67
NHS trust, Adult social care	1
NHS trust, Hospice services	2
NHS trust, Primary medical services and urgent care	1
NHS trust, Primary medical services and urgent care, Independent healthcare, Adult	1
Primary medical services and urgent care	26
Substance misuse services	1
TOTAL	**201**

Table 2-3: Counts for CQC staff member respondents, by CQC directorate, if specified

	Count
Adult Social Care (including registration, safeguarding and market oversight)	19
Hospitals (including Mental Health)	17
Primary Medical Services and Integrated Care	12
Strategy and Intelligence	2

Customer and Corporate Services	0
Not specified	1
TOTAL	**51**

Table 2-4: Counts for 'Interested in' subcategories for all other respondents (respondents could tick more than one subcategory)

	Count
Acute or general hospital	68
Adult social care	3
All doctors	1
All sectors	83
Ambulance service	27
Care or nursing home	58
Challenging behaviour care services	1
Charity	1
Community health service, including district nurse, health visitor	48
Council	1
Dental service	23
Developing standards	1
Dispensing doctors	1
End of life care	1
GP practice	55
Health and social care system	1
Home care agency, housing with care or supported living	43
Hospice	16
Independent healthcare	2
Information governance in NHS	1
Learning disability service	43
Local Authority	1
Mental health service	38
NHS 111	15
Not specified	4
Out-of-hours service	21
Pharmacy	1
Represent those who voluntary and private sector who provide palliative care to babies	1
Services for people with a disability	1
Substance misuse service	12
Number of services mentioned across all users who ticked at least one	**572**

As is common in public consultations, the number of responses per question varied, as not all respondents chose to respond to all questions. Table 2-5 below provides an overview of the number of responses received to each question.

Table 2-5: Count of respondents by question by "responding as"

	Q1a	Q1b	Q2a	Q2b	Q3a	Q3b	Q4	Q5	Q6	Q7	Q8	Q9a	Q9b	Q10a	Q10b	Q11a	Q11b	Q12	Events
Carer of someone who uses health or social care services	15	15	16	13	11	11	15	10	9	10	13	9	8	13	10	11	10	9	
CQC Expert by Experience	6	7	6	5	6	6	5	6	5	5	6	5	5	6	4	6	5	5	
CQC staff member	40	34	40	28	40	34	31	27	27	27	31	25	21	33	21	33	25	20	
Health or social care commissioner	5	4	5	5	5	3	3	3	2	3	4	3	3	4	3	4	3	2	
Local authority	19	20	19	20	19	19	18	13	11	10	11	9	9	10	9	11	9	10	
Member of a foundation trust council of governors	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
Member of a local Healthwatch or local Healthwatch staff	12	14	12	12	10	7	10	10	10	10	11	8	7	10	8	10	8	8	

	Q1a	Q1b	Q2a	Q2b	Q3a	Q3b	Q4	Q5	Q6	Q7	Q8	Q9a	Q9b	Q10a	Q10b	Q11a	Q11b	Q12	Events
Member of an overview and scrutiny committee		1																	
Member of the public/person who uses health or social care services	45	47	45	35	34	33	38	30	32	33	37	32	34	38	31	37	32	33	
Other	16	18	15	10	13	11	12	10	11	11	10	9	9	11	10	12	11	11	
Parliamentarian		3					1	1		1			1						
Provider trade body or membership organisation	23	33	23	24	24	19	19	18	18	20	15	15	16	17	14	17	17	17	
Provider/professional: I work at or am associated with a CQC-registered health or social care service	173	168	176	151	155	145	136	136	123	124	138	115	114	133	106	134	124	114	
Researcher/student	2	1	1		1			1	1	1				1		1			

	Q1a	Q1b	Q2a	Q2b	Q3a	Q3b	Q4	Q5	Q6	Q7	Q8	Q9a	Q9b	Q10a	Q10b	Q11a	Q11b	Q12	Events
Staff member of an arm's length body or other regulator	6	11	4	5	8	3	3	4	2	3	2	2	3	2	2	3	3	2	
Voluntary or community sector representative	18	31	18	18	21	16	17	10	11	11	13	10	11	12	11	11	9	11	
Events																			7
Grand Total	**381**	**408**[1]	**381**	**327**	**348**	**308**	**309**	**280**	**263**	**270**	**292**	**243**	**242**	**291**	**230**	**293**	**257**	**242**	**7**

Please refer to Appendix 3 for Tables A-8-1 to A-8-4 for breakdowns of questions 1a, 2a, 10a and 11a by respondent category.

[1] This count includes responses received by email: See Section 3.2

Table 2-6: Counts by individual question[2] for sector if provider/professional (respondents could tick more than one sector)

Question	Adult social care	Hospice services	Independent healthcare	NHS trust	Other	Primary medical services and urgent care
Q1b.	56	6	17	62	7	19
Q2b.	48	5	16	59	6	16
Q3a.	52	5	14	61	7	15
Q3b.	46	5	15	56	7	15
Q4.	47	2	15	51	6	14
Q5.	35	3	12	63	7	15
Q6.	30	3	13	63	6	8
Q7.	31	3	13	61	7	9
Q8.	35	3	13	63	7	17
Q9a.	29	2	12	57	6	9
Q9b.	29	2	13	56	5	9
Q10b	24	3	9	52	5	12
Q11b	31	3	12	59	5	13
Q12.	25	3	9	60	7	10

2.4 This report

2.4.1 Structure

The structure of this summary report follows the order of sections in the consultation document, *Our next phase of regulation: a more targeted, responsive and collaborative approach*. In each chapter of this report, the comments are further broken down into sub-sections covering 'supportive comments' and 'issues and suggestions'. The chapters are:

3. New models of care and complex providers

4. Assessment framework

5. Registering the right support: CQC's policy on registration and variations to registration for providers supporting people with a learning disability and/or autism

6.1 NHS trusts: CQC Insight and Provider Information Requests (PIRs)

6.2 NHS trusts: Inspections

[2] Note that this table includes providers who may include more than one of these services, in which case they would be counted more than once. CQC's online questionnaire did not ask respondents to categorise themselves along these lines. Therefore, this table is an indicative only in terms of respondent breakdown by these categories.

6.3 NHS trusts: Rating

6.4 Comments on CQC's proposals for regulating NHS trusts from independent healthcare providers and professionals.

Further chapters are included covering responses on the pre-consultation events (chapter 7) and comments that were not specific to any of the vision themes (chapter 8).

The report has four appendices:

- Appendix 1: Consultation questionnaire;
- Appendix 2: Coding framework used to analyse the responses;
- Appendix 3: Breakdown of responses to closed questions by respondent category;
- Appendix 4: List of organisations responding to the consultation as entered by respondents.

2.4.2 Guide to the narrative

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

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

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

Where a specific theme or point was raised by a relatively large number of respondents, the report uses the phrase 'many respondents'. Where themes are analysed and divided out into sub-themes, phrases such as 'some' or 'a few respondents' – 'a few' would signify much fewer respondents than 'some' – are used instead of smaller numbers. Because of the qualitative nature of the data and variations in respondents' use of the consultation questionnaire, any numbers relating to the open questions are indicative. The focus of the analysis is on issues raised by respondents, and opinions are often shared across respondent categories. However, where appropriate the report specifies where views were expressed by a specific category of respondents or sector.

It is common in consultations that respondents provide greater detail or variety in critical comments than they do in supportive comments. Readers should therefore note that the

relative length of sections (i.e. supportive comments compared to issues and suggestions) is not necessarily a reflection of the balance of opinion.

Sections summarising consultation responses refer to those who expressed their views as 'respondents'; sections summarising feedback from events refer to those who expressed their views as 'attendees or stakeholders'.

The sections covering comments made in responses to consultation questions include quotations from responses from individuals or from organisations to illustrate issues raised by respondents. Most quotes are on behalf of an organisation unless otherwise stated. The quotations should not be interpreted as an indication that the view has greater significance than others. Nor should quotations be interpreted as representative of the views of other respondents of the same type.

Throughout the sections covering comments made in consultation events, the narrative uses the word 'attendees' or 'stakeholders' in a non-specific manner. It is not intended to suggest that there was broad consensus on any of the views summarised in the report. The events were not designed to seek consensus, but rather as an opportunity to gain insight in the range of views and opinions that are held by those with an interest in CQC's work. The notes from the events were not specific about who said what and whether others agreed and neither is this report. Some of the views summarised below may indeed have been the opinion of a single participant.

It is important to note that, throughout the document, there is no specific 'weight' given to any respondents over others, for example, based on size. This report summarises comments based on individual responses, and themes are generally prioritised by the frequency with which they were discussed across individual responses.

Within chapter 6 on NHS trusts, the summaries of comments focus primarily on NHS trust provider/professional respondents, as the corresponding proposals are directed at them.

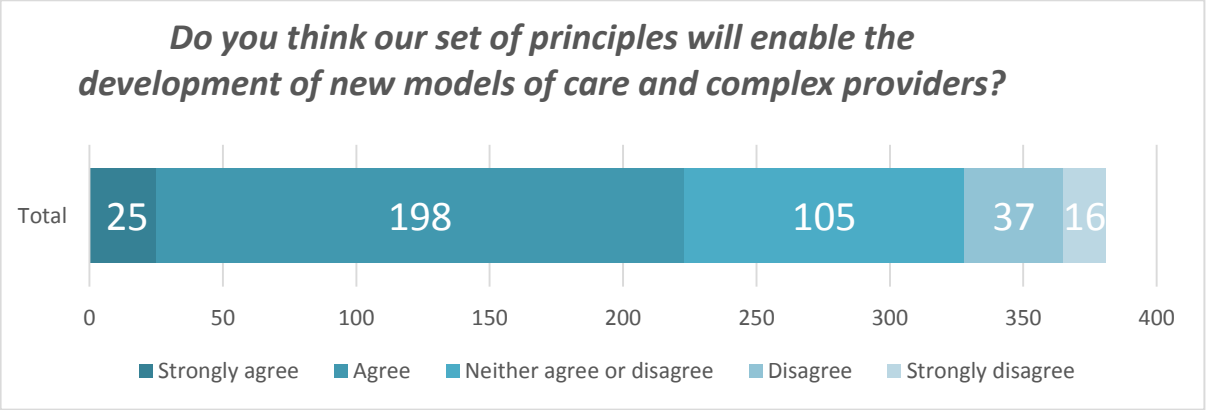
3. New models of care and complex providers

3.1 Responses to question 1a

Of the 496 responses, 381[3] are in response to question 1a, which states: ***Do you think our set of principles will enable the development of new models of care and complex providers?*** This was a closed question and respondents could choose from five options between strongly agree and strongly disagree.

[3] See breakdown: Table 2-5: Count of respondents by question by "responding as"

Figure 1 - Responses to question 1a



The majority[4] (223) of responses to this question agree or strongly agree that CQC's set of principles will enable the development of new models of care and complex providers. 53 responses indicate that they disagree or strongly disagree with this question.

3.2 Responses to question 1b

Of the 496 responses, 408[5] were in response to question 1b, which states*:* ***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 figure of 408 above includes 326 responses to question 1b on the consultation questionnaire, as well as 82 responses that did not use the consultation questions (e.g. submissions via email). These 82 responses were analysed alongside responses to question 1b, which accounts for their inclusion in the response count here. Comments from these responses are considered in the relevant sections of this report; not necessarily in the section on question 1b. However, 'overall sentiments' from these 82 responses have only been recorded in relation to question 1b.

3.2.1 Overall sentiment

Analysts categorised respondents' comments to question 1b for the overall sentiment they appeared to convey about CQC's set of principles.

Of the 408 responses to question 1b (including 326 responses to the consultation question and 82 responses that do not specify which question they address – see above), 314 express an overall sentiment. Analysts identified these sentiments as follows:

[4] See breakdown: Table A-0-1: Responses to Q1a by overall respondent category

[5] See breakdown: Table 2-5: Count of respondents by question by "responding as"

- 137 responses were identified as conveying a positive overall sentiment. These responses state general support for CQC's set of principles aimed at enabling new models of care, or make positive comments about one or more of the individual principles;
- 85 responses were identified as conveying a sentiment of 'constructive criticism', meaning they discuss issues or suggestions specific to the principles, such as hesitation about their effect or implementation;
- 34 responses were identified as conveying a neutral overall sentiment;
- 24 responses were identified as conveying a sceptical overall sentiment, expressing doubt about the feasibility or the impact of CQC's principles for regulating new models of care;
- 34 responses were identified as conveying a negative overall sentiment. These responses often focus on potential complications that would hinder the ambitions stated in the principles.

A total of 94 responses were identified as expressing no overall sentiment. This includes responses that state 'no comment' as well as responses to question 1b focusing on topics other than CQC's set of principles.

3.2.2 Supportive comments

General support

Many respondents, from varied backgrounds but including a large proportion of providers and professionals, express general support for the set of nine principles that CQC proposes to use to guide its approach to regulating in a changing landscape of care provision. Respondents comment that they think the principles are clear, detailed, useful, and an improvement on previous guidance. Some praise the set of principles for its potential longevity. A few respondents are pleased that the principles seem to take into account feedback CQC has received previously, such as on not penalising providers that have taken over, or merged with, other providers.

Many respondents believe that the principles would enable or support, or at least not hinder, the development of new models of care. This sentiment seems to be based on their view that the principles are now more targeted to the realities of provision. Respondents generally agree with the perceived focus on person-centred care in the principles, as well as the way in which the principles consider the care sector's diversity and complexity.

"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."

User 251 (Provider/professional, adult social care)

Various respondents emphasise the importance of appropriately regulating new models of care, highlighting the rapid pace of change in health and social care. Respondents agree that CQC needs to have an efficient approach in place to respond to these changes, and express support for CQC's ambition to achieve this.

Support for individual principles

Each of the nine principles receives a degree of support in respondents' comments. There is outspoken support for a few of them, and this section focuses on the principles that many respondents singled out for praise.

Several respondents make supportive comments about **principle 2**, which states: *We will hold to account those responsible for the quality and safety of care*. Respondents welcome the added emphasis on accountability, and some specify that effective leadership is crucial in safeguarding quality in complex organisations.

CQC's pledge to proportionality, expressed in **principle 3**, which states: *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*.), is popular among respondents. Many express general agreement with the principle; some particularly welcome the consideration of organisations' track records in CQC's decisions about when and how to inspect.

Many respondents comment on **principle 4**, which states: *We will align our inspection process, where possible, to minimise complexity for providers that deliver more than one type of service*. Respondents welcome CQC's commitment to aligning its inspection process, sometimes specifying that alignment with NHS Improvement and NHS England should be the highest priority. Most feel that health assessment and social care assessment should be kept separate. Respondents emphasise the importance of reducing complexity, supporting the reduction of the number of assessment frameworks to two. They note the potential benefits for providers that deliver more than one type or service, or services at multiple locations.

Several respondents single out **principle 6**, which states: *We will not penalise providers that have taken over poor services because they want to improve them*. Respondents highlight that this is crucial if CQC wishes to encourage successful providers to take charge of poorly performing services previously delivered by others. They believe this principle, and its embedding in regulation, would assist providers to take on additional services and improve these, which they might have been reluctant to do otherwise.

Many comments emphasise the importance of service user engagement and involvement, partly in terms of making CQC reports and ratings meaningful, which reflects the role of **principle 8**. This states: *We will rate and report in a way that is meaningful to the public, people using services and providers.* Some comments specifically on question 1b suggest that more work could be done to show that sufficient user involvement is taking place. Comments across all of the consultation questions frequently cite meaningfulness to service users when making decisions as a core role of CQC ratings and information.

Some respondents express particular support for **principle 9**, which states: *We will bring together inspectors who have specialist knowledge of different sectors to inspect jointly, where this is most appropriate for the provider*. Respondents emphasise that they appreciate the flexibility of approach implied in the principle, and highlight its potential to improve the regulation of new models of care, or integration of health and social care services more generally.

"In addition, the aim of minimising complexity of the inspection process for providers delivering more than one type of service (i.e. acute services as well as community, mental health or primary care services) is welcome, given the increasingly diverse range of organisational structures and models that are developing in the NHS."

User 341 (Provider trade body or membership organisation)

A few respondents specifically welcome the inclusion of promoting (alongside protecting) health and well-being in **principle 1.**

Other positive comments

Many respondents think the principles would benefit providers, mostly through simplifying the regulatory process and removing duplication where this currently exists. There are various comments hailing an anticipated reduction in the burden for providers, which respondents think will follow from greater clarity, alignment and flexibility. Some respondents are hopeful, but not yet persuaded, that the principles will help tackle bureaucracy. To these respondents, seeing improved efficiency in practice would be an important measure of success for CQC's new set of principles. A few respondents suggest that greater alignment and efficiency would also benefit CQC's own resources.

Respondents also support the inclusion of flexibility in the principles, emphasising its importance in a rapidly changing context. They see flexibility as a prerequisite for making fair and appropriate assessments of new models of care, as well as for appreciating differences between providers and/or services that are linked to the context rather than the quality of care provision.

"Flexibility is fundamental in the regulation of healthcare, given the nature of how health services evolve. This is especially relevant to independent healthcare where services evolve rapidly in response to patient needs."

User 473 (Provider trade body or membership organisation)

Respondents make a variety of positive comments about CQC's proposals for registration, the CQC assessment framework, inspection, and rating, closely related to CQC's proposed set of principles. These themes relate to other consultation questions, and this report summarises relevant comments – including support for the reduction of the number of handbooks and for a targeted and tailored approach to inspections – – in later, corresponding sections.

3.2.3 Issues and suggestions

Many respondents commenting on CQC's set of principles feel that their success will depend on how CQC implements them. Some respondents add that the principles would need to be reviewed as new models of care evolve.

"The principles are statements of intent. It is how they are put into practice that will impact on developing new models of care."

User 173 (Provider/professional, adult social care)

Clarity and detail

Where respondents express criticism of the principles, many feel that more detail is needed on the elements that influence new models of care, such as financial factors, healthcare politics or commissioning decisions. In some contrast, other respondents state that flexibility in the principles will be important as new models of care develop.

Some respondents who are concerned about the clarity of the principles say that they need to demonstrate in greater detail that CQC understands complex providers, and clarify how the updated assessment framework would address cross-sector working and problems such as patients having a poor experience when being transferred between services.

Respondents suggest that CQC should also clarify how intermediate care services would be addressed by the assessment framework, and how different ratings between levels of service would be aggregated. One respondent highlights the increasing expectation on providers to work across boundaries. A few respondents advise CQC to consider contextual factors such as local demographics in applying its principles.

Some respondents caution against an oversimplification of the assessment framework, stressing the importance of developing a robust approach balanced against reducing the burden on providers.

"I can understand why simplifying assessment processes is attractive. However the complexity of different services requires skilful interpretation of measures by assessors."

User 59 (Carer)

Accountability

Several respondents comment on principle 2 which focuses on holding those responsible for providing care accountable for the quality delivered. Some feel that it is not clear how CQC aims to execute this – for example, where services are provided across several organisations, it is not always clear who is to be held accountable for the quality of care provided. Other respondents comment that while it is important to hold those in charge to account, it is also important that services are accountable to the public and other stakeholders such as Healthwatch. These respondents suggest that there needs to be more

information sharing with the public through more meaningful inspection reports. Some respondents comment that commissioning bodies are also responsible for quality of care within services, and CQC should further recognise their role.

"We believe that where services are provided across a number of organisations there should be clarity on who is ultimately responsible for the quality of 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."

User 340 (Member of a local Healthwatch)

Some respondents feel uncertain around how CQC will evolve its inspection methods to fit the development of new models of care, and be able to assess integrated models appropriately and fairly, and so more clarity on this is requested. Some respondents are unsure of how principle 4 (alignment of inspection process) will be implemented given that health care and adult social care will be assessed against different frameworks. Some respondents are concerned that principle 3 (proportionality based on track record) may be flawed, arguing that track record can be a poor indicator of current performance, for example when key staff change.

Other respondents are concerned that principle 6 (not penalising those who take over poor services) could be used as a loophole for more persistent poor quality care and that there needs to be an agreed timeframe for improvements.

CQC impact on new models of care

Many respondents are sceptical about the extent to which CQC can influence the development of new models of care via these principles. Most feel that developments will be led by providers, and suggest that CQC's impact will be limited to assessing whether changes adhere to safety and policy standards. They question whether the principles will actually enable the new models, rather than simply regulating them.

Other respondents comment on the development of new models of care in general. Some are sceptical, for example, about whether the NHS has the right skills to deliver significant change; others feel that the influence lies with commissioners who specify new service models.

Inspectors

Many respondents comment that bringing together specialised inspectors to inspect together will be a welcome improvement. A few respondents cautioned that increased demands are seemingly being placed on each inspector based on a shorter time frame, and wanted reassurance that inspection quality would be maintained and sufficient staff provided. Some respondents comment that the inspectors need to work with Experts by Experience for a consistent approach. Some query how principle 9 will be implemented, with some asking whether specialist knowledge from outside CQC could be used.

Feedback and transparency

Some respondents are concerned that the emphasis on integrated models of care and complex providers could make it more complicated for service users to make complaints and argue that this needs to be seriously considered. While transparency for the public in terms of regulatory decisions and reporting (principles 5 and 8) is generally lauded, some respondents express concern that if it is too simplified this could disadvantage larger providers who deliver a complex range of services and are therefore more likely to have some poor ratings.

Some respondents request that principle 8 also includes a clear definition about what constitutes excellence in ratings of new care models. Some respondents call for further transparency for the public on what is meant by 'new models of care'. Many respondents comment that reported ratings may be out of date as inspections occur on average every three years. Some say that CQC should further clarify what ratings signify, or that CQC should be clearer about how well ratings reflect current practice.

Contradictions between principles

Some respondents feel that a few of the principles contradict each other. Some respondents comment that principle 2 (accountability) and principle 6 (not penalising those who take over poor services) will be difficult to realise simultaneously. They argue that if an organisation takes over a poorly-rated provider it is unclear who would be held accountable for the outcomes.

Burden on providers

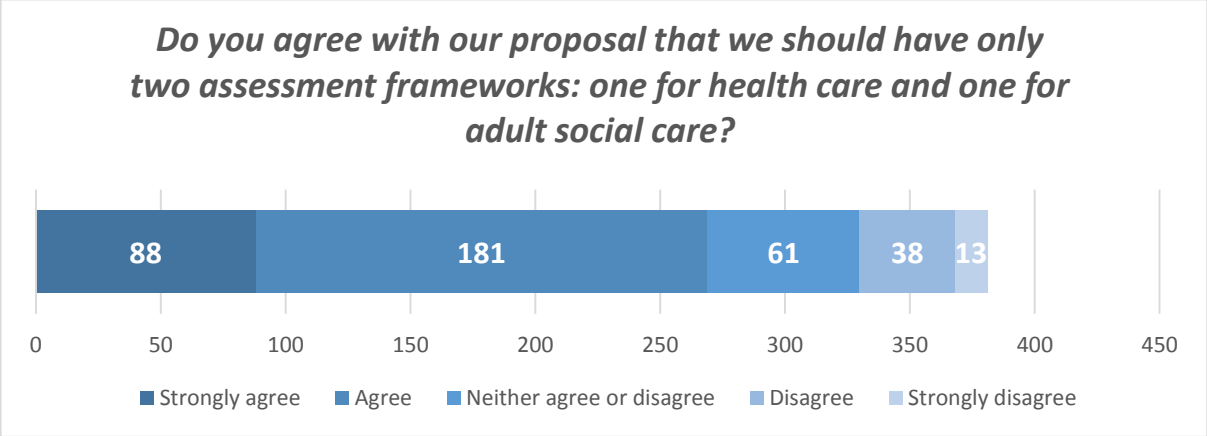
Respondents from across a number of respondent types raise the issue of burden on providers in relation to facilitating the delivery of new models of care. Most respondents welcome CQC's proposals for potentially reducing the burden on providers, for example through streamlined information requests. Some respondents think that CQC could further reduce the burden by timely information requests, or by improving its guidance on online data collection. Some respondents are concerned that the proposed changes would add to the burden for providers, for example if providers need to accommodate additional inspections, or as a result of new CQC guidance. Some respondents emphasise that providers often experience reporting requirements from local authorities too, and ask that CQC takes that into account.

4. Assessment framework

4.1 Responses to question 2a

Of the 496 responses to the consultation, 381[6] are in response to question 2a, which states: ***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)?***

Figure 2 - Responses to question 2a



The overwhelming majority of responses[7] (269) to this question either agree or strongly agree that CQC should have only two assessment frameworks. A total of 51 responses indicate that they disagree or strongly disagree. A further 61 respondents neither agree nor disagree with the proposal.

4.2 Responses to question 2b

Of the 496 responses to the consultation, 327[8] are in response to question 2b, which states: ***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.***

[6] See breakdown: Table 2-5: Count of respondents by question by "responding as"

[7] See breakdown: Table A-0-2: Responses to Q2a by overall respondent category

[8] See breakdown: Table 2-5: Count of respondents by question by "responding as"

4.2.1 Overall sentiment

Analysts categorised respondents' comments to question 2b for the overall sentiment they appeared to convey about CQC's proposal to have only two assessment frameworks.

Of the 327 responses to this question, 296 express an overall sentiment. Analysts identified these sentiments as follows:

- 157 responses were identified as conveying a positive overall sentiment. These responses state agreement with CQC's proposal to use two assessment frameworks, praising the clarity and potential reduction of administrative burden;
- 84 responses were identified as conveying a sentiment of 'constructive criticism', meaning they discuss issues or suggestions specific to the proposal, stressing for example that the two frameworks should consider the complexity and variety of providers;
- 12 responses were identified as conveying a neutral overall sentiment;
- 17 responses were identified as conveying a sceptical overall sentiment, questioning the merit of the proposal without fully dismissing it. These respondents express concern about services which may span or fall between the two frameworks, or query how CQC specialist expertise would be used;
- 26 responses were identified as conveying a negative overall sentiment. Several of these responses argue that using only two frameworks would not be appropriate for the wide variety of care services.

A total of 93 responses were identified as expressing no overall sentiment. This includes responses that state 'no comment' as well as responses to question 2b focusing on topics other than CQC's proposal to have only two assessment frameworks.

4.2.2 Supportive comments

Transparency, clarity and consistency

Many respondents believe that reducing the number of assessment frameworks from 11 to two will improve the inspections' transparency and clarity. They explain how only having two assessment frameworks would make the process less confusing for both the assessors and the assessed. For providers, respondents argue that with more streamlined frameworks, they will be better placed to understand how they will be assessed. Some respondents argue that because of this simplification and clarity, service quality will improve.

Respondents also believe the two new frameworks could make comparison between different providers and services easier primarily for complex providers that deliver a wide variety of different services. In relation to this, many respondents comment that using two assessment frameworks could improve the continuity and consistency of the inspections. They comment that by consolidating the current 11 frameworks into two, the process would be less fragmented and simplify CQC assessment of providers' overall service quality.

Respondents also comment that this could allow the public to better understand the assessment processes that lead to the ratings.

"This also helps larger and more complex organisations that provide a range of services to be clear what standards need to be met, rather than needing to refer to different handbooks to understand the requirements."

User 451 (Provider/professional, NHS trust)

A few respondents, primarily representing hospice services and the voluntary sector, support the inclusion of hospices within the health care assessment framework. Comments discuss the importance of equipping CQC inspectors for considering this new area, ensuring that the vital non-medical aspects of care such as patient and family experience are strongly considered as well as clinical aspects, and that the move of children's hospice services from the adult social care to health care assessment framework is welcome. Voluntary sector and hospice service respondents hope to work closely with CQC in developing this approach.

Reduced bureaucracy

Some respondents comment that reducing the number of assessment frameworks would reduce the burden and bureaucracy on providers. They highlight the smaller number of documents and the potential reduction in preparation time before inspections.

In addition to aiding providers, some respondents believe that the reduced bureaucracy would also benefit CQC inspectors by dealing with fewer documents.

A small number of respondents are concerned about increased burden, for example that there will be potentially a high cost and additional bureaucracy involved with complying with new frameworks having been familiar with the current ones.

4.2.3 Issues and suggestions

Complexity and flexibility

Many respondents express the concern that using only two assessment frameworks may not appropriately reflect the complexity and variety of health and social care. They believe that a potential 'one size fits all' approach may reduce the focus that the existing frameworks facilitate. Respondents believe that it could be problematic to combine services with very different working cultures and ethos. For example, there is an observation that some service types are staffed by highly qualified practitioners while others use workers who are mostly on the national minimum wage. Similarly, respondents highlight the potential issues of using the same approach for small standalone providers and complex, often geographically-dispersed organisations; they argue that frameworks that are sufficiently detailed to assess large providers may be too detailed and bureaucratic for smaller providers.

"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."

User 295 (Local authority)

Some respondents state that the reduction to two frameworks would only work if these include more detail – for example, detailed KLOEs, exhaustive criteria or appendices - to help providers to see how these would work for the variety of different services.

Respondents stress the importance of flexibility between different types of services as well as picking up on the individual nuances that differentiate these services. For example, some respondents believe that settings such as homecare and care homes are too different to be consolidated into a single framework. Respondents express concerns that inspectors may appropriately be trained for care homes, but not for homecare. Many providers emphasise the need for inspectors to keep their expertise in their sector. Regarding mental health services, there is a concern that they would be inappropriately assessed in the same way as services dealing with physical health.

Some respondents are concerned that if the new frameworks are designed to assess large, multi-speciality providers, then they may not be well understood in terms of how they apply to small or single-speciality providers. In relation to this, a few respondents comment that they would prefer the frameworks to be retained in their current setup. Some providers, trade bodies and membership organisations comment that they value CQC inspectors' specialist knowledge of sectors, and worry that this could be lost in the reduction of the frameworks.

Alignment between health and social care frameworks

Other respondents highlight potential issues with services that spread across or fall between health care and adult social care. These include substance misuse, hospice and dementia services, as well as children's palliative care, though it is welcome that the latter will now be assessed under the health care framework. Respondents often comment that these conditions are too complex to be confined to health care or adult social care as there is transition between the two depending on the severity of the conditions. On these issues, respondents request clarity on where the dividing lines are between health and social care for the benefit of the public, those who use care and providers.

A few respondents go further to suggest that the two frameworks should be merged into one. They argue that this would benefit care coordination, improve service quality and avoid the ambiguity of which framework services come under.

Respondents also comment that, compared to the staff delivering services, management does not vary between the health care and adult social care. A few respondents make an alternative suggestion, a third framework for use by providers that offer health care and social care in addition to the two proposed frameworks.

4.3 Responses to question 3a and 3b

This section summarises responses to questions 3a and 3b. Of the 496 responses, 348[9] were in response to question 3a, which states: ***What do you think about our proposed changes to the key lines of enquiry, prompts and ratings characteristics?***

There were 308[10] responses to question 3b, which states: ***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)?***

Except for sub-section on overall sentiment, the report makes no distinction between responses to question 3a and responses to question 3b and so comments on each are reported together. This makes it easier for readers to see comments about the proposed changes and comments about their perceived impacts together.

4.3.1 Overall sentiment

Analysts categorised respondents' comments for the overall sentiment they appeared to convey in response to each question. The findings on overall sentiments in responses to questions 3a and 3b are discussed in turn, below.

Overall sentiment on the proposed changes to the key lines of enquiry, prompts and ratings characteristics

Of the 348 responses to question 3a, 325 express an overall sentiment on the proposed changes to the key lines of enquiry (KLOEs), prompts and ratings characteristics. Analysts identified these sentiments as follows:

- 171 responses were identified as conveying a positive overall sentiment. These responses state agreement with CQC's proposed changes to the KLOEs, prompts and ratings characteristics, praising the improved clarity and transparency;
- 115 responses were identified as conveying a sentiment of 'constructive criticism', meaning they discuss issues or suggestions specific to the proposed changes. These include comments about the placement of the Mental Capacity Act and consent, calls for additional prompts, or requests for clarification on certain prompts, for example those pertaining to end-of-life care;
- Five responses were identified as conveying a neutral overall sentiment;

[9] See breakdown: Table 2-5: Count of respondents by question by "responding as"

[10] See breakdown: Table 2-5: Count of respondents by question by "responding as"

- 13 responses were identified as conveying a sceptical overall sentiment, questioning the merit of the proposal without fully dismissing it;
- 21 responses were identified as conveying a negative overall sentiment, including responses arguing against changing the KLOEs.

A total of 23 responses were identified as expressing no overall sentiment. This includes responses that state 'no comment' as well as responses to question 3a focusing on topics other than CQC's proposed changes to the KLOEs.

Overall sentiment on the impact the changes will have

Of the 308 responses to question 3b, 242 express an overall sentiment on the impact the changes will have. Analysts identified these sentiments as follows:

- 105 responses were identified as conveying a positive overall sentiment, often stating that they expect a positive impact from the changes;
- 27 responses were identified as conveying a sentiment of 'constructive criticism', meaning they discuss issues or suggestions specific to the principles, for example how the proposed changes will take providers' context into account and how they will affect overall provider ratings;
- 61 responses were identified as conveying a neutral overall sentiment, including many responses arguing that the proposed changes would have no discernible impact;
- 25 responses were identified as conveying a sceptical overall sentiment, questioning whether the proposed changes could achieve the impact CQC aims for;
- 24 responses were identified as conveying a negative overall sentiment.

A total of 66 responses were identified as expressing no overall sentiment. This includes responses that state 'no comment' as well as responses to question 3b focusing on topics other than the impact of the proposed changes to KLOEs, prompts and ratings characteristics.

4.3.2 Supportive comments

Many comments to questions 3a and 3b express support for the proposed changes to the key lines of enquiries (KLOEs), prompts and ratings characteristics. Many respondents state they are pleased that the five key questions remain as the basis of the assessment frameworks.

Some go into detail, stating that the proposed changes make the KLOEs more relevant, bringing them in line with general changes and developments in care. Respondents also welcome the improved transparency that they associate with the proposed changes, which they say will bring regulation in line with public expectations.

Many agree that the new assessment frameworks are clearer and simpler than the previous ones, and further clarify what CQC inspectors will focus on during inspection. Some state that this would clarify the approach to determining ratings, allow for more consistency in inspections and improve ease of comparison between providers. Respondents express specific support for the proposed more structured approach in the characteristics of ratings for adult social care services.

Some respondents agree that the changes would encourage greater accuracy and accountability from providers. Some say that the proposed changes to the KLOEs could improve the health and wellbeing of patients and carers by allowing providers to focus on patients' needs as a whole rather than just the illnesses for which they are receiving care.

Comments on the movement and addition of KLOEs

There is broad agreement from respondents that the proposed changes and additions to the KLOES could help improve the quality of care, for instance through encouraging a person-centred approach. Some respondents specify that the more personalised approach to care as set out in the proposed assessment framework would allow flexibility to consider a user's specific and changing circumstances and needs. Some respondents welcome the movement of 'end-of-life' care to the responsive key question.

Many respondents comment that the introduction of new questions regarding information governance and data assurance in the framework is useful and places clearer accountability on providers. Some respondents add that the increased emphasis on information sharing could encourage consistency of quality across services and encourage adoption of best practices. Many respondents agree that the increased focus on leadership, through additional KLOEs under the well-led key question, would strengthen provider governance and accountability, and ultimately the quality of care. Some respondents expect that the proposed additions to the well-led section could help identify where leadership requires additional support, where responsibilities need to be clarified and where there exists a high quality of leadership. Some respondents say that in their opinion the additional prompts under the well-led theme reflect an understanding of the importance of good leadership in delivering care. Some respondents welcome the development of the well-led KLOE in alignment with NHS Improvement and believe that this will reduce duplication of work.

Several respondents specify that the addition of a KLOE regarding social action and the active recruitment, training and support of volunteers is a positive inclusion as this better acknowledges the importance of volunteers.

Some respondents welcome a more detailed KLOE focusing on medicines management, especially as they see this as a crucial area of safety and quality in healthcare.

"The addition of prompts for all providers about encouraging healthier lifestyles is positive, as this has sometimes been seen in the NHS as an issue for primary care and public health only. Additional prompts regarding use of technology are

welcome, as there are wide differences between how different trusts make use of new technologies, especially with regard to information systems."

User 253 (Provider/professional, NHS trust)

Clarity of new assessment framework

Several respondents support the added clarity for 'good' and 'outstanding' rating and suggest that this would support self-assessment and quality assurance. However, many respondents state that CQC has not made the distinction between 'good' and 'outstanding' clear enough. A few make suggestions, such as splitting 'good' into two levels or clarifying what would prompt CQC to close a service.

They also say that the increased transparency of the framework might improve public understanding of ratings and perceptions of providers to be safe, effective and well-led.

"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"

User 497 (Provider/professional, NHS trust)

4.3.3 Issues and suggestions

While many respondents support the proposed changes to KLOEs, some disagree or have reservations. Commenting on the proposed changes generally, various respondents argue that they are unnecessary, stating for instance that the current KLOEs work well, or well enough.

Impact of the proposed changes

As highlighted in section 4.3.1, many respondents expect the impact of the proposed changes to the KLOEs to be positive, while a smaller number think the impact will be negative. Several respondents observe that from their point of view, there would be no discernible impact from the proposed changes.

Consistency of regulatory approach

Many respondents express concern that the proposed changes represent a break with current practice and as such, will affect CQC's ability to effectively assess the quality of care. According to respondents, the changes would make it more difficult to obtain comparable data on providers, which in turn would hinder benchmarking as well as measuring providers' progress over time.

Effectiveness and relevance of KLOEs

Some respondents are generally sceptical about the KLOEs and think that proposals to change these represent an unhelpful distraction from delivering and improving care. Several respondents worry that the changes would result in confusion among providers, and some think they may undermine relationships between CQC and providers.

Others signal that in their view the significance of the KLOEs entirely depends on how thoroughly CQC inspects providers, offering suggestions as to what CQC should focus on when inspecting providers.

"I think you are getting too tied up with minor nuances to the process when you are too concerned about which category a KLOE should be allocated."

User 298 (Provider/professional, adult social care)

Several respondents complain that the proposed new set of KLOEs and prompts includes elements that would not be applicable to certain providers or services. Some respondents are especially concerned about this given the description of the KLOEs as 'mandatory'. They ask CQC to clarify this and to clearly brief inspectors which KLOE prompts apply to which services. Examples of provider types that respondents believe would be faced with non-applicable enquiry lines are GPs, independent sector providers, services for people with a learning disability and/or autism, and substance misuse services.

Suggested additions to or further clarification on KLOEs

Many respondents comment on the clarity of KLOEs. These are often detailed comments about a particular prompt or theme, including system leadership, population level planning, and innovation. Given the variety and specific nature of these comments, this report cannot cover each and every suggestion. The analysed comments on individual (changes to) KLOEs have been made available to CQC for detailed review.

Several respondents make generic comments about the clarity of KLOEs, arguing for example that their current wording makes many KLOEs open to interpretation, which could undermine the consistency of their application. Respondents also argue that some terminology used in the proposed new KLOEs is inconsistent with CQC guidance or reports. A few respondents ask CQC to improve the consistency between the healthcare and adult social care annexes, both in terms of content and in terms of structure.

Regarding the ratings characteristics, some respondents suggest that more clarity on what 'outstanding' looks like would motivate providers and assist CQC inspectors in making robust, consistent judgements.

Many respondents make suggestions for the inclusion of additional prompts that they believe to be important. Some call for the addition of a measurement to understand how effectively complaints are being handled to emphasise the person-centred approach. Many respondents mention that there should be more focus within the 'caring' KLOE on patients

and their families and carers within the assessment, as they express that it is not clear to what degree they will be included in the investigations. Many respondents comment that there needs to be an increased emphasis on the perception of care (not only the delivery). They suggest that there should be more focus on the views of service users, families and carers throughout inspection.

While respondents are pleased that there is an increased focus on medicines administration within the assessment frameworks, some suggest that there are elements missing. These include issues surrounding the administration of medication once a patient has been discharged. Some respondents comment that 'medicine administration/management' should be included not only in the 'safe' KLOE, but also in the 'effective' KLOE, as a 'treatment' often included medication.

Some respondents request clarification of the definition of 'end-of-life' as this seems to vary depending on the provider. Some suggest that while the added emphasis on 'end-of-life care' is welcome, there is a risk that long gaps between inspections could have direct effects on the patients in this category if there are unnoticed long-term issues. One respondent suggests that with the increased emphasis on end-of-life care within the assessment framework, references to 'care' could be changed to 'care and support' to better reflect this approach to supporting people. Several participants would welcome additional emphasis on end-of-life planning rather than only on end-of-life care within the assessment.

Some respondents comment that there is not adequate focus on whether training for staff is being effectively directed, this can have a huge impact on the delivery of services for patients (for example dementia services and administering of medicines), as well as the adoption and effective use of new processes and technologies. Some request that a greater emphasis and detail on staff training be included within the new assessment frameworks.

"Where reference is made to specific training being required it will be important to clarify i) the type and level of training expected, ii) the learning outcomes that must be covered, iii) the frequency of refresher training required."

User 250 (Other, improvement agency)

Burden on providers

In opposition to comments in the supportive comments sub-section of this chapter, some respondents argue that the proposed changes to the KLOEs may give providers additional work. As mentioned above, some are concerned that providers would need to spend time and resource on amending their quality systems to mirror the new KLOE framework. Others are critical of the number of enquiry lines, stating that the changes result in more KLOEs, while they would have hoped to see fewer. Some respondents add that the changed KLOEs include duplication across themes and request that CQC merges some of its KLOEs to control the volume of the documents. A few of the comments about KLOE duplication appear to be specific to the health care framework and a few to the adult social care framework.

"The number of prompts and KLOEs has increased to cover more situations, but as previously stated, this increase in detail, number and range of areas to provide evidence of meeting will add to the regulatory burden on providers at a time when they are being squeezed from all angles, and the danger is that more will leave the market and the negative consequences of this."

User 255 (Provider/professional, adult social care)

A few respondents express concern that the proposed changes would disproportionately impact on smaller providers, or single service providers, who would be faced with a large number of non-applicable prompts to respond to**.**

Implementation

A few respondents express concern that certain KLOEs make demands of providers that currently fall outside the scope of regulation. Respondents are keen to highlight the differences between care homes and home care. They feel that the KLOEs are trying to pressure providers of care to people living in their own homes into providing facilities and services required of care homes, which falls well outside of their remit. Many respondents also take issue with the assessment framework taking into account associated services and resources that providers have no control over. Respondents say that in effect occupancy and staffing as well as funding are not controllable by the provider, so they do not think a provider should be held to account against certain standards for these in the KLOEs and ratings characteristics.

Several respondents comment on the new emphasis on collaborations with external partners, saying that they can only attempt to collaborate with external partners (who may be unwilling) and cannot control whether this occurs. Some respondents express concern that the proposed timelines for implementing the changed KLOEs is not realistic. As a consequence, respondents request the publication of CQCs documentation as rapidly as possible to give them time to prepare.

Echoing responses to question 2b, reported in section 4.2.3 above, several respondents to question 3 also ask CQC to regularly monitor and review the proposed changes to the assessment frameworks and their impacts. After the review, they suggest to adapt the frameworks if necessary to ensure a positive impact and that the KLOEs reflect the most current methods and issues in care.

Complexity and flexibility

Many respondents comment that there should be room for greater flexibility in applying the KLOEs depending on the service provider. Some comment specifically that the well-led provisions are too corporate-focused and only refer to providers of a large size; this serves to ignore the accountable yet flatter management systems in place in some smaller organisations.

Some respondents state that CQC would need to consider the difference between an NHS trust and an independent health care provider when measuring their level of care against these new KLOEs. For example, respondents note that independent health care providers may only see a patient for a small part of their patient journey and therefore would struggle to demonstrate how they have involved them in the decision-making process on their overall care. Some respondents also call for a distinction between clinical and business leadership within the well-led proposals.

"However we would want to see them used in practice in a way that takes into account the nature of the organisation being inspected. i.e: Prompts would be evidenced and assessment differently in a community provider as opposed to an acute setting"

User 339 (Provider/professional, NHS trust)

4.3.4 The key line of enquiry on the Mental Capacity Act

Many respondents comment specifically on the KLOE on the Mental Capacity Act (MCA), which CQC proposes to move from the effective key question to the responsive key question. The majority of these respondents agree with the proposed change. They expect that, along with other proposed changes and additions, this will encourage a more person-centred approach with the welcome potential for delivering a higher quality of care.

"We think it makes sense to have the KLOE for consent and the MCA under 'responsive' as this better reflects fluctuating mental capacity and the need for services to be alert to this and be flexible in how consent is obtained / established"

User 449 (Provider/professional, adult social care)

However, a minority of respondents disagree with the proposed change. A few members of the public who would like to keep the MCA-related KLOE in the effective key question and argue that the current arrangement works well. Other respondents suggest that the proposed move of the KLOE covering the MCA could cause confusion among providers or lead them to be less conscientious in their efforts to meet MCA requirements. Some respondents argue that moving the KLOE on the MCA from one theme to another would make no difference to the quality of care.

Several respondents express concern that the proposed change to the KLOE on the MCA will negatively affect consistency, in comments echoing respondents' overall concerns about balancing the need for change with the need to preserve consistency in the regulation of care providers.

There is no clear-cut correlation between support for the proposed move of the MCA-related KLOE and the category a respondent belongs to. Respondents from a variety of categories

are found among both proponents and opponents of the move. It appears that among those responding on behalf of providers or as professionals, respondents in the adult social care sector are more likely to express opposition than other providers and professionals.

Some respondents suggest that many in the sector, including provider staff, independent providers and CQC inspectors, are uncertain how to use or interpret the MCA with regard to their work. Respondents argue that professionals need to improve their understanding of the MCA to be able to implement it.

5. Registering the right support – CQC's policy on registration and variations to registration for providers supporting people with a learning disability and/or autism

5.1 Responses to question 4

Of the 496 responses to the consultation, 309[11] were in response to question 4, which states: ***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.***

5.1.1 Overall sentiment

Analysts categorised respondents' comments to question 4 for the overall sentiment they appeared to convey about CQC's revised guidance for registering services for people with a learning disability and/or autism.

Of the 309 responses to this question, 256 express an overall sentiment. Analysts identified these sentiments as follows:

- 139 responses were identified as conveying a positive overall sentiment. These responses state agreement with CQC's revised guidance, praising its aims, its alignment with national policy and best practice, and its potential to support improvements to care for people with a learning disability and/or autism;
- 69 responses were identified as conveying a sentiment of 'constructive criticism', meaning they discuss issues or suggestions specific to the revised guidance, stressing for example that it would need to be more flexible, or that CQC would need to clarify how it applies to previously registered services;
- Eight responses were identified as conveying a neutral overall sentiment;
- 14 responses were identified as conveying a sceptical overall sentiment, questioning the merit of the revised guidance without fully dismissing it. Some of these responses question whether the guidance would have any leverage in a context of scarce financial resources;

[11] See breakdown: Table 2-5: Count of respondents by question by "responding as"

- 26 responses were identified as conveying a negative overall sentiment, expressing detailed criticism of the revised guidance, and especially the 'small-scale housing' requirement that it proposes.

A total of 53 responses were identified as expressing no overall sentiment. This includes responses that state 'no comment' as well as responses to question 4 focusing on topics other than CQC's revised guidance.

Support and criticism by respondent group

The analysis looked at responses from specific groups of respondents to see if within those groups, respondents shared the same views. Most respondents who describe themselves as members of the public or people who use services make positive comments about CQC's proposals for registering services for people with a learning disability and/or autism. The same is true for people who identify themselves as carers. A few carers state specific support for CQC's proposal to apply a 'small-scale housing' requirement.

Respondents who describe themselves as voluntary or community sector representatives also make predominantly favourable comments about the proposals, as do respondents describing themselves as local Healthwatch representatives, local authorities and CQC staff members. Looking at respondents identifying themselves as providers and professionals, most of those who say they work in an NHS trust make supportive comments in response to question 4.

The picture is mixed when the analysis looks at respondents who describe themselves as providers and professionals in adult social care, independent healthcare, and primary care. Along some making positive comments, other respondents in these groups express criticism, sometimes detailed and often citing the proposed 'small-scale housing' requirement. This picture extends to respondents identifying themselves as provider trade bodies or membership organisations.

5.1.2 Supportive comments

Several respondents who make positive comments in response to question 4 do so in a general manner. Often, respondents add that in their view the revised guidance is appropriate or fair. Some respondents specifically welcome the alignment with national policy, other relevant guidance, or best practice regarding services for people with a learning disability and/or autism.

"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."

User 396 (Local authority)

Some respondents believe that the guidance will result in improved services for people with a learning disability and/or autism, sometimes adding that improvements are badly needed to ensure people in this group are adequately cared for. A few emphasise that in their opinion the guidance should have been revised earlier. Some respondents highlight how in their view the revisions will help further person-centred care for people with a learning disability and/or autism. For example, some praise the revised guidance for enabling a bespoke registration process for services in this sector.

"It is vital that services for people with Ld and Asd are consistent and based on the persons needs and preferences in a way that is meaningful to them."(User 19, Carer)

Several respondents comment that they value the clarity or the detail offered by the guidance, stating for example that this will make it easier for providers to know exactly what is expected from them if they wish to register new services for people with a learning disability and/or autism. Respondents also say they welcome CQC's efforts to strengthen elements of the guidance that were previously seen as ambiguous.

5.1.3 Issues and suggestions

Respondents discuss a range of issues and suggestions in their responses to question 4. This section covers general issues and suggestions first, before concentrating on specific topics that attracted detailed feedback from respondents, namely:

- Scope of guidance;
- Impact of application of the proposed 'small-scale housing' requirement;
- Location of care homes;
- Impact of policy on existing registration;
- Funding;
- Supported living;
- Other issues.

General issues

Several respondents think the revised guidance lacks clarity, either in general or in relation to specific issues. A few respondents argue that the guidance as a whole is too complex. Where respondents call for greater clarity, this often coincides with wider questions or concerns they have about elements of the revised guidance, such as the proposed 'small-scale housing' requirement and the implementation of the revised guidance for currently registered services.

Respondents also ask CQC to clarify whether and how it proposes to register supported living schemes, and how, if at all, the revised guidance differentiates between various groups

of people with a learning disability and/or autism. A few respondents query how CQC intends to apply the guidance to services not primarily aimed at people with a learning disability and/or autism.

Several respondents argue that the revised guidance appears to lack flexibility. They are concerned that the guidance represents a move to a one-size-fits-all approach, which they believe is inappropriate for this sector. Various respondents provide examples of services that they say are successful, but who would be refused registration based on the revised guidance. Respondents are particularly concerned about the perceived lack of flexibility in relation to the proposed 'small-scale housing' requirement, often referred to as "six-bed limit" (further discussed below).

Various respondents refer to the case studies included in the revised guidance. A few respondents criticise these for not accurately reflecting the reality of the sector. A few others comment that the case studies are not helpful as they are too narrow in scope.

Scope of guidance

Several respondents express concern about the legitimacy or rationale for the revised guidelines. They argue that CQC is proposing to use advisory guidelines from the National Institute for Health and Care Excellence (NICE) to impose firm restrictions on care providers, which they say would be inappropriate for a number of reasons.

A few respondents highlight that the NICE guidance that informed the revised guidance is advisory and not statutory and they object to CQC using this to potentially block the registration of new services. Respondents also suggest that the NICE guidance was based on findings specific to people with autism, questioning why CQC uses it as a basis for its guidance on services for people with learning disability, a much broader group.

Some respondents question whether CQC has considered sufficient evidence prior to publishing the revised guidance. Respondents argue that the introduction of far-reaching measures needs to be robustly backed up by evidence, which they say is not obvious from CQC's revised guidance. For example, respondents suggest that the guidance should cite evidence from research and policy documents beyond the NICE guidance, such as peer-reviewed research papers and evaluations of small-scale care homes for people with a learning disability and/or autism.

"Quality and practice recommendations by advisory bodies, such as NICE, are welcome clarity or guidance in most cases, but they are not regulations, and it is a concern that they may be used as grounds for CQC's refusal of registration applications. This includes the Reach Standards and the Real Tenancy Test."

User 216 (Provider/professional, adult social care)

Some respondents wonder if the revised guidance and its potential impact on registrations of new services are within CQC's remit. A few respondents argue that the prescriptive nature of the guidance – in particular its intention to refuse registration to services with more than six

beds – amounts to shaping the market, which they say is the prerogative of local authorities, not the regulator.

A few respondents suggest that the revised guidance would see CQC regulating services for people with a learning disability and/or autism much more severely than other types of health and social care. For instance, some wonder whether CQC will develop similar guidance for care homes for older people, prescribing a maximum number of beds and/or specific restrictions to the location of new homes.

Impact of application of the proposed 'small-scale housing' requirement

Many respondents comment on the size limitations for residential care services included in the guidance. A few respondents express agreement with the idea that new services for people with a learning disability and/or autism should only be registered if they offer up to six places, but most are critical of the cap.

A common objection to the proposed 'small-scale housing' requirement is that such a measure would be too generic to benefit the quality of all services in what respondents insist is a diverse sector. For example, some respondents suggest that the limit might be appropriate for services for people with a learning disability and/or autism who display challenging behaviour, but not for services aimed at people with a learning disability and/or autism who do not display challenging behaviour. Several respondents emphasise that many existing services for the latter group currently have 'good' or 'outstanding' CQC ratings despite having more than six places.

Several respondents argue that smaller-sized residences do not guarantee high-quality care. They urge CQC to concentrate on other factors, such as staff skills, residents' preferences and organisational values and culture. A few respondents remark that crucial aspects of care are not mentioned in the revised guidance.

Respondents also worry that a limitation on the number of places per service would affect the viability of residential services for people with a learning disability and/or autism. They cite a variety of examples of services that are modelled to provide care to a greater number of people, which they say would be difficult to sustain if funding was based on six or fewer places. Some respondents emphasise that commissioners would favour cost-effective services and that, given the financial pressures they experience, they would not support a move to smaller, more expensive, services.

"With the need to apply higher fees for placements in new smaller services this is likely to cause problems with commissioners who are used to paying less for placements within our larger services."

User 247 (Provider/professional, adult social care)

Several respondents express concern about the potential impact of the revised guidance and the adoption of the NICE definition of small-scale housing, in particular on the development of new models of care. Respondents argue that the prescriptive nature of the revised

guidance could stifle innovation in the sector, as providers would find it difficult to innovate within the boundaries set by the guidance – an issue that respondents believe would be exacerbated by the financial implications of a 'small-scale housing' requirement.

Location of care homes

Many respondents comment on how the revised guidance addresses issues relating to the location of care homes. Some respondents express agreement with the aim to move away from campus-style models. Similarly, various respondents support the idea of encouraging providers to locate care homes within communities, as well as the aim to ensure people with a learning disability and/or autism can be housed within proximity of family and friends.

However, several respondents say that the revised guidance lacks flexibility on this issue, or that assumptions that have informed the guidance are unjustified. Respondents believe that the guidance on this point should explicitly acknowledge the preferences of individuals with a learning disability and/or autism, which will be diverse and in some cases differ from what is assumed in the revised guidance.

While supportive of community-based provision, respondents argue that a care home based in a community would not suit all people with a learning disability and/or autism, some of whom would rather live in a quiet environment. A few respondents think CQC's definition of a community setting is biased towards urban environments, stating that different criteria would apply to rural communities.

A few respondents comment that a requirement to house people with a learning disability and/or autism near family members should not be imposed on them, arguing that individuals should have a say in it. Similarly, a few respondents question the merits of a blanket requirement for family members to be involved in the design of services, saying it may not be desirable or practicable.

Financial pressures on the care sector are mentioned by numerous respondents who comment on the location of care homes for people with a learning disability and/or autism. Respondents argue that housing and staff costs vary considerably across the country, and that this drives commissioners and providers towards areas where costs are low, while hampering the sector's ability to develop enough high-quality homes in expensive areas. They suggest this circumstance should be acknowledged in the guidance.

Impacts of policy on existing registration

Several respondents mention the potential impact of the revised guidance on existing services for people with a learning disability and/or autism. Some of these respondents merely ask for clarifications as to how CQC will implement the revised guidance and what this would mean for previously registered services, especially if these services would not meet CQC's new guidelines. A few respondents request that there should be a transition period.

Other respondents express concern about negative consequences for existing providers, worrying for instance that services would be forced to close or reduce in size, that high-

quality care providers would be downgraded, or that improvements would be thwarted by what they see as too stringent registration criteria. Several respondents call on CQC to engage with providers at the earliest possible opportunity.

Some respondents argue that the revised guidance could detrimentally affect the availability and quality of care for people with a learning disability and/or autism, instead of improving it. For instance, some think that good care homes may be forced to close or move to qualify for re-registration and that this could impact on residents, especially those who are likely to suffer from change. Other respondents say that the revised guidance could lead to a lack of adequate care provision, mainly because of viability concerns.

Several respondents question whether the revised guidance would support innovation and new models of care. Some are concerned that the perceived prescriptive nature of the guidance would discourage providers from attempting to register an innovative service. Others refer to the financial situation of the sector, emphasising that this is a barrier to the development of expensive services, such as small-scale housing for people with a learning disability and/or autism.

"The outcomes are key and forcing small scale housing through may stifle innovative models of support and care and make services too expensive to develop"

User 269 (Local authority)

Funding

The funding context is mentioned in many comments. Respondents express concern that financial constraints would prevail over good intentions and that the aims of the revised guidance would suffer from this, as commissioners are under great pressure to make savings.

As reported in previous paragraphs, respondents express concern about funding issues in relation to the revised guidance both on residence size and residence location. Regarding size, several respondents express concern that a 'small-scale housing' requirement would make care homes for people with a learning disability and/or autism less viable, especially in a context of cash-strapped commissioning. Regarding location – and the guidance to favour care homes within communities, close to residents' relatives – respondents again question the viability, in particular for areas where property prices and staff costs are high.

Respondents ask that CQC takes these difficulties into consideration as it develops its guidance. Some respondents argue that CQC should not implement the guidance until it is reassured that viability issues following from its revised guidance will not hamper the quality of care for people with a learning disability and/or autism.

Supported living

Respondents make a variety of comments about supported living services, which the revised guidance discusses in a set of case studies. Some comments are, in essence, asking CQC

to further clarify its approach to registering and regulating supported living schemes, as the revised guidance has left some respondents confused. A few respondents say that CQC needs to make clear how it envisages regulating these services, in particular its approach to registering premises.

Some respondents are concerned that the currently unregulated nature of supported living services might present a loophole that poor providers could use to continue delivering inadequate services to people with a learning disability and/or autism, without CQC detecting. A few respondents warn that providers might re-register a care home as a supported living service to exploit this loophole.

Various respondents think that it is currently insufficiently clear how CQC would assess supported living services and that specific guidance for this is required. A few respondents question the criteria and indicators used in the revised guidance, stating that these may not apply, or that they are contradictory.

A few respondents wonder whether and how the proposed 'small-scale housing' requirement would be applied to a supported living scheme in a single location, or to a supported living scheme located adjacent to a care home for people with a learning disability and/or autism.

Other issues

Respondents comment on a range of other issues in their responses to question 4, some of which echo comments made in response to other questions. For example, several respondents emphasise the importance of feedback from people who use services, and a few respondents highlight the importance of feedback from provider staff. A small number of respondents express concern about the burden of the registration process to providers.

As in response to other questions, some respondents mention the importance of inspections (over and above registration) and a few express concerns about how the revised guidance might affect provider ratings. Several respondents make comments about the current provision of care for people with a learning disability and/or autism, including some detailed comments based on personal experience.

6. NHS trusts

6.1 CQC Insight and Provider Information Requests (PIRs)

6.1.1 Responses to question 5 (CQC Insight and relationship management)

Of the 496 responses to the consultation, 280[12] were in response to question 5, which states: ***What should we consider in strengthening our relationship management, and in our new CQC Insight approach?***

Analysts categorised respondents' comments for the overall sentiment they appeared to convey about each of the two elements of the question. Of the 280 responses to this question, 161 express an overall sentiment on the new CQC Insight approach and 179 express an overall sentiment on strengthening relationship management.

Overall sentiment on the new CQC Insight approach

Of the 161 responses to the part of this question which focuses on the new CQC insight approach and who express an overall sentiment, these have been identified as follows:

- 17 responses were identified as conveying a positive overall sentiment. These respondents express support for the proposed alignment with NHS Improvement, as they believe it will reduce the regulatory burden. Many also comment positively on the proposal to use a wider range of data as part of this new approach.
- 132 responses were identified as conveying a sentiment of 'constructive criticism'. It should be noted that the question in effect asks respondents to provide constructive criticism, hence the high proportion expressing this sentiment. Some express concern that this new approach may not succeed in reducing the regulatory burden, others query how CQC will ensure that the data is accurate. Some ask that CQC remains transparent about data sources.
- Four respondents were identified as expressing a neutral overall sentiment.
- Six respondents were identified as expressing a sceptical overall sentiment.
- Two respondents were identified as expressing a negative overall sentiment. These respondents query the motive of this initiative.

[12] See breakdown: Table 2-5: Count of respondents by question by "responding as"

126 respondents were identified as expressing no overall sentiment. This includes comments which stated 'no comment' or were focused on topics other than CQC's new insight approach.

Comments on the new CQC Insight approach

This section summarises respondents' comments on the new CQC Insight approach – a separate section further down covers comments specific to strengthening relationship management.

The summary of comments on the new CQC Insight approach is broken down by respondent type – in turn it covers responses from:

- NHS trust providers and professionals;
- Other respondents (e.g. provider trade bodies and membership associations; members of the public; local authorities; and other stakeholders and representative groups).

Comments from NHS trust providers and professionals

Positive comments

Several NHS trust respondents make positive comments about the new CQC Insight approach, stating that they welcome the new approach in general or a particular aspect of it, for example the use of qualitative data, triangulation of data gathering, or the structure of the Insight model. A few respondents emphasise that they are pleased CQC are moving on from previous intelligence gathering approaches.

Some respondents speak in favour of access to CQC Insight for NHS trusts, either stating that they are satisfied with what is proposed or expressing a desire for greater access. A few respondents say they support the proposed alignment with NHS Improvement activity, highlighting that this would help reduce the regulatory burden on trusts.

"The organisation welcomes the more joined up approach suggested and a consistent and shared view of quality"

User 499 (Provider/professional, NHS trust)

Issues and suggestions

Not all respondents are convinced that the new approach would reduce the burden NHS trusts experience from CQC monitoring. Several respondents urge CQC to ensure that its new Insight approach does not increase the burden perceived by providers, by preventing duplication and using existing data as much as possible. Some respondents are concerned that the proposed staff focus groups might take resource away from delivering care, and ask CQC to reassure trusts about this by giving greater detail.

The collection and analysis of data is discussed in many responses from NHS trust providers and professionals. Respondents emphasise the importance of accurate and up-to-date intelligence, sometimes indicating that this has been a weakness of past models used by CQC.

Some respondents ask CQC to further clarify how it will verify data for accuracy as part of its new Insight approach. Respondents emphasise the need for the methodology to be robust and transparent, including fair assessment of feedback from staff, people who use services, and others. They say CQC should be open about which sources have provided input and that it should give appropriate weighting to data from different sources. A few respondents emphasise the importance of considering information in its context, expressing concern that CQC might reach conclusions based on anecdotal data rather than robust evidence.

A few respondents request that CQC shares its findings with NHS trusts at the earliest possible opportunity, or ask that CQC clarifies how it will work with providers to review and address any concerns it identifies, including a formal response process.

"We welcome the introduction of the new insight model and the proposed use, however we would benefit greatly if this was made more readily available to all providers so that any issues can be picked up quickly with CQC relationship managers"

User 506 (Provider/professional, individual respondent from an NHS trust)

Some respondents ask that CQC clarifies how it will apply its new Insight approach to trusts operating at multiple locations or providing multiple services. Respondents suggest that CQC's approach in the past has not been consistent, and request that the new approach is clear about which indicators apply at what level.

A few respondents comment on the new CQC Insight approach for mental health services in particular, stating that they are awaiting further detail on this.

Comments from other respondents

Positive comments

Various other respondents commenting on the new CQC Insight approach make positive comments. Some of these respondents say that they agree with using intelligence to decide which providers or services would need to be inspected. In related comments, a few respondents argue that the new approach would reduce the burden that providers may experience from CQC regulation.

Several respondents express agreement with CQC's proposal to use a wider range of data, including qualitative information, as part of the new approach. A few respondents particularly welcome that CQC would consider feedback from people who use services.

Some respondents support the collaboration between CQC, NHS Improvement and others. A few say they welcome the prospect of CQC sharing data with partners and providers.

"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."

User 386 (Arm's length body or other regulator)

Issues and suggestions

Reducing the burden on providers

Mirroring comments from NHS trusts, some other respondents also express concern about the burden on providers associated with CQC regulation. They request that the new CQC Insight approach achieves a reduction in paperwork, and seek assurances that the new approach will not take up more resources from providers than CQC's existing data collection.

Clarity and consistency

Several respondents ask for greater clarity on the new CQC Insight approach, particularly on how the proposals would work in practice. For example, respondents would like to have a better understanding of what qualitative information CQC will collect, how third parties would be involved in data collection, and how data sharing with partners would work. Respondents also ask CQC to be clearer about how the new approach will address independent sector providers.

Some respondents would like CQC to clarify how it proposes to collaborate with NHS Improvement. A few respondents make further comments about the proposed alignment with NHS Improvement, confirming the need for alignment and making suggestions about how this might benefit providers in practice.

A few respondents emphasise a need for consistency in implementing the new CQC Insight approach, such as making sure that CQC inspectors use data in the same way. A few respondents suggest that this could mitigate risks associated with self-reporting and with collaborative relationships between providers and CQC inspectors.

Data

Respondents make a variety of comments and suggestions with regard to the collection and analysis of data for CQC's new Insight approach. A few of these reflect comments made by respondents from NHS trusts, such as an emphasis on accurate, up-to-date information, and a request to use data from existing sources (e.g. commissioners) where possible. The issue of transparency about how data is collected and used also preoccupies both groups of respondents.

"You are proposing to use a wider range of data sources, including qualitative information from individuals using the service. How will this be incorporated and the weighting of this type of data be considered alongside other sources?"

User 373 (Arm's length body)

Some of the respondents from other groups emphasise the importance of collecting particular qualitative data, often mentioning feedback from people who use services or the public more widely, as well as provider staff. Several respondents argue that CQC should not only engage directly with provider management, but also with these groups, so that it obtains a fuller picture of the reality within a service.

A few respondents mention particular groups from whom CQC should seek feedback, such as children and young people, people with dementia, LGBT people and other equality groups. A few respondents also call on CQC to engage widely to ascertain what information should be collected to inform its new Insight approach. Specific suggestions for data that CQC could consider include feedback from local community professionals and volunteers, staff records, and data from local Healthwatch groups.

Priorities

Respondents make a variety of suggestions about what they think CQC should look out for when they assess and inspect providers. In some instances, respondents argue that current regulation of specific elements of care is insufficient. Examples of priorities, each mentioned by one or two respondents, include:

- dementia care,
- crisis care, and
- the transition from children's services to adult care for young people.

A few respondents say they would like CQC to ensure its Insight approach encourages new models of care, for instance by being flexible enough to allow providers – the independent sector was mentioned specifically – to develop their own quality monitoring approaches.

A few respondents say that they welcome CQC's stronger focus on how services are led, and ask CQC to ensure that this is properly reflected in how it delivers the new Insight approach. For instance, respondents suggest that CQC should gain a full understanding of who has responsibility for the quality of services a provider offers.

CQC practice

Several respondents say that CQC will need to have sufficient qualified staff to make its proposed new Insight approach effective, with some questioning if that is currently the case. A few respondents emphasise the importance of testing the new CQC Insight approach before all providers start to use it.

Many respondents make comments about CQC inspections (covered in detail in section 6.2 below). A few respondents express concern that the new CQC Insight approach and the associated targeted approach to inspections may result in greater risks to people who use services, as inspections would be less frequent and/or comprehensive.

Working with others

Various respondents argue that CQC should collaborate with other organisations when it develops its new Insight approach. Respondents highlight the specialist knowledge or the

local knowledge held by those organisations. Some offer their help with the design of the new CQC Insight approach, others point to data that they hold or generate which CQC could use when reviewing providers' performance. Types of organisations that respondents think CQC should involve include national expert bodies, arm's length bodies, royal colleges, branch organisations, local authorities, and local Healthwatch organisations.

"Given the strengthened focus on the well led KLOE, the CQC Insight Approach could be extended to seeing commissioners of services as information sources. Where trusts are making required improvements, commissioners will often be involved, if not driving that process."

User 496 (Local authority)

Overall sentiment on strengthening relationship management

Of the 179 responses which refer to the part of this question about relationship management and who express an overall sentiment, there were identified as follows:

- 31 responses were identified as conveying a positive overall sentiment. These positive responses mostly come from members of NHS trusts who express that they would welcome more open discussion with CQC and that this could work to reduce regulatory burdens and increase the quality of care delivered.
- 130 responses were identified as conveying a sentiment of 'constructive criticism'. Once again, this high proportion is likely to relate to the wording of the question. These comments mainly surround the need to create an organised, structured approach to relationship management.
- Six respondents were identified as expressing a neutral overall sentiment.
- Eight respondents were identified as expressing a sceptical overall sentiment.
- Four respondents were identified as expressing a negative overall sentiment. Some are concerned that this strengthened relationship management could lead to an increased regulatory burden and others express concern that it could lead to more lenient and inaccurate inspections.

98 respondents were identified as expressing no overall sentiment. This includes comments which stated 'no comment' or were focused on topics other than strengthening relationship management.

Comments on strengthening relationship management

This section summarises respondents' comments on strengthening relationship management. The summary of comments on strengthening relationship management is broken down by respondent type – in turn it covers responses from:

- NHS trust providers and professionals;
- Other respondents (e.g. provider trade bodies and membership associations; members of the public; local authorities; and other stakeholders and representative groups).

Comments from NHS trust providers and professionals

Positive comments

Many of those who respond as NHS trust providers and professionals say they welcome CQC's proposed changes to relationship management. Respondents say their trusts would benefit from having regular meetings with CQC, in which they would openly discuss priorities and challenges for the trust. Some respondents highlight that they have already adopted an approach of ongoing engagement with their CQC inspector, adding that they are keen to continue such an arrangement.

"We agree that strengthening relationship management, building on what happens currently would be helpful. The importance of two way communication and the development of a relationship is crucial."

User 355 (Provider/professional, NHS trust)

A few respondents highlight that they would also welcome the proposed alignment of oversight and reporting, that CQC would undertake together with NHS Improvement. Respondents think that this would reduce the regulatory burden that providers might experience.

Issues and suggestions

Several respondents from NHS trusts suggest that the annual meeting cycle between providers and CQC would benefit from a formal and consistent approach, which some suggest is currently missing. Respondents would like to see meetings scheduled well in advance, and be confident that the meetings will not be re-scheduled or cancelled at short notice.

Some respondents further emphasise the importance of clearly agreeing an agenda for meetings and making sure that outputs of engagement meetings are recorded. Respondents also request that CQC ensures that its approach to relationship management is consistent between inspectors (or between providers).

"It will help to ensure there is an agreed record for example of where improvements have been achieved, areas of concern."

User 433 (Provider/professional, NHS trust)

A few respondents say that providers would benefit from continuously working with the same CQC inspectors, rather than frequently changing contact. Respondents emphasise the

importance of inspectors' expertise, saying a knowledgeable inspector enhances the relationship.

Some NHS trust respondents argue that transparency is vital for relationships between providers and CQC inspectors to be constructive. For instance, a few respondents say CQC should clarify how it will use the information it gathers at engagement meetings, and whether it might inform decisions about a provider's rating. Others say that if CQC has relevant information about a provider, it should share this information with the provider and be clear about the source. A few respondents speak in general terms, stressing the importance of openness and two-way dialogue between provider and regulator.

Other comments about strengthening relationship management from NHS trust respondents include:

- One respondent suggests that CQC could integrate its relationship management into the local commissioners' clinical review cycle.
- A request that CQC uses engagement meetings to discuss findings from CQC Insight with providers;
- A suggestion that providers should be able to request a re-inspection from CQC;
- A suggestion that CQC needs to improve its relationships with GP provider organisations;
- A request that senior CQC staff get involved and meet with providers.

Comments from other respondents

Positive comments

Where respondents from NHS trusts make overwhelmingly positive comments on the issue of strengthening relationship management, the feedback from other respondents is mixed overall. Nonetheless, several respondents from the 'other' category express support for the proposed approach, often in general terms.

Some respondents say that they think strengthening relationship management is important in the context of changes and challenges in the care sector, for instance the development of new models of care and the integration of health and social care locally. Others echo comments from NHS trust respondents and highlight how strengthening relationship management could reduce the burden experienced by providers, as well as helping them improve the quality of services. A few respondents think the approach will encourage sharing best practice between providers.

"The new approach to relationship management with providers is likely able to build continuous improvement process."

User 376 (Researcher/student)

Issues and suggestions

Feedback from other respondents often reflects that of NHS trust respondents. Virtually all of the issues highlighted in comments from NHS trust providers and professionals, reported above, are also mentioned in comments from the 'other respondents' group. To avoid unnecessary repetition, the current section covers these issues in the briefest possible way, then summarises in more detail any new issues raised by other respondents.

Comments from other respondents mirror those from NHS trust respondents on the need for clarity and consistency for the engagement process between CQC and providers. They also highlight the importance of trust and transparency, as well as the need for CQC inspectors to be highly knowledgeable about the services they inspect.

The importance of developing relationships between individuals (provider managers and CQC inspectors) comes up in comments from both groups of respondents, but more prominently in comments by 'other' respondents. A few respondents say CQC inspectors should have more time to become familiar with the providers they inspect; others emphasise the benefits to providers of having a named individual to speak to at CQC.

Burden on providers

In some contrast to comments from NHS trust respondents, several other respondents express concern that strengthened relationship management would result in an increased burden, in terms of time and cost, for providers. Respondents would like CQC to reassure them that ongoing contact does not equate to a net increase in provider time spent on responding to requests for information.

> *"However, great care needs to be taken to ensure that more contact does also increase the burden on providers or divert scant resources away from care and leadership towards managing the CQC relationship."*
>
> *User 166 (Provider trade body or membership organisation)*

A few respondents highlight that smaller provider organisations may struggle to free up sufficient resource to meet the requirements of ongoing contact with CQC. Respondents express concern that larger trusts could be better equipped to benefit from CQC's strengthened relationship management approach, and that smaller providers would risk being left behind. Respondents urge CQC to address this risk.

CQC capacity

Similarly, some respondents believe that the approach to strengthening relationship management will require more resources from CQC. Respondents wonder if CQC would be able to fulfil its requirements, both in terms of the availability and the skill levels of its staff. A few respondents criticise CQC's organisational model, saying for instance that it changes too often for inspectors to be effective or that it hinders communication between staff in different directorates.

Balance of relationships

Several respondents say that they would like CQC to give more prominence to its objective of supporting providers to improve services, through partnership working and sharing good practice. They say that some providers' perception of CQC as an organisation that seeks to punish them for their failures can hamper relationship development and stand in the way of working together to achieve improvement.

However, a few other respondents express concern about the potential for strengthening relationship management to result in 'cosy' relationships between providers and CQC inspectors. They believe this would prevent sufficient scrutiny of a provider's performance, especially within a regulatory model where it self-assesses the quality of its care. One respondent adds that CQC's reputation would suffer if the public were to perceive it as being too close to providers.

"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."

User 17 (Member of the public)

Relationship management beyond providers

Several respondents think CQC should expand its relationship management to local authorities or commissioners, which in their view play a crucial part in managing and overseeing care provision in their area. A few respondents think CQC should support and influence commissioners to enable care services to improve; a few others believe commissioners' data and expertise would be valuable to CQC.

Working with others

As in comments on the new CQC Insight approach, respondents suggest a variety of organisations that they believe CQC should collaborate with in its effort to strengthen relationship management. Organisations that respondents would like CQC to work with on strengthening relationship management include voluntary organisations, patient groups, local Healthwatch groups, local community professionals, and NHS England regional quality surveillance groups. A few respondents mention royal colleges, national expert bodies, trade unions and professional organisations.

6.1.2 Responses to question 6 (provider information requests)

Of the 496 responses to the consultation, 263[13] were in response to question 6, which states: ***What do you think of our proposed new approach for the provider information request for NHS trusts?***

Overall sentiment

Analysts categorised respondents' comments for the overall sentiment they appeared to convey about the proposal. Of the 263 respondents who answered question 6, 185 were found to express an overall sentiment. These were identified as follows:

- 97 convey a positive overall sentiment, stating agreement with the proposal for a new approach to provider information requests (PIRs) for NHS trusts as they believe that this more 'streamlined' approach will diminish trusts' administrative burden.
- Another 63 responses were categorised as constructively critical. These responses generally include comments requesting a more detailed template for submitting the information requested, as well as commenting on the timings for submission and the possibility for forward planning.
- Six responses were categorised as conveying a neutral overall sentiment.
- Ten responses were categorised as sceptical – often based on their questioning of relying on self-reporting by providers.
- Nine responses were categorised as having a negative sentiment, also usually in relation to criticism of self-reporting.

78 respondents express no overall sentiment. These include those that answered with 'no comment' or those who made comments unrelated to CQC's approach to PIRs.

The summary of comments on the proposed CQC approach to PIRs is broken down by respondent type – in turn it covers responses from:

- NHS trust providers and professionals;
- Other respondents (e.g. provider trade bodies and membership associations; members of the public; local authorities; and other stakeholders and representative groups).

[13] See breakdown: Table 2-5: Count of respondents by question by "responding as"

Comments from NHS trust providers and professionals

Supportive comments

Many comments submitted by respondents from NHS trusts express broad support for the new approach CQC put forward for PIRs. Many state that they support this "more streamlined" approach and that it will reduce their current administrative burden. A few respondents from NHS trusts specify that they support the proposed self-assessment methods.

Reducing the bureaucratic burden

Many of the NHS trust respondents who approve of the new approach to PIRs express support for the proposal to obtain data from alternative sources where possible. They think that using readily available information will reduce the time required from providers to complete the PIR. Some say that this approach could also lead to greater consistency of the data CQC considers for all NHS trusts, particularly if all data is gathered from the same openly available sources. They feel this new approach would be beneficial to both trusts and CQC.

Several NHS trust respondents also welcome the proposed changes to CQC's approach for collecting data from providers, which would be through a single annual return rather than a two-part data gathering exercise 20 weeks prior to inspections. They believe the new approach would reduce the total time spent on collecting information.

"The current process of providing information prior to and during inspections is really intense, taking up a lot of man hours, so to significantly reduce [the] amount of information requested by collecting on an annual basis would be welcomed"

User 181 (Provider/professional, NHS trust)

Issues and suggestions

Whilst no respondents from NHS trusts make overall negative comments about the proposed new approach to PIRs, many who express overall support also provide suggestions they think would strengthen the proposals. These include requests for further clarity on the information requirements of the new PIR and queries as to how CQC would achieve consistency in data collection, particularly given the self-assessment methods proposed. Some respondents question whether this new PIR process would be effective in reducing duplication of information requested.

Clarifying the requirements of the new PIR

While generally supported by respondents from NHS trusts, the proposed move towards self-assessment raises some concerns. Respondents worry that information reported in self-assessments might be subjective, and ask how CQC will ensure that the data collected is

consistent and reliable. Some respondents suggest that CQC should share a PIR template with providers which clearly outlines how information from self-assessments should be reported. They hope that this will address variation and optimise standardisation. Furthermore, respondents believe that a PIR template would be helpful in ensuring that providers submit the right level of detail, thus mitigating the potential need for NHS trusts to submit supplementary data.

Many respondents from NHS trusts also want CQC to clarify the timing of PIR submission to allow them to effectively plan for the proposed new annual collection process. They express concern that it could otherwise coincide with other reporting requirements and cause unwarranted additional stress. Some query whether the PIR submission will take place at the same time for all trusts.

"It should be very clear in advance when the information is required during the year so that trusts have maximum preparation time"

User 355 (Provider/professional, NHS trust)

Repeated information requested

Some respondents from NHS trusts state that the proposed new PIR process may lead to duplication, as it requests data that is similar to information already supplied to commissioners. They welcome opportunities to further streamline the data requested.

How CQC will use the data from the PIR

Some respondents from NHS trusts express comments or questions about how CQC will use the data obtained through the new PIR. These include:

- Suggestions that an annual PIR may mean that some data is out of date at the time of inspection. Respondents ask that CQC ensures that all data it uses is up-to-date and consistent across providers.
- Requests that IT systems are tested to ensure that there are no issues when providers upload PIR data.
- Requests that all information submitted in the PIR is made accessible to inspectors prior to inspection, to avoid providers having to resubmit information at the time of an inspection, which they say would create a greater workload.
- A suggestion that CQC provides a template for trusts that do not have data sets in place yet.
- A suggestion to use the PIR information for benchmarking trusts, with the information available to all.

Comments from other respondents

Many respondents from other categories make positive comments about the proposed new PIR, stating for instance that it would be an improved approach and that it would minimise the regulatory burden on providers by using data already available. Many express particular agreement with the proposal to streamline the PIR and use an online single collection mechanism, saying these changes would reduce time for administrative reporting, which would free up time for trusts to deliver care. Some respondents express concern, especially about relying on self-assessments for detecting risks or issues.

"The old style PIR was very time consuming and complex to complete. The new style shorter PIR will be very welcomed along with the opportunity to self-assess."
User 176 (Hospice provider)

Issues and suggestions from other respondents

Accuracy of self-assessment

As mentioned above, the primary concern in comments from respondents in this category is that data obtained through self-assessment would not always be reliable. Some believe this would increase risk to people who use services, as ongoing issues might go unnoticed, which they say would be a step in the wrong direction.

Several respondents comment that there should be an increased focus on feedback from people who use services which in their opinion the new PIR process does not do.

Data collection and accuracy

Respondents from other categories also cite concern about ensuring that data is up-to-date, particularly if there would be a long time between the annual PIR and a provider inspection. Many respondents emphasise the need for applying the new PIR consistently to produce reliable and transparent findings. Some respondents wonder how the new approach might affect provider ratings, particularly in terms of offering providers more frequent opportunities to demonstrate improvements to services, which could prompt CQC to update their rating.

Some respondents highlight that the PIR approach needs to allow enough flexibility to accommodate variety between services, and providers' capabilities to produce data.

6.2 Inspections

6.2.1 Responses to question 7 (Well-led and core service inspections)

Of the 496 responses to the consultation, 270[14] were in response to question 7, which states: ***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?***

Overall sentiment

Analysts categorised respondents' comments for the overall sentiment they appeared to convey about the proposed approach to core services and the well-led key line of enquiry (KLOE). Of the 270 responses to this question, 213 expressed an overall sentiment. These sentiments are broken down as follows:

- 106 responses were identified as conveying a positive overall sentiment. These responses state agreement with CQC's new approach for core services and well-led inspections, highlighting the benefits of a more targeted approach and the potential for reduced bureaucracy.
- 65 responses were identified as conveying a sentiment of 'constructive criticism', meaning they discuss issues or suggestions specific to the proposal, querying for example how the proposed approach would work for different sized providers and how the inspections would be coordinated in terms of timescale.
- Five responses were identified as conveying a neutral overall sentiment.
- 23 responses were identified as conveying a sceptical overall sentiment, questioning the merit of the proposal without fully dismissing it. These respondents express concern about CQC's capacity to carry out the new approach or the potential for increased bureaucracy.
- 14 responses were identified as conveying a negative overall sentiment. Several of these responses argue that intervals such as five years for outstanding services may be too infrequent.

A total of 57 responses were identified as expressing no overall sentiment. This includes responses that state 'no comment' as well as responses to question 7 focusing on topics other than CQC's new approach for core services and well-led inspections.

[14] See breakdown: Table 2-5: Count of respondents by question by "responding as"

The summary of comments on the new approach to inspecting core services and well-led is broken down by respondent type: in turn it covers responses from:

- NHS trust providers and professionals;
- Other respondents. (e.g. provider trade bodies and membership associations; members of the public; local authorities; and other stakeholders and representative groups).

Comments from NHS trust providers and professionals – Well-led

A few NHS trust providers and professionals add detail to their supportive comments about CQC's new approach to well-led. These comments focus on the importance of regularly assessing leadership, especially as the leadership of trusts can change frequently. They tend to believe that leadership is a crucial aspect of organisational success, and note that this approach seems to fit with trust board schedules for reviewing effectiveness.

Other NHS trust providers and professionals highlight potential issues, including the importance of being able to fully and accurately identify the underlying issues around inappropriate care. Respondents also comment that the inspections may be too frequent, resource-intensive or duplicating the work done by NHS Improvement.

Comments from NHS trust providers and professionals – Core services

Supportive comments

Some NHS trust providers and professionals highlight the potential benefit of more targeted inspections resulting from the CQC's new approach to core service inspections. These comments often focus on the reduced size of inspections, increased cost-effectiveness, along with reduced disruption and bureaucracy for providers. NHS providers also identify the potential for the targeted inspections to improve services by highlighting areas of concern.

> *"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."*
>
> *User 286 (Provider/professional, NHS trust)*

In relation to a more targeted approach, a small number of NHS trust providers and professionals specifically support the principle of annual inspections. They see this as a proportionate frequency for ensuring service quality is maintained without becoming a burden or increasing bureaucracy.

Issues and suggestions

Implementation and methodology

Some NHS trust providers and professionals argue that the effectiveness of the new approach to inspecting core services will depend on how this is implemented. One such concern is how the proposals would apply to different sizes of trusts, with larger providers expressing concern that the level of inspections may be diluted compared to smaller providers.

> *"The proposal overall seems appropriate. However for larger organisations providing many core services we are concerned there is potential for more services to be missed and equally it is not clear the impact of a negative inspection in a relatively small core service could have on the overall organisation rating."*
>
> *User 239 (Provider/professional, NHS trust)*

In relation to this, another concern is that the new approach may be interpreted as 'light touch' and they suggest that CQC provides assurances to explain otherwise.

NHS trust providers and professionals query how the new approach to inspections will affect the accuracy of the service quality rating when it is more targeted and less comprehensive. Similarly, NHS trust providers and professionals express the concern that with a proposed decrease in inspections, it may take providers more time to improve their rating to a higher bracket.

A few NHS trust providers and professionals believe that the new approach to core service inspections would increase, rather than decrease, the bureaucratic burden on service providers; they argue that information requests still require time to prepare and that inspections, however infrequent, can create a burden on providers.

Other queries regarding implementation and methodology include:

- How CQC's change in approach will impact on NHS trusts' financial contributions;
- How CQC will share data with trusts in preparation for and during inspections;
- Whether CQC has sufficient expert capacity to carry out the proposed inspections;
- Whether CQC could work more with commissioners to encourage top-down improvement.

Timing and frequency

Several NHS trust providers and professionals raise potential issues with the timing and frequency of the new approach to inspecting core services. One of the most frequent points raised is how the well-led and core service inspections would be coordinated and scheduled. NHS providers argue that this may result in delays to updating ratings, sometimes citing their own existing experience with alleged delays by CQC.

Another frequent point surrounds the proposed five-year interval for re-inspecting core services rated 'outstanding. NHS providers argue that this may be too infrequent as trusts' leadership may change within that timeframe. Some suggestions made regarding time and frequency include:

- Changing the annual inspection to a frequency which is proportionate to the rating of each provider;
- Regular unannounced inspections to correspond to providers' quality cycles.

Comments from other respondents – Well-led

Some respondents make supportive comments about CQC's new approach to the well-led assessment. Respondents often stress the importance of assessing good management to make sure providers are efficient and effective. Another common view is that by assessing at the level of management, CQC finds a good indication of service quality throughout services of a provider.

A few respondents dispute this view that leadership gives an accurate indication of provider quality. They explain that it can be hard to achieve consistency across large providers with different types of services. Another concern surrounds the potential for duplication between NHS Improvement assessment of use of resources, and CQC well-led assessment.

Other suggestions regarding well-led include:

- Scheduling well-led and core service inspections at the same time;
- Not separating well-led out as an inspection criterion;
- For independent providers, inspecting well-led at head office instead of at individual hospitals.

Comments from other respondents – Core services

Supportive comments

Some respondents highlight the potential benefit of more targeted inspections resulting from CQC's new approach to core service inspections. These comments focus on making the process more effective and efficient, focusing on the areas that need most work and moving to a place-based approach instead of provider-wide.

"It's an effective way of completing inspections as it allows focus on the areas where it is most needed."

User 68 (Provider/professional)

A few respondents express general support for the annual inspection while others support the principle of unannounced inspections. In both cases, these respondents do not qualify their support.

Timing and frequency

Some respondents raise potential issues with the timing and frequency of the new approach to inspecting core services. The key concern here is that the new approach to inspecting core services may not be frequent enough, leading to out-of-date information or the deterioration of care. In particular, respondents query the proposed five-year interval for providers rated as outstanding.

> *"I do have concerns about a 5-year interval, regardless of a service deemed as 'outstanding', not least because the 'well-led' KLOE does not necessarily guarantee the actual service delivered remains outstanding."*
>
> *User 390 (Carer)*

In contrast, a few respondents believe that annual inspections are too frequent for providers that CQC has assessed as providing high quality care.

Implementation

Some respondents argue that the effectiveness of the new approach to inspecting core services will depend on how it is implemented. One issue they highlight is how the proposals would adapt to different sizes of trust. In addition, respondents express the concern that services they believe are high risk, such as mental and sexual health, are not categorised as core services.

Resourcing is another caveat respondents give for the new approach's success; they query whether CQC would have enough capacity to implement the new approach to inspecting core services. In relation to this, respondents express concerns that the new approach may not be affordable, or that it may impose a bureaucratic burden on providers.

Methodology

Some respondents express concerns with the overall efficiency or robustness of the new approach to inspecting core services. Specifically, there is a concern that the motivation for providers to improve may be reduced if it takes several years to appear in their rating. Other respondents query how the new approach to inspecting core services will work with the ratings system in practice.

Other respondents believe that these inspections may be less comprehensive or too 'light touch' to sufficiently assess provider quality. A small number of respondents stress the importance of gaining feedback from provider staff and people who use services. They believe this would give a 'true' or 'full' picture of service quality.

Other suggestions regarding the methodology include:

- Allowing providers to request re-inspection following evidence of improvement;
- Using Experts by Experience to carry out inspections;
- Inspecting more than one core service to follow a pathway approach.

6.2.2 Responses to question 8 (unannounced core service inspections)

Of the 496 responses to the consultation, 292 were in response to question 8, which states: ***What do you think about our proposal that the majority of our inspections of core services will be unannounced?***

Overall sentiment

Analysts categorised respondents' comments to question 8 for the overall sentiment they appeared to convey about CQC's proposal for all core service inspections to be unannounced. Of the 292 responses to this question, 266 express an overall sentiment. Analysts identified these sentiments as follows:

- 170 responses were identified as conveying a positive overall sentiment. These responses state agreement with CQC's proposal that the majority of core service inspections will be carried out unannounced or at short notice;
- 69 responses were identified as conveying a sentiment of 'constructive criticism', meaning that they discuss issues or suggestions specific to the proposal, stressing for example that unannounced inspections be carried out in ways that minimise adverse impacts for provider staff;
- Five responses were identified as conveying a sceptical overall sentiment, questioning the merit of conducting announced inspection on core services without dismissing it;
- Eight responses were identified as conveying a negative overall sentiment, some of which include detailed criticism of unannounced inspections;
- 14 responses were identified as conveying a neutral overall sentiment.

A total of 26 responses were identified as expressing no overall sentiment. This includes responses that state 'no comment' as well as responses to question 8 focusing on topics other that CQC's proposal for unannounced inspections.

The summary of comments on the proposal to introduce unannounced inspections for core services is broken down by respondent type – in turn it covers responses from:

- NHS trust providers and professionals;
- Other respondents (e.g. provider trade bodies and membership associations; members of the public; local authorities; and other stakeholders and representative groups).

Comments from NHS trust providers and professionals

Supportive comments

Approximately half of all responses to question 8 from NHS trust respondents involve positive comments on the proposal for unannounced core services inspections. Some of these comments are general in nature however most include a rationale for the respondent's support of the proposal. These include opinions that the proposed new approach would:

- Foster provider cultures where higher care standards are the norm;
- Improve the quality of providers' care every day rather than only on days when inspections are scheduled;
- Allow CQC to gain a more accurate representation of a provider's care on any given day;
- Prevent providers from overpreparing for inspections or misleading CQC inspectors; and
- Prevent high levels of anxiety among provider staff in anticipation of prearranged inspections.

"[I]t will help to build a culture whereby quality is business as usual and what a patient experiences on the day of an inspection should be no different to their experience at any other time"

User 499 (Provider/professional, NHS trust)

Many NHS trust respondents believe that unannounced inspections would give CQC a more accurate understanding of a provider's service and that this would result in more realistic CQC ratings of providers' care.

Some respondents comment that unannounced inspections would reduce the possibility of providers over-preparing for inspections which distorts CQC's view of their service. Some others believe that not being able to prepare for inspections would result in better usage of provider staff time. For example, staff time would be freed up from preparing for inspections and channelled back into care provision, monitoring the quality of care provision and other core tasks.

Few NHS trust respondents oppose the proposal for unannounced CQC core services inspections. The responses of those who oppose the proposal are either:

- of the opinion that there is no need to make changes to the existing system of inspections in which one month notice is provided because it works well; or
- would prefer announced inspections because they ensure that inspectors engage with key provider staff on the day of inspection.

Issues and suggestions

Many NHS trust respondents with a positive stance toward the proposal would like CQC to address specific aspects of the approach to strengthen it or mitigate possible negative impacts for providers. These issues fall into two main categories:

- Issues related to increased pressure for provider staff and/or subsequent disruption to their services;
- Issues related to the practicality of implementing unannounced inspections – both for CQC inspectors and for the providers being inspected.

Some respondents provide specific suggestions as to how their concerns could be addressed. The issues and suggestions raised are summarised under the headings below.

Pressure and disruption for providers

Some NHS trust respondents believe that unannounced inspections would create a high stress environment and/or increased workloads on the day of the inspection. This is due, for example, to the need for providers to arrange appointments with inspectors, meeting rooms or care cover, without advance notice.

Some respondents advise that the care needs of people using services would be affected by unanticipated inspections that cause disruptions to provider staff. Similarly, one respondent suggests that specific groups of people who use services, for example people with dementia, may be distressed by the presence of strangers if there is no opportunity to inform them beforehand.

Feasibility and logistical challenges

Many NHS trust respondents express the opinion that inspecting core services unannounced is a positive approach *in theory* however may be difficult to implement *in practice*.

Some NHS trust respondents raise concerns that unannounced inspections would be logistically challenging for CQC to arrange for certain types of providers because of the nature of the providers' services or operating models. For example, it may be a challenge to arrive without notice to inspect small providers, peripatetic services (such as those that conduct home visits) and community based services because staff are not always in the same location, have multiple prior commitments or no one to pass their workload to.

Similarly, some NHS trust respondents express a concern that inspectors would not be able to access the most appropriate provider staff, such as managers or area leads, due to workloads, clinical commitments, leave or working away from the provider's main location, for example, conducting house calls or community visits. Some respondents who express this concern explicitly state that the inaccessibility of key individuals would affect the comprehensiveness of CQC inspections as important information might be overlooked.

Contrary to the majority view among NHS trust respondents, a small number believe that unannounced inspections will not gain an accurate picture of the quality of providers' services because the day of inspection may not be representative of a typical day.

"There will need to be a balance, however, as inspections will impact service delivery 'on the day', and thought needs to be given as to how to assess services on the day without interfering with day to day business"

User 355 (Provider/professional, NHS trust)

Finally, a few NHS trust respondents believe the introduction of unannounced inspections risks losing the patient perspective of a provider's care.

Suggestions

Many NHS trust respondents who believe unannounced inspections will cause undue disruption to providers or will result in key staff not being available request that CQC implement ways to mitigate these effects by allowing providers to be prepared to host people at their site/s. Suggestions for how to do this include:

- Providing short notice of an inspection, such as one day, especially to peripatetic and community-based services;
- Providing services with an inspection 'window' or a period of time within which an unannounced inspection may occur;
- Not scheduling unannounced inspections in providers' peak periods or seasons, for example, not inspecting services for children in school holidays or bedded units in winter; or
- Establishing a set cycle for core services inspections, such as by conducting routine inspections at the same point every year.

Comments from other respondents

Supportive comments

The majority of other respondents express support for the proposal for unannounced inspections of core services; a large subset of respondents provide constructive feedback on the approach; some respondents are neutral or sceptical; and a small portion are opposed to it.

A small number of other respondents who express support for the proposed approach comment in a general manner. The majority of these explain that they support the proposal because they feel that it would:

- Lead to a consistency of higher care provision because providers will be more likely to improve the quality of their care every day, not only on the day of the inspection;
- Increase the accuracy and robustness of the data CQC collect during inspections and base its provider rating decisions on.

"I agree with this proposal, far too often organisations over 'prepare' for inspections, this can give a false impression of what is happening on a daily basis"

User 273 (Member of a local Healthwatch)

In addition, a few respondents think that the introduction of unannounced inspections would increase public, provider and service user trust in CQC's approach and increased confidence in CQC as a regulator.

Issues and suggestions

The key issues this group of respondents raise include the following; these are explained in more detail below.

- The potential to overlook key staff members on the day of an unannounced inspection;
- Small, community-based or peripatetic services being disproportionately burdened on the inspection day;
- Disruptions and anxiety for provider staff and people who use services;
- CQC inspectors' approach to supporting provider change; and
- Consideration of the feedback of people who use services.

Some respondents from this group think that unannounced inspections may overlook key provider staff members who are not available on the day of inspection. Several respondents who express this belief also express concern about the effectiveness of CQC inspections if important information cannot be collected from providers' key staff.

"If your teams cannot receive documentation in advance of inspections without providing advanced warning, it may also reduce the effectiveness and efficiency of the time spent at the on-site inspection"

User 373 (Arm's length body or other regulator)

Several others with this concern focus on equity, for example, stating that a realistic impression of the service will not be possible if certain staff are not spoken to during an inspection, or by speaking to the wrong people.

Several respondents believe that unannounced inspections will not work for community health services because every day in these (and other peripatetic) services is different and will not afford inspectors a holistic view of the care they provide.

Some respondents suggest the timing of inspections is an important consideration to ensure adequate information is captured. Several respondents suggest that services should be inspected both during peak and off-peak times. For example, A&E departments and care homes should be inspected overnight and on weekends.

"Excellent... and also make the inspections at weekends and late at night/early morning"

User 35 (CQC Expert by Experience)

Some respondents think unannounced inspections have the potential to disrupt providers' services on the day of the inspection or cause undue anxiety among staff members and possibly representing a drain on resources within a climate of financial constraint. These respondents' comments are similar in nature to those given by NHS trust providers and professionals.

A few respondents suggest that CQC inspectors should take a supportive approach to conducting inspections as opposed to an interrogative one. A few points to the importance of considering and measuring variation.

Some respondents mention CQC risk losing the ability to hear the feedback and opinions of people using services by using unannounced inspections, for example:

"There is evidence in my area that there is a distinctive gap between CQC findings and feedback from patients, carers and staff."

User 102 (Voluntary or community sector individual)

Suggestions made to decrease the impact that unannounced inspections may have on providers and their staff include:

- Conducting a main unannounced inspection and a follow-up meeting to ensure all relevant staff are included;
- Providing a short notice period of inspection, such as 48 hours, or a rough timetable for inspections in advance;
- Conducting a mixture of announced and unannounced inspections and deciding which type of inspection is appropriate based on the inspections' purpose;
- Making the criteria for announced versus unannounced inspections extremely clear to providers;
- Ensuring feedback from the public and people who use services is captured;

- Working closely with local Healthwatch and taking account of their Enter and View reports;
- Providing more support to providers to make improvements after an inspection finds fault with their care;
- Increasing the frequency of inspections for providers with low ratings. For example, a couple of respondents suggest that inspections should occur more frequently both to encourage and support change in providers with low ratings and to ensure providers rated 'good' or 'outstanding' maintain their high standard.

Sceptical or negative comments

Several respondents express scepticism about the ability of CQC to deal with the types of issues and amount of data that unannounced inspections may reveal. For example, one respondent suggests that CQC will need to 'close down every provider' and another warns CQC not to attempt to police everything.

Several respondents express scepticism that unannounced inspections would be feasible, for example because of the need for CQC to request information from providers prior to an inspection which would reveal to providers that an inspection was being planned.

Core and additional services

6.2.3 Responses to question 9a (maternity and gynaecology core service)

Of the 496 responses to the consultation, 243[15] were in response to question 9a, which states: ***What do you think about the changes we have proposed to inspecting the maternity and gynaecology core service?***

Overall sentiment

Analysts categorised respondents' comments to question 9a for the overall sentiment they appeared to convey about CQC's proposal to consider gynaecology separately from the maternity core service area.

Of the 243 responses to question 9a, 121 express an overall sentiment. Analysts identified these sentiments as follows:

[15] See breakdown: Table 2-5: Count of respondents by question by "responding as"

- 87 responses were identified as conveying a positive overall sentiment. These responses state agreement with CQC's proposal for gynaecology to be inspected as an additional service, praising its separation from maternity;
- 26 responses were identified as conveying a sentiment of 'constructive criticism', meaning they discuss issues or suggestions specific to the proposal, stressing for example that it may be more appropriate to include inspections of gynaecology in the surgery core service;
- Three responses were identified as conveying a neutral overall sentiment;
- One response was identified as sceptical, questioning the practicality of separating the two service areas;
- Four responses were identified as conveying a negative overall sentiment. Some of these responses argue that separating the two areas would not be appropriate.

A total of 122 responses were identified as expressing no overall sentiment. This includes responses that state 'no comment' as well as responses to question 9a focusing on topics other than CQC's proposal to inspect gynaecology and maternity separately.

The summary of comments on the proposal to separate the service areas of maternity and gynaecology into core and additional services respectively, is broken down by respondent type: in turn it covers responses from:

- NHS trust providers and professionals;
- Other respondents (e.g. provider trade bodies and membership associations; members of the public; local authorities; and other stakeholders and representative groups).

Comments from NHS trust providers and professionals

NHS trust providers and professionals account for 57 responses to question 9a. A significant proportion (21) of these responses offered no comment on question 9a.

Some NHS trust respondents welcome the proposal to separate gynaecology and maternity into additional and core service areas, respectively, expressing the opinion that they should be considered separately because they are distinct specialities. A few respondents elaborate on this view, stating that different staff and providers are involved in the provision of the two service areas.

"The two services are distinct, and separating them for inspection purposes will provide useful information for stakeholders about the performance of each."

User 253 (Provider/professional, NHS trust)

In contrast, a few respondents believe that the proposal to inspect the service areas separately could result in duplication in the inspection process or be a burden for the

providers involved. For example, a couple of respondents note that gynaecology and obstetrics services may be carried out by the same professionals or managed by the same leadership team within small providers.

Of the respondents that provide constructive criticism or suggestions for improving the proposal, the key issues include:

- Ensuring that any co-dependencies or shared pathways between the two service areas are considered and not left out of inspections;
- Not including terminations as part of the maternity service, rather as part of gynaecology;
- Including early pregnancy care in maternity, not gynaecology;
- Piloting the proposed approach before committing to its adoption; and
- Consulting on the proposal directly with clinical leads in gynaecology and maternity.

A few respondents who express positive opinions towards separating gynaecology and maternity inspections suggest that it is more appropriate to inspect gynaecology within the surgery core service. They believe that gynaecology is a surgical speciality and should be considered alongside other surgical specialities. One respondent expresses concern that inspecting gynaecology separately may set a precedent which providers of other surgical specialities may wish to follow.

"I think it risks setting a difficult precedent- unless there are long term plans to separate other surgical specialities out. Gynaecology is after all a surgical speciality?"

User 278 (Provider/professional, individual respondent from an NHS trust)

Comments from other respondents

A large number of the responses (79) provided no comment on the content of the proposal to separate gynaecology and maternity into additional and core service areas, respectively.

Some other respondents express support for the separation of gynaecology and maternity due to the opinion that they are quite different service areas. For example, because maternity services generally treat women who are well and gynaecology services treat women who are unwell.

"These are clearly appropriate given that they are essentially different services. Gynaecology is more closely allied to Urology."

User 271 (Provider trade body or membership organisation)

A few respondents express the opinion that inspections and monitoring are positive in general.

Some respondents provide constructive feedback on the proposal, suggesting the following issues.

- Separate inspections may cause a loss of integration or coordination between related specialisms, potentially outweighing the gains the approach would achieve;
- Separate inspections will be useful only if standards, methodology and people employed to implement it are good enough; and
- The expected outcomes of conducting separate inspections for these service areas are not clear.

A few respondents express concern that the proposed approach to inspect gynaecology as an additional service would marginalise it as a service for women. Of these respondents, a couple request that CQC checks if this change in policy would fail CQC's equality impact assessment.

Other suggestions for how the proposed approach may be strengthened include:

- Inspecting gynaecology not as an additional service, rather as an aspect of surgery or other related core service areas, such as medicine, outpatients.

"The different aspects of gynaecology should be included where possible in the other core services - medical gynaecology under Medicine, surgical gynaecology under Surgery, and emergency gynaecology units under Urgent and Emergency Care."

User 135 (CQC staff member)

- Ensuring that any overlap or shared responsibilities between the two service areas are adequately inspected, for example, early bleeding in pregnancy, sonography services and specific staff with roles that place their work in both gynaecology and maternity;
- Placing more emphasis on the experiences of people who use services to ensure consumers interests and feedback are considered, for example by garnering the views from patient support groups;
- Inspecting how providers work effectively across groups of providers and the quality of leadership and management;
- Inspecting how providers conduct onward referrals and coordinate with related services, for example because perinatal care is an opportunity to support various health conditions including mental health;
- Including perinatal mental health services and other related services in the inspection of the maternity core service;

- Considering providers that may operate as both CQC registered service providers and operate privately;
- Adopting the six key statements and auditable standards for service delivery laid out in the Royal College of Midwives' Standards for midwifery services in the UK in the design of inspections;
- Including outpatient maternity care services in inspections;
- Supporting the improvement of providers who are assessed as being of concern;
- Proving the usefulness of separate inspections in practice; and
- Increasing the frequency of inspections.

6.2.4 Responses to question 9b (outpatients and diagnostic imaging core service)

Of the 496 responses to the consultation, 242[16] were in response to question 9b, which states: ***What do you think about the changes we have proposed to inspecting the outpatients and diagnostic imaging core service?***

Overall sentiment

Analysts categorised respondents' comments for the overall sentiment they appeared to convey about the proposal to separate diagnostic imaging out from the core service of outpatients as an additional service.

Of the 242 responses to question 9b, 132 express an overall sentiment. Analysts identified these sentiments as follows:

- 100 responses were identified as conveying a positive overall sentiment. These states agreement with CQC's proposal for diagnostic imaging to be inspected as an additional service, no longer combined with the outpatients core service;
- 15 responses were identified as conveying a sentiment of 'constructive criticism', meaning they discuss issues or suggestions specific to the proposal;
- Five responses were identified as conveying a neutral overall sentiment;
- Six responses were identified as conveying a sceptical overall sentiment, questioning the merit or practicality of separating the two service areas;
- Six responses were identified as conveying a negative overall sentiment, some of which include detailed criticism of the proposed approach.

[16] See breakdown: Table 2-5: Count of respondents by question by "responding as"

A total of 110 responses were identified as expressing no overall sentiment. This includes responses that state 'no comment' as well as responses to question 9b focusing on topics other than CQC's proposal to conduct separate inspections of diagnostic imaging and outpatients services.

The summary of comments on the proposal to separate the service areas of outpatients and diagnostic imaging into core and additional services respectively is broken down by respondent type – in turn it covers responses from:

- NHS trust providers and professionals;
- Other respondents (e.g. provider trade bodies and membership associations; members of the public; local authorities; and other stakeholders and representative groups).

Comments from NHS trust providers and professionals

NHS trust providers and professionals account for 56 responses to question 9b. A significant proportion (17) of these responses offered no comment.

Some NHS trust providers and professionals fully agree with the proposal to split diagnostic imaging out from outpatients as an additional service. Of these supportive responses, a few clarify the reasons for their support, saying that:

- The two service areas are distinct from one another;
- The current consideration of diagnostic imaging in the outpatients core service is illogical, for example, because diagnostic imaging relates to both outpatient and inpatient services;
- The two areas have separate quality assurance processes;
- Many trusts manage the two services from different divisions; or
- Diagnostic imaging has different risks to other outpatient services.

Several supportive respondents believe that a strong aspect of the proposal is CQC's intention to, where possible, make better use of relevant accreditation schemes for diagnostic imaging providers to reduce or replace regulatory review. For example, to reduce duplication.

"We welcome the separation of the two aspects which will provide clarity of where improvements could be targeted as well as clearer understanding for public and stakeholders of the issues within each"

User 177 (Provider/professional, NHS trust)

Some NHS trust respondents provide caveats on the proposal to separate the two service areas, raising issues that include:

- The risk of separate inspections overlooking the impact of waiting times and/or standards in diagnostics imaging on outpatient services;
- The risk of overlooking the journey of people who use services through related outpatient and diagnostic imaging services; and
- The significant financial commitment providers make in providing evidence to CQC during inspections.

Some NHS trust respondents suggest ways the proposal can be strengthened, these include:

- Ensuring that co-dependencies and shared pathways are not overlooked, particularly those in which outpatient and diagnostic imaging services are closely linked, such as ophthalmology;
- Improving the customer service standards of provider reception and administrative staff;
- Applying the proposal to underperforming trusts only;
- Consulting on the proposal directly with clinical leads from the two areas;
- Consider whether CQC needs to know who providers outsource their imaging services to; and
- Providing information on the decision-making process CQC is taking to consider separate inspections for diagnostic imaging.

Comments from other respondents

Respondents from outside of NHS trusts or independent healthcare submitted 171 responses to question 9b. A large proportion of these responses do not provide comment on the question.

Many of the respondents express support for the proposed approach to inspecting diagnostic imaging as an additional service, separately from the outpatients core service without specifying a reason for this support. A few supportive respondents explain that separate inspections for the two service areas is welcome because they are distinct services. A couple believe that the proposed approach would have positive impacts for diagnostic imaging providers, for example:

"A number of […] members have expressed frustration that the existing inspection arrangements do not allow for a separate assessment of diagnostic imaging services. It is encouraging that front-line employees are keen to demonstrate the quality of the services that they provide. Consequently, we welcome the change to dis-aggregate the diagnostic imaging service from outpatients"

User 455 (Provider trade body or membership organisation)

Some supportive comments specifically support a move towards accreditation schemes becoming more important.

Some respondents provide constructive feedback on the proposed approach. This includes the desire to see inspections of the two service areas undertaken flexibly; garner feedback from people who use services; and not overlook the interdependencies between the two service areas, especially in certain specialisms such as ophthalmology.

"Separating diagnostic services where this is clearly a significant and separate or standalone service is acceptable but some services have both of these so closely interlinked and specialty specific that it would be better inspecting them as a whole and this is usually the case with ophthalmology"

User 166 (Provider trade body or membership organisation)

A few respondents specify concerns about:

- Transparency around the decision to separate diagnostic imaging out as an additional service and, for example, request that it is based on a complete consultation process and reflects the views of all key stakeholders; or
- The risk that issues of concern within trusts will be overlooked if the service areas are inspected separately.

Some respondents suggest a way in which the proposal can be strengthened, these suggestions include:

- Incorporating outpatient services into the CQC core service of surgery or medicine;
- Looking to garner feedback from people who use services by methods such as phone calls about services they have used in the last six months;
- Considering the impact of waiting times on people who use services and other, related service areas;
- Ensuring CQC inspections don't adversely impact provider service delivery or the level of service received by people who use services;
- Ensuring out-of-hours services are inspected; or
- Considering how best to inspect diagnostic imaging where NHS trusts outsource these services to providers in the independent sector, for example by inspecting these providers at the same time.

"… there are many cases where NHS trusts contract out their diagnostic imaging to independent providers. ...it is only possible to understand the impact on patients by considering how the organisations work together. Therefore, it makes sense to carry out inspections of trusts and their contracted diagnostic imaging services concurrently wherever possible".

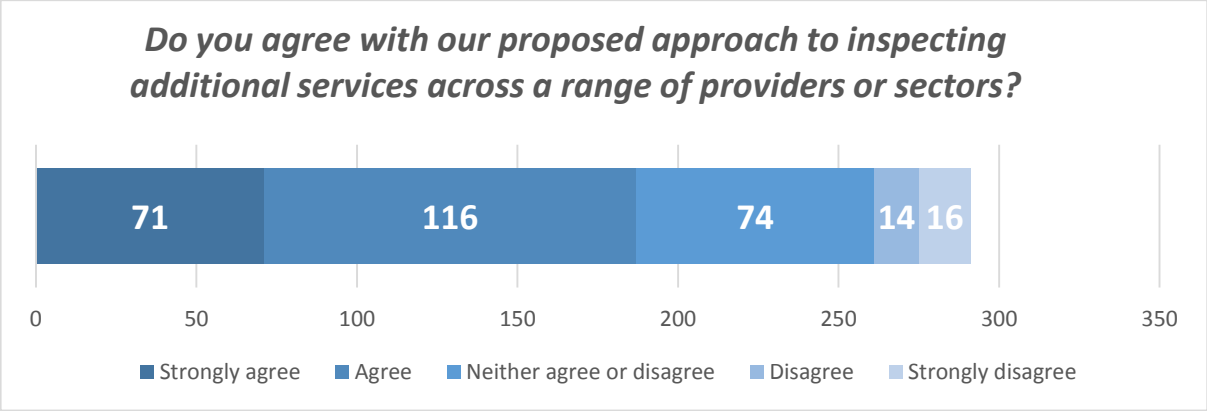
User 352 (Provider body or membership organisation)

Several respondents suggest that CQQ only endorse accreditation schemes for diagnostics services that are based on the Imaging Services Accreditation Scheme standards developed by radiographer representative bodies, such as United Kingdom Accreditation Service.

6.2.5 Responses to question 10a (additional services)

Of the 496 responses to the consultation, 291[17] were in response to question 10a, which states: ***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?***

Figure 3 - Responses to question 10a



The majority of responses[18] to this question (187) either agree or strongly agree with CQC's proposed approach to inspecting additional services across a range of providers or sectors. A comparatively small amount of responses (30) disagree or strongly disagree with the question. A further 74 respondents indicate a neutral stance, neither agreeing nor disagreeing.

6.2.6 Responses to question 10b (additional services)

Of the 496 responses to the consultation, 230[19] were in response to question 10b, which states: ***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.***

[17] See breakdown: Table 2-5: Count of respondents by question by "responding as"

[18] See breakdown: Table A-0-3: Responses to Q10a by overall respondent category

[19] See breakdown: Table 2-5: Count of respondents by question by "responding as"

Overall sentiment

Analysts categorised respondents' comments to question 10b for the overall sentiment they appeared to convey about CQC's proposed approach to inspecting additional services.

Of the 303 responses to question 10b, 185 express an overall sentiment. Analysts identified these sentiments as follows:

- 116 responses were identified as conveying a positive overall sentiment. These responses state agreement with CQC's proposed approach to inspecting additional services, most often highlighting the potential for ensuring consistency of standards across services;
- 40 responses were identified as conveying a sentiment of 'constructive criticism', meaning they discuss issues or suggestions specific to the proposals, querying for example the size and frequency of additional service inspections;
- Seven responses were identified as conveying a neutral overall sentiment;
- 13 responses were identified as conveying a sceptical overall sentiment, questioning the merit of the proposal without fully dismissing it. These respondents express concerns such as the potential ambiguity or overlap between core and additional services;
- Nine responses were identified as conveying a negative overall sentiment. Several of these responses argue that aggregation should be applied following additional service inspections.

A total of 118 responses were identified as expressing no overall sentiment. This includes responses that state 'no comment' as well as responses to question 10b focusing on topics other than CQC's proposed approach to inspecting additional services.

The summary of comments on the proposed CQC approach to inspect additional services is broken down by respondent type: in turn it covers responses from:

- NHS trust providers and professionals;
- Other respondents (e.g. provider trade bodies and membership associations; members of the public; local authorities; and other stakeholders and representative groups).

Comments from NHS trust providers and professionals

Supportive comments

Consistency of standards across services

Many NHS trusts respondents comment on the additional service inspections' potential for ensuring consistency of standards across services. Respondents often describe the proposals as facilitating a 'system-wide' or 'whole spectrum' view of service quality. Others argue that this approach would benefit the recent increase in provider collaboration. This

includes shared care approaches and schemes such as Sustainability and Transformation Plans. Respondents also relate the consistency of standards across services to the inspection methodology. They comment that it will help better assess service integration and continuity of care, instead of considering core services in isolation.

A system wide approach is crucial to assess the quality and safety of a patient's care pathway/journey

User 97 (Provider/professionals, NHS trust)

In relation to consistency of care, several respondents comment that inspecting additional services will improve service standards in general. Common themes include improving patient safety and increasing the scrutiny of partner services which work with core services and may indirectly affect their service quality. Other respondents highlight the potential for CQC's proposals to increase the public and patients' confidence in services.

Inspection across all services

Some respondents highlight their belief that all services which provide care should be inspected, and that CQC's proposals subscribe to this principle. A few respondents go further to say that all services which provide care should be held accountable.

Support for providers

A few NHS trusts comment on the potential for additional service inspections to benefit providers. Respondents give reasons such as adapting to the way that modern providers operate as well as allowing providers to oversee the quality of additional services carried out by other organisations.

Methodology

A small number of respondents explicitly support the proposals' methodology. These include CQC's decision not to aggregate ratings from additional service inspections, the potential for shared learning on inspection methodology and supporting enforcement following inspections. None of these respondents qualify these statements of support.

Issues and suggestions

Implementation

Some NHS trusts respondents who are sceptical or provide constructive criticism highlight potential issues with how these proposals would be implemented. Several of these comments are phrased as queries requesting more clarity on how the proposals would work in practice, such as the size or frequency of inspections. Other NHS trust respondents support the proposal but request that it is undertaken with principles such as consistency and integrity.

Respondents also make suggestions for how the proposals could be implemented. This includes following care pathways, avoiding potential duplication where there is overlap with core services as well as reducing the frequency of repeat inspections where a service is assessed at an acceptable level.

Aggregation of ratings

Several NHS trust representatives highlight perceived issues with CQC's proposal that additional service inspections would not affect the overall trust-level ratings. Some of these respondents query how this lack of aggregation would work in practice. This includes clarifying the boundaries between core and additional services where these work closely together. Other respondents argue that the quality of any part of a provider, good or bad, reflects on the provider and that because of this, the inspections should affect the overall rating.

"However it is not very clear from the consultation that when assessing the service (rather than the provider) how the aggregation rules will apply i.e. ratings of services inspected under this approach would not affect overall trust-level ratings. Good or bad."

User 97 (Provider/professional, NHS trust)

Categorisation of 'additional services'

A few respondents commented on which services should be categorised as 'additional services'. These include:

- Suggestion that the maternity pathway should include early pregnancy care; and
- concern that gynaecology is defined as an additional service when it does not have its own accreditation scheme as diagnostic imaging does.

Comments from other respondents

Supportive comments

Consistency of standards

Of the other respondents who make positive comments, many comment on the proposal's potential for ensuring consistency of standards across different types of services. Respondents often describe the proposed approach as facilitating an 'overview' or 'whole picture' of service quality. Others relate this potential benefit to the inspection methodology, commenting that it would help better assess service integration and continuity of care, instead of considering core services in isolation. Several respondents also comment that creating consistency of standards allows the public and those who use care to better compare services.

"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."

User 102 (Voluntary/community sector individual)

In relation to consistency of care, some respondents comment that CQC's proposed approach will improve service standards in general. Common themes include patient safety, reduced time in hospital and increasing the scrutiny of those who provide poor quality care. Other respondents highlight the potential for CQC's proposal to increase the public's confidence in services.

Inspections across all services

Many respondents highlight their belief that all services which provide care should be inspected, and that CQC's proposals subscribe to this principle. Some respondents go further to suggest that services which provide care should be held accountable. Others qualify their comments by stating that all services should be inspected 'at some point', indicating that not all services necessitate the same frequency of inspections.

"I cannot stress enough that all services being provided to the public should be inspected."

User 95 (Provider/professional, adult social care)

Methodology

A few respondents make positive comments regarding the proposed approach's methodology. One common point is the potential for shared learning and best practice: respondents argue that the more inspections that take place, the more CQC can refine its inspection methodology. Other respondents praise CQC's decision not to aggregate ratings, meaning that the additional services inspections would not affect the overall rating. None of these respondents qualify their reason for supporting this part of the methodology.

Support for providers

A small number of respondents comment on the proposed approach's potential to benefit providers, citing reasons such as decreased bureaucracy and a more suitable arrangement to reflect how modern providers operate through collaboration and across geographic locations.

Issues and suggestions

Implementation

Some respondents who are sceptical or provide constructive criticism highlight issues about the implementation of the proposed approach. Most of these comments are phrased as queries requesting more general clarity on how the proposals would work in practice and how they would help improve service quality. Another more detailed query asks how services can be assessed separately when they are within the same system as core services. In relation to this, some respondents express a concern that providers may give additional services less attention than core services in terms of service improvement. Respondents also request clarity on the frequency of additional service inspections and whether the inspections would be across the country or 'place-based'.

"We understand that there are general concerns about the integration of services across a range of providers along a patient pathway, but to turn this into an actionable programme, there must be more clarity about specific problems that the CQC aims to address through this approach, and in turn how the proposed approach will help."

User 352 (Provider trade body or membership organisation)

In addition to highlighting potential issues, some respondents make suggestions for how CQC should implement the proposed approach for inspecting additional services. One common suggestion was to base inspections on the pathways or care plans of those who use care. Other respondents suggest, as a caveat to their support, that this approach should be tried or piloted to determine its level of success. Borrowing from CQC's proposals for core services, a few respondents suggest that more additional service inspections should be announced. Other respondents suggest using volunteers to assist with additional service inspections.

Categorisation of 'additional services'

A few respondents comment on which services should be categorised as 'additional services'. Some of these respondents suggest alterations to CQC's proposals, for example including:

- national diagnostic centres within diagnostic imaging,
- the different aspects of gynaecology within core services,
- mental health with emergency department inspections, and
- integrating maternity with perinatal health services and sexual health services.

Other respondents suggest a variety of services that could be inspected beyond those that CQC proposes. These include:

- day services;
- ophthalmology;
- psychology/psychotherapy; and
- social services/social work cases.

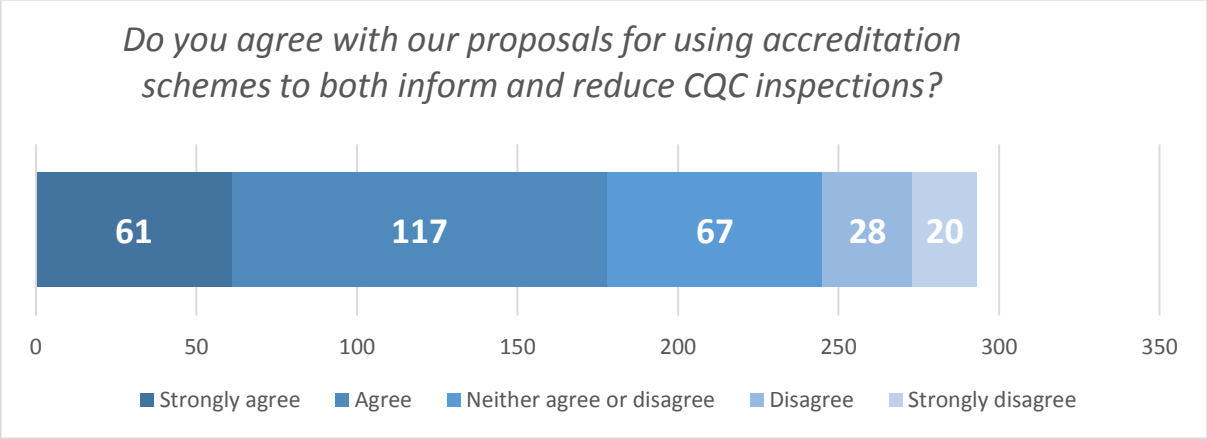
Aggregation of ratings

A small number of respondents highlight perceived issues with CQC's proposal that additional service inspections would not affect the overall trust-level ratings. Some of these respondents query how this lack of aggregation would work in practice. Others worry that there could be a decrease in accountability for these services, or that providers may give less attention to improving these services.

6.2.7 Responses to question 11a (accreditation schemes)

Of the 496 responses to the consultation, 293[20] responded to question 11a which asked: ***Do you agree with our proposals for using accreditation schemes to both inform and reduce CQC inspections?***

Figure 4 - Responses to question 11a



The majority of responses[21] to this question (178) either agree or strongly agree that accreditation schemes could be used to inform and reduce CQC inspections. A smaller number of respondents (48) either disagree or strongly disagree. 67 respondents state that they neither agree nor disagree.

[20] See breakdown: Table 2-1: Count of overall respondents by "responding as"

[21] See breakdown: Table A-0-4: Responses to Q11a by overall respondent category

6.2.8 Responses to question 11b (accreditation schemes)

Of the 496 responses to the consultation, 257[22] responded to question 11b which asked: ***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.***

Overall sentiment

Analysts categorised respondents' comments to question 11b for the overall sentiment they appeared to convey about CQC's potential use of accreditation schemes to inform and reduce CQC inspections.

Of the 257 responses to question 11b, 203 express an overall sentiment. Analysts identified these sentiments as follows:

- 112 responses were identified as conveying a positive overall sentiment. These responses support the use of accreditation to potentially reduce burden and use of resources on inspections.
- 41 responses were identified as conveying a sentiment of 'constructive criticism', meaning they discuss issues or suggestions specific to the proposal, for example CQC providing more clarity on specifically how accreditation schemes would be used and which ones preferred. They also query the overlap in data used by CQC and such schemes
- Two responses were identified as conveying a neutral overall sentiment;
- 18 responses were identified as conveying a sceptical overall sentiment, questioning the merit of CQC's proposals around use of accreditation schemes without dismissing them. They suggest that use of such schemes should not replace CQC inspections, due to their variability and reach.
- 30 responses were identified as conveying a negative overall sentiment. These responses generally argue that accreditation schemes are not well understood by the public, that they have limited reach across services and that their use would not likely support quality improvement beyond CQC's role. Some see seeking accreditation as an additional burden, particularly if it is not clear how this sits alongside CQC's role.

A total of 54 responses were identified as expressing no overall sentiment. This includes responses that state 'no comment' as well as responses to question 12 focusing on topics other than CQC's approach to trust-level ratings.

The summary of comments on the question about accreditation is broken down by respondent type – in turn it covers responses from:

[22] See breakdown: Table 2-1: Count of overall respondents by "responding as"

- NHS trust providers and professionals;
- Other respondents (e.g. provider trade bodies and membership associations; members of the public; local authorities; and other stakeholders and representative groups).

Issues raised by NHS trusts

Supportive comments

These comments focus on how using accreditation schemes to support CQC's ratings approach could reduce duplication of effort and support transparency, where the accreditation scheme is clear.

"Helps to reduce duplication and reduces the burden on staff providing the same information twice but in a slightly different way"

User 234 (Provider/professional, NHS trust)

Many NHS trusts that had gone through the accreditation process see value in how they contribute to internal approaches to improvement and learning, and consistency of standards across certain services. Specific accreditation schemes – for example ISO accreditation, Clinical Pathology Accreditation (CPA), and the Joint Advisory Group (on GI Endoscopy (JAG) – are recognised as high quality by some respondents.

Issues and suggestions

Suggestions covered issues related to powers of accreditation schemes, their role in relation to CQC and 'replacing' CQC's role, communication to the public, and burden related to seeking accreditation.

Several respondents discuss enforcement of accreditation, in terms of what power CQC would have to enforce accreditation uptake or compliance with its terms. Many feel that CQC would need to be clear about which accreditations would be considered and what their relationship to CQC ratings would be in terms of weighting. To avoid burden, NHS trusts ask CQC to look in parallel at what both CQC ratings and different accreditation schemes consider – in particular, with reference to how accreditation schemes align with the KLOEs. They express concern that CQC might assume that providers using accreditation schemes are of better quality than those that do not – a statement they contest.

Communication about accreditation schemes more broadly is a common theme throughout responses to Q11b. Many argue that the purpose and scope of accreditation schemes should be clarified to the public, and that there would need to be a common understanding between CQC and providers about the value of accreditation.

Many NHS trusts respondents feel that accreditation schemes, while potentially useful, should not replace CQC ratings. This is mainly due to concerns about variation in schemes,

and the reliability of the approach taken by each. Some feel that, currently, schemes have limited reach across services. Several respondents feel that the CQC approach to use of accreditation needs further consultation.

"…there would be a need to ensure that the frameworks were consistent and addressed areas from Key Lines of Enquiry".

User 239 (Provider/professional, NHS trust)

With regards to burden, one respondent raises a concern about the impact that requirements around accreditation would have on CQC ratings – if the CQC process was to become more light touch due to increased use of accreditations, there is concern that this would simply lead to more work, and resources being called for, by accreditation bodies.

A small number of respondents discuss the cost of accreditation schemes, noting that these would be additional to fees paid to CQC, which themselves are increasing.

Issues raised by other respondents

Issues and suggestions

These comments cover issues around provider fees, comparability of data used by CQC and accreditation schemes, the role of accreditation and the extent to which it would 'replace' CQC's role, and how these schemes may inform the public.

Some comments from provider trade bodies/membership organisations and other providers note that provider fees to CQC are considerable, and the cost of accreditation would need to be considered alongside this. Similarly, many respondents feel that other resource, such as staff time, put into the accreditation process could be high. They emphasise that resource consumed by both CQC inspections and accreditation does not become disproportionate.

Further comments and queries discuss the quality and nature of specific accreditation schemes. Some respondents ask whether the quality of data and intelligence used by accrediting bodies is similar to that used by CQC.

Additionally, a high proportion of respondents feel that accreditation schemes should not replace CQC ratings. Respondents are concerned about their robustness in comparison to the CQC process, the frequency of accreditation compared to CQC annual inspections, and variation across accreditation schemes.

Respondents request further clarity on how accreditation schemes would be used alongside or in place of CQC ratings, and whether they would relate to powers of enforcement e.g. where poor care is found.

Comments also discuss the role of ratings in informing the public about services, and the need therefore to ensure that accreditation plays a similar role. They suggest that the specific features of individual schemes would need to be communicated carefully to this audience.

6.3 Rating: Responses to question 12

Of the 496 responses to the consultation, 242[23] responded to question 12 which asked: ***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)?***

Overall sentiment

Analysts categorised respondents' comments to question 12 for the overall sentiment they appeared to convey about CQC's current approach to trust-level ratings (including the new use of resources rating.

Of the 242 responses to this question, 160 express an overall sentiment. Analysts identified these sentiments as follows:

- 25 responses were identified as conveying a positive overall sentiment. These responses support the current approach, for example because it seems to be clear and supports accountability for care. They also express that the use of resources rating is fit for purpose;
- 76 responses were identified as conveying a sentiment of 'constructive criticism', meaning they discuss issues or suggestions specific to the proposal, for example making sure the ratings better reflect the context of services such as size or local needs, and the feeling that CQC inspectors should take a flexible approach or engage in more dialogue with services around ratings decisions;
- 19 responses were identified as conveying a neutral overall sentiment;
- 18 responses were identified as conveying a sceptical overall sentiment, questioning the merit of CQC's approach to trust-level ratings without dismissing it. They tend to express concern about the negative impacts of ratings, including inability to reflect certain aspects of care such as joint-working between services, that they do not adequately capture changes in services between inspections, and impact on staff morale, for example;
- 22 responses were identified as conveying a negative overall sentiment. Several of these responses argue that the current ratings approach does not promote improvements in care, for example, or are not meaningful to patients and the public.

A total of 82 responses were identified as expressing no overall sentiment. This includes responses that state 'no comment' as well as responses to question 12 focusing on topics other than CQC's approach to trust-level ratings.

[23] See breakdown: Table 2-1: Count of overall respondents by "responding as"

The summary of comments on the question about trust-level ratings is broken down by respondent type – in turn it covers responses from:

- NHS trust providers and professionals;
- Other respondents (e.g. provider trade bodies and membership associations; members of the public; local authorities; and other stakeholders and representative groups).

Issues raised by NHS trusts

Supportive comments

Some respondents emphasise the importance of clarity in the approach to rating services. This is both in terms of transparency of decision-making to the provider and clarity to the public and patients about what each rating means. Some respondents feel that the current approach is clear to both, and that the public now have a good level of awareness of CQC ratings. A small number suggest that ratings are important for prompting improved performance, and are a way to hold providers accountable for quality.

"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."

User 490 (Member of local Healthwatch)

NHS trust respondents who discuss mergers all welcome proposals to report separately on recently-merged providers for a defined period of time. They also welcome increased joint-working between CQC and NHS Improvement.

Issues and suggestions

Timing of ratings

Several respondents raise queries or concerns related to the timing of CQC rating decisions, and the limitations these place on interpreting the ratings as well as how they relate to quality improvement. They note that it would be difficult to see if quality had rapidly improved or deteriorated between rating decisions, and that if only some aspects of provision would be assessed regularly – for example, the "well-led" aspects of services – then this should be made clear in ratings reports. Some are concerned that certain services would have long intervals between assessments, and that this would limit the speed with which NHS trusts could demonstrate improvement.

Informing the public and patients

Another common theme amongst the NHS trusts respondents is the role of CQC ratings in informing the public and patients, and transparency to providers about how decisions are

made. Many respondents feel that the latter needs improvement, and one respondent notes that better presentation of ratings could improve staff morale.

Several respondents feel that wider communication around rating decisions could be improved, particularly in terms of reflecting quality within individual services. Some feel that any changes to rating methodology in light of the development of new models of care should be carefully considered with regards to clarity.

"… 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."

User 355 (Provider/professional, NHS trust)

Similarly, some NHS trusts note that it would be helpful for ratings to provide a picture of change across time rather than the current "snapshot" approach.

Similar points around communication are made about rating reports. Some feel that these are too long, making them particularly inaccessible to patients and the public, and welcome shorter, condensed reports.

Methodology

In general, several comments suggest continued monitoring of the relevance of the current approach to ratings as new models of care develop. Some NHS trusts respondents query how the use of resources rating will apply across different provider models. Others seek additional clarity on how new inspections for cancer and mental health services might impact on overall ratings for core service inspections.

Many comments discuss the granularity of ratings or how different metrics are weighted within overall trust-level ratings. They express concern about the link between quality of individual services or individual locations within a wider provider, and the aggregate rating. The comments suggest that making it explicit which services had been assessed when reporting to promote clarity, or making the amount of assessment proportionate to provider size:

"We believe the ratings need to be proportionate to the size of the service. For example an overall rating for a group of social care homes or smaller units would be helpful which could potentially equate to the size of a core service."

User 433 (Provider/professional, NHS trust)

Similarly, some respondents query how well aggregation works for larger, complex trusts, and several comments state the importance of reflecting each provider's context in the rating. Another respondent suggests putting in place individual ratings which would correspond with the different KLOEs, providing a more targeted view of different elements of

services. However, one comment notes that splitting out inspection of certain services, for example maternity and gynaecology inspections, could lead to more targeted ratings.

Similarly, some respondents discuss comparability across different types of trust, noting that the rationale for rating decisions had not always been clear. Some of these comments welcome safeguards designed to minimise the risk of inconsistency, and consider that the proposed changes to the assessment framework would improve clarity of rating decisions, but suggest that further thinking on this issue would be helpful.

Some respondents express concern about the scope of CQC ratings – several would like to see substance misuse services included, for example.

A small number of NHS trusts respondents make comments on evidence collection within inspections, requesting that inspectors talk to a wide range of staff, volunteers and patients. One respondent suggests that it would be helpful for providers to be able to check the accuracy of evidence collected by inspectors. Another (one) respondent suggests that there is a potential inequity in how NHS and independent providers are assessed, given that use of resources does not apply to the independent sector.

Most comments on use of resources suggest that this should be rated separately and not included in the overall trust-level rating. Some respondents do not want use of resources to be aggregated for a whole trust, for example where the trust comprises multiple locations and services. One comment notes that independent providers are not rated based on use of resources. A small number of comments suggest that use of resources should be part of the well-led KLOE, and considered as an aspect of leadership.

Issues raised by other respondents

Supportive comments

Supportive comments tend to emphasise the importance of ratings in informing the public and driving quality improvement, and to suggest that awareness of the current ratings is high. However, they stress that the process for aggregating measures of different services should be transparent. Other respondents suggest the continued need to increase understanding of the ratings and how they apply to specific services. One suggestion is to work more closely with Royal Colleges and professional bodies in the ongoing development of ratings.

Issues and suggestions

Methodology and scope

Regarding methodology, several respondents suggest that the ratings approach should consider:

- The specific context of local areas and health economies;

- Proportionality, for example how individual adverse events are judged in relation to overall service performance;
- A dynamic view of performance, accounting for real-time service change;
- Types of evidence used - measures informing rating decisions should be continually reviewed to determine whether they are giving a full picture of the quality of care;
- Further research to look at the approach to assessments, for example considering reliability of approach amongst inspectors; and
- Patient and service user feedback to inform rating decisions.

A small number of comments discuss specific disparities between how ratings would affect services. For example, while adult social care providers are not rated, NHS trusts which provided an element of adult social care would be rated.

Some comments cover the need to ensure appropriate training and expertise of inspectors, particularly on subjective issues and in specialist sectors, to promote consistency.

Similarly to NHS trusts respondents, other respondents note the need for flexibility in the approach to ratings to account for quality across different locations, providers who are collaborating on service provision, and increasingly complex services within individual providers. Some feel that more detail on this is needed:

"Ideally a clear methodology will eventually merge. Not only do you need to consider where trusts merge or work together but also where providers supply good quality services to challenged organisations, how will you tease apart the issues from the provider and from the host?"

User 166 (Provider trade body or membership organisation)

Use of resources

There is some concern, particularly from Royal Colleges, that aggregating quality measures and use of resources into a single rating would be unhelpful when informing the public about service quality, though this view is not shared by all respondents who commented on this.

Some respondents request further detail about the working relationship between CQC and NHS Improvement on this measure. Several comments stress the constraints of the overall funding environment within the NHS.

Regarding collaboration, one respondent queries how collaboration between trusts, and therefore efficiency in resource use, would be reflected in the use of resources rating:

Further comments query whether the measure would take into account:

- Wider funding and commissioning constraints;
- Service takeovers and mergers;

- Different levels of responsibility for resources across trusts (between leaders and service managers, for example) in relation to the well-led KLOE.
- One respondent also suggests that the use of resources rating could be used for comparative discussion amongst providers, and sharing of best practice.

There are different ideas about how to achieve a balance between clarity, and recognising the complexity of provision. Some feel that the current ratings system is easy to understand, but others caution against oversimplification that would mask different issues across a complex set of services. Again, one suggestion is to include a breakdown of ratings across KLOEs.

Supporting the public and providers

Several comments emphasise the importance of public understanding of CQC ratings. Many feel that work is needed to improve understanding, and to make ratings themselves meaningful to the public. Therefore, they suggest:

- More granular ratings corresponding to specific services to inform the public when considering services, or advocate for improvements in local services. Many respondents feel that more detail is needed on how ratings will adapt as new models of care develop.
- Ratings could be expressed as a range rather than a single measure.
- More concise, accessible reports.

Ratings could be made more specific to local services to increase their meaning for service users in the surrounding area.

Several, general comments refer to the readability of ratings reports – these respondents feel that reports tended to be quite long and therefore could be made more succinct and accessible to non-experts.

Similarly, some comments address how to make rating decisions clearer to providers. They suggest that rating decisions should include more targeted information for providers on how they might achieve an improved rating, and faster action around rating changes when improved quality is acknowledged. Some respondents discuss cases where ratings decisions were felt to be arbitrary, and note that considerable time is spent by providers checking the accuracy of reports.

A small number of respondents make general comments that poor ratings, especially where the rationale for the decision is not clear, negatively impact staff morale and recruitment.

6.4 Comments on CQC's proposals for regulating NHS trusts from independent healthcare providers and professionals

This section summarises comments from respondents who describe themselves as independent healthcare providers or professionals. It covers all the proposals and their

associated consultation questions discussed in sections 6.1, 6.2 and 6.3 above. Please note that in the above sections, responding independent healthcare providers and professionals are included in the quantitative information for questions 10a and 11a, as well as the overall sentiment count for each open question.

Only a small number of respondents who identify themselves as providers or professionals in the independent healthcare sector[24] – up to 12 – responded to questions 5-12 of the consultation. Respondents from the independent sector regularly indicate that they have no comments to make in response to questions that are specific to NHS trusts.

Where independent healthcare providers and professionals do respond to these consultation questions, they frequently state support for CQC's proposals. There are instances where respondents from the independent sector express some criticism, but outright negative comments are very rare.

Question 5: CQC Insight approach and strengthening relationship management

Some comments from independent healthcare providers and professionals on the new CQC Insight approach echo those of respondents from NHS trust providers and professionals, such as requests to consider the impact on provider resources and comments about sharing findings with providers. A few respondents question how the new CQC Insight approach might work for providers in the independent sector, citing issues around data sharing and benchmarking. One respondent highlights the importance of flexibility, saying this is needed for a level playing field for NHS and independent providers.

On strengthening relationship management, a few respondents are positive about regular engagement meetings. One respondent requests that CQC provides a feedback loop to share insights from staff engagement with the management of the provider.

Question 6: Provider Information Request (PIR) process approach

- Independent healthcare providers and professionals comment that: they have caveats about the accuracy of information generated through provider self-assessments
- CQC should provide a clear and comprehensive timeframe for submitting the new annual PIR, allowing providers to plan for this.

Question 7: Inspection of core services and the well-led key question

Comments from independent healthcare providers and professionals include:

- Query whether these proposals would be extended beyond NHS trusts;

[24] See breakdown: Table 2-6: Counts by individual question for sector

- Concern that annual inspections are not frequent enough;
- Query on how focus groups will be arranged when inspections are unannounced.

Question 8: Unannounced core service inspections

Respondents who indicate support for the proposal about unannounced core service inspections say that it would:

- Enable CQC to observe the standard of care given by providers who are not prepared for an inspection;
- Support the consistent provision of care by providers.

A few respondents note the need for CQC inspections to be flexible to avoid causing large disruptions to the services of providers. Respondents also comment on the risk that key staff are not available on inspection day if no notice is given.

Question 9a: Maternity and gynaecology core services

Comments from independent healthcare providers and professionals include:

- A concern that inspecting gynaecology separately from other surgical specialities places a disproportionate burden on providers in gynaecology relative to providers of other surgical specialities;
- The possibility of generating disparity between the NHS trust and independent sectors, with respondents expressing concern that the proposal would result in different inspection regimes for gynaecology providers between the NHS and the independent sector.

Question 9b: Outpatients and diagnostic imaging core services

Respondents from the independent healthcare sector express support for the proposal to inspect the two service areas separately. One respondent states:

"This is a positive step as they are two very different services and diagnostic imaging services should be working towards accreditation."

User 58 (Provider/professional, independent healthcare)

Question 10b: Inspecting additional services

A few respondents commented on this question, highlighting for instance:

- the importance of inspecting all types of services; and
- the need to restrict inspections where there is need for concern.

Question 11b: Using accreditation schemes

Independent providers and professionals ask CQC to be clearer about how it would consider accreditation schemes. Respondents express concern that they would need to deploy additional resource to gain accreditation, where this would not be useful for assessing quality. However, others believe the effective use of accreditation schemes could reduce duplication and burden.

Question 12: CQC approach to trust-level ratings

Respondents' comments focus on the importance of succinct, clear communication to the public about ratings.

7. Other comments from pre-consultation events

Seven pre-consultation events were held in the final months of 2016, consisting of a series of meetings held between CQC and staff from key stakeholder organisations. The number of attendees varied for each event, from five to over 60. Attendees ranged from health professionals and managers of varying levels of seniority, CQC inspection staff, voluntary and community sector organisations, people who use health or care services and their carers, representatives from foundation trust councils of governors, and councillors and council scrutiny officers.

These events focused on discussion of the draft consultation proposals – some events focused on single issues, such as KLOEs relevant to specific sectors - and how partnership working with the organisations represented could be made more effective.

Registering the right support guidance

Stakeholders were concerned about the implications of the National Institute for Health and Care Excellence (NICE) guidance on "small" providers. They generally felt that funding availability would limit the development of small homes, and some raised concerns about how the definition applies to different styles of accommodation (e.g. "campus" style homes). Attendees noted that, in some cases, homes with large numbers of beds had been rated Outstanding.

CQC regulatory approach

Comments addressed how CQC must balance managing relationships with providers and robust regulation, avoiding becoming "too light touch". Stakeholders also felt that CQC could do more to align with local councils around the approach to scrutiny, and could consider how to feed findings and evidence into the work of other national bodies (for example, the Healthcare Quality Improvement Partnership).

Some stakeholders suggested practical changes such as more timely delivery of inspection reports for providers to consider, increased clarity on how CQC conceptualises good leadership, and clarity on the triggers for re-inspection.

User engagement was another frequently-mentioned theme. CQC staff in particular noted the value in engaging with local Healthwatch on issues such as problematic transfer between services, and many felt that there is potential for CQC to work more with Independent Mental Capacity Advocates.

Relationship management

Comments from events suggested that increased communication, for example with foundation trust governors, would be desirable around inspections and in an ongoing manner. Some stakeholders felt that inspection reports could be shared with providers for discussion before wider release.

Quality care and the 'caring' KLOE

Stakeholders felt that several factors impact on how 'caring' a service may be, including how well staff understand the service user, user control over their own care, and provider investment in compassionate and well-trained staff. Some made suggestions about topics that the 'caring' KLOE should address, such as the anticipation of equalities needs, support for staff, and the handling of transfers between services. Some shared thoughts on how to move from a good to outstanding rating, for example working closely with the wider community and community groups.

CQC Experts by Experience

One event aimed to discuss the role of CQC Experts by Experience (ExE): individuals with direct experiences of using specific services who support CQC inspectors in their roles and help gather the views of other individuals with specific health or care needs. Key issues raised included the need for more ExEs to support core services inspections, involving ExEs more at the pre-inspection stage, better publicising the role of the ExE, and using ExE quotes in CQC inspection reports.

8. Other comments about CQC and wider context

It is common in consultations for respondents to make comments outside the scope of the specific questions, which touch upon the wider environment in health and social care, or general thoughts about CQC. The below sections discuss the main issues raised amongst these types of comment.

Overall comments about CQC

Many respondents express a general view about CQC as an organisation or its role in the wider health and social care system. Those who make comments about CQC outside the scope of the questions more often make negative comments, though several make positive comments. This is to be expected, because respondents with negative views about CQC as an organisation are more likely to disagree with the premise of the consultation questions and therefore need to make comments about CQC outside of their scope. The below summary should be read with this in mind.

Amongst these, many are comments for example expressing doubt about the role of CQC being a main driver of quality improvement compared to other factors, or comments about the general burden of inspections and assessment. Some feel that the CQC as an organisation is too large, and many express anxiety about use of resources needed for inspections or to run CQC in general in a wider context of financial austerity.

Positive comments, however, tend to express confidence in the inspectorate team or welcome the strategy for 2016 to 2021 and direction of travel.

Other comments address:

- Organisational aims, as some respondents are concerned that these are not always clear, and some caution against 'mission creep' or taking a 'market-shaping' role. They explain that CQC should not shape how services are set up or run, it should maintain its core functions of inspecting, monitoring and rating them. However, a small number of comments support an increased role for CQC in investigating complaints.
- Staff support and retention. These comments say, for example, that inspectors are increasingly expected to understand a wide range of services and should be offered additional training, and that CQC could bring in more staff to cope with increased demand around assessment and inspections.
- Value of CQC in quality improvement. Some respondents suggest that inspections do not create improvements in services; rather that investment and other contextual factors create this. Others suggest that some aspects of the assessment framework, such as the presence of 'innovation' are too subjective to be fairly assessed.

- Transparency and trust. These comments note that some health professionals do not have full confidence in the evidence base used by CQC, or note that increased transparency around decision-making (particularly relating to borderline decisions) would improve confidence.

Criticism of CQC approach and perceived poor practice

Several respondents offer criticisms either of CQC's approach to assessment in general – for example, citing impact of inspections on staff morale or the perceived inflexibility of the approach – or making specific criticisms about its impact. For example, some respondents feel that there is not enough compliance with the Mental Capacity Act and this is not being detected by assessment. A few comments address specific experiences of apparently poor care that they feel are not being addressed by CQC, such as repeated inability to get a GP appointment, lack of access to interpreters, or poor understanding of disabilities from some healthcare professionals which would then affect individuals' entitlements to certain benefits. Some also note where the assessment framework might not be designed to detect issues: They suggest CQC may consider lack of verbal abuse but this does not allow an assessment of truly compassionate care.

Some respondents refer to specific examples of their experiences with what they perceive to be poor practice from CQC staff. These include comments on consistency of application of the assessment framework from inspectors, perceived inexperience of inspectors in certain areas, and clarity of reports.

Some respondents highlight equality as an area for greater focus by CQC. While many comments are positive about CQC's approach and praise its attempts to include equality and human rights into its frameworks, others note perceived oversights, such as labelling services specific to women as 'additional' and not 'core' or not detecting equalities problems within providers (e.g. dietary issues related to religion not being catered for in hospitals).These respondents also call for the wording of human rights and equality legislation to be consistent throughout CQC, but overall praise its handling of the subject.

Bureaucracy and burden

Some respondents perceive CQC to be bureaucratic, or excessive in its approach to regulation. Some refer to the size of CQC, suggesting that it should be 'slimmed down'. Others feel that its methods are overly complex and often burdensome. These respondents tend to refer to what they believe are negative consequences on services, namely time spent away from patient care.

Communication

Some respondents feel that CQC's communication with providers is inadequate. They say, for example, that CQC can be defensive or legalistic when providers try to contact them.

Some respondents feel that CQC should have stronger relationships with patient groups. They say that building these relationships would improve CQC's understanding of how they operate.

Some also feel that CQC's internal communication is inadequate because teams appear not to take advantage of data already collected when conducting inspections in other work. Some CQC staff also discuss internal communication, and feel that communication across directorates could be improved.

Provider fees

Some respondents are concerned about increasing provider fees, and caution CQC against further increases. Some of these comments blame rising bureaucracy on fee increases.

Service pressures and funding for health and social care

Some respondents discuss wider pressures on services, such as increased demand across services, need for better equipment, problems with discharge and workforce needs. These comments do not focus on any one sector in particular.

Many respondents are concerned about the current state of NHS and social care funding, and relate their experiences of service pressures to this. Some feel that these circumstances create an extremely difficult environment in which to meet the standards expected by CQC. Many of these respondents call for more investment nationally and for local authorities to alleviate service pressures.

Policy issues

Two key areas relate to comments on policy issues: need for greater integration and parity of health and social care, and greater focus on early intervention and prevention within health and social care services. The small number of comments addressing these issues express scepticism that services are adequately addressing these issues.

Appendix 1: Consultation questionnaire

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 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 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)?

Appendix 2: Coding framework

Below is a key to acronyms used within the codes to analyse the responses to the consultation:

AF – Assessment framework
AFR – Assessment framework references (i.e. references to specific, numbered items)
AFT - Assessment framework themes
C – Context (wider NHS, CQC organisational issues)
CP – Consultation process
CS – Core services
LD – Learning disabilities guidance
NM – New models of care
O – Other (includes e.g. 'no comment' and 'refer to other comment' codes)
PIR – Provider Information Requests
PS – Provider services
R - Ratings
RM – Relationship management
WL – Well-led

AF - Comments on private provision/sub-contracts
AF - CQC - ability/capacity
AF - Effective
AF - End of life care
AF - Issue - accountability
AF - Issue - ASC - feedback from people who use services
AF - Issue - ASC - measuring/rating
AF - Issue - burden/bureaucracy
AF - Issue - Caring
AF - Issue - children's services
AF - Issue - communication
AF - Issue - consistency
AF - Issue - Consistency of application

AF - Issue - Context
AF - Issue - CQC staff/inspectors
AF - Issue - CQC/NHS Improvement joint-working
AF - Issue - effective
AF - Issue - equality
AF - Issue - feedback from people who use services
AF - Issue - flexibility
AF - Issue - Funding constraints
AF - Issue - funding/commissioning
AF - Issue - HC - children's services
AF - Issue - human rights
AF - Issue - implementation/outcomes
AF - Issue - improving services
AF - Issue - informing the public
AF - Issue - innovation
AF - Issue - inspection focus/priority
AF - Issue - inspection frequency
AF - Issue - Inspection timing and/or frequency
AF - Issue - integration of care
AF - Issue - integration of health and social care
AF - Issue - Integration/holistic inspection
AF - Issue - language
AF - Issue - measuring/rating
AF - Issue - medicine
AF - Issue - Methodology
AF - Issue - recognising complexity/variety
AF - Issue - relevance of KLOEs
AF - Issue - responsive
AF - Issue - safe
AF - Issue - staff feedback/wellbeing
AF - Issue - Supporting innovation
AF - Issue - supporting providers
AF - Issue - Takeovers
AF - Issue - technology
AF - Issue - timings
AF - Issue - training
AF - Issue - transition (betw. Health and SC frameworks)
AF - Issue - transparency/clarity
AF - Issue - understanding provider context
AF - Issue - Unintended consequences
AF - Issue - working with others
AF - KLOEs - change/addition
AF - KLOEs - change/addition - positive
AF - KLOEs - suggestion
AF - MCA - issue

AF - MCA - Issue - transparency/clarity
AF - MCA - Negative
AF - MCA - Positive
AF - Medication
AF - Negative/risk - clarity
AF - Negative/risk - effectiveness
AF - Negative/risk - feasibility
AF - Negative/risk - improvement of services
AF - Negative/risk - Need to be more robust
AF - Negative/risk - outcomes/improving services
AF - Negative/risk - prefer no change
AF - No impact anticipated
AF - Overall sentiment - 0 negative
AF - Overall sentiment - 1 sceptical/doubtful
AF - Overall sentiment - 2 neutral
AF - Overall sentiment - 3 constructive criticism
AF - Overall sentiment - 4 positive
AF - Overall sentiment - none expressed
AF - Positive/opportunity - accountability
AF - Positive/opportunity - adequate priorities
AF - Positive/opportunity - alignment
AF - Positive/opportunity - caring
AF - Positive/opportunity - communication
AF - Positive/opportunity - continuity/consistency
AF - Positive/opportunity - continuity/keeping key questions
AF - Positive/opportunity - data collection
AF - Positive/opportunity - data collection/analysis
AF - Positive/opportunity - effective
AF - Positive/opportunity - flexibility
AF - Positive/opportunity - focus/priority
AF - Positive/opportunity - improving services
AF - Positive/opportunity - innovation
AF - Positive/opportunity - integration/holistic inspection
AF - Positive/opportunity - measuring/rating
AF - Positive/opportunity - person-centred care
AF - Positive/opportunity - reduce burden/bureaucracy
AF - Positive/opportunity - responsive
AF - Positive/opportunity - safe
AF - Positive/opportunity - transparency/clarity
AF - Positive/opportunity - understanding provider context
AF - Positive/opportunity - well-led
AF - Principles - Criticism
AF - Principles - H&SC assessment models
AF - Principles - promote transparency/accountability
AF - Principles - Rapid intervention/safety

AF - Principles - suggestion
AF - Principles - User involvement
AF - Process - criticism
AF - Process - Suggestion
AF - Safeguarding - impact on provider
AF - Suggestion - alternative framework setup
AF - Suggestion - implementation
AF - Suggestion/query
AF - Use of resources - comments
AFR - ASC - caring - C1.1
AFR - ASC - caring - C1.2, C1.5
AFR - ASC - caring - C1.3
AFR - ASC - caring - C2
AFR - ASC - caring - C2.1
AFR - ASC - caring - C2.3
AFR - ASC - caring - C2.3, C3.2
AFR - ASC - caring - C3.5
AFR - ASC - caring - C3.6
AFR - ASC - effective - E1.1
AFR - ASC - effective - E1.2
AFR - ASC - effective - E2
AFR - ASC - effective - E2.2
AFR - ASC - effective - E3
AFR - ASC - effective - E4
AFR - ASC - effective - E4.3
AFR - ASC - effective - E4.4
AFR - ASC - effective - E4.5
AFR - ASC - effective - E5
AFR - ASC - effective - E5.1
AFR - ASC - responsive - R1
AFR - ASC - responsive - R1.3
AFR - ASC - responsive - R1.4
AFR - ASC - responsive - R1.5
AFR - ASC - responsive - R1.6
AFR - ASC - responsive - R2
AFR - ASC - responsive - R2.9-2.11
AFR - ASC - responsive - R3.3
AFR - ASC - responsive - R3.4
AFR - ASC - responsive - R3.5
AFR - ASC - responsive - R4
AFR - ASC - responsive - R4.1
AFR - ASC - responsive - R4.7
AFR - ASC - safe - S1
AFR - ASC - safe - S1.1
AFR - ASC - safe - S1.2

AFR - ASC - safe - S1.3
AFR - ASC - safe - S1.5
AFR - ASC - safe - S1.6
AFR - ASC - safe - S2
AFR - ASC - safe - S2.1
AFR - ASC - safe - S2.4
AFR - ASC - safe - S2.5
AFR - ASC - safe - S2.6
AFR - ASC - safe - S2.7
AFR - ASC - safe - S2.8
AFR - ASC - safe - S2.9
AFR - ASC - safe - S3.3
AFR - ASC - safe - S4
AFR - ASC - safe - S4.1
AFR - ASC - safe - S4.3
AFR - ASC - safe - S4.5
AFR - ASC - safe - S4.6
AFR - ASC - safe - S4.8
AFR - ASC - safe - S5
AFR - ASC - safe - S5.4
AFR - ASC - safe - S5.5
AFR - ASC - well-led - W1
AFR - ASC - well-led - W1.2
AFR - ASC - well-led - W1.5
AFR - ASC - well-led - W1.6
AFR - ASC - well-led - W1.8
AFR - ASC - well-led - W2.3
AFR - ASC - well-led - W3
AFR - ASC - well-led - W4
AFR - ASC - well-led - W4.1
AFR - ASC - well-led - W4.4
AFR - ASC - well-led - W4.6
AFR - ASC - well-led - W5
AFR - HC - caring - C1.1
AFR - HC - caring - C1.5
AFR - HC - caring - C2
AFR - HC - caring - C2.2
AFR - HC - caring - C2.3
AFR - HC - caring - C2.4
AFR - HC - caring - C2.5
AFR - HC - caring - C2.6
AFR - HC - caring - C2.7
AFR - HC - caring - C3
AFR - HC - caring - C3.2
AFR - HC - caring - C3.3

AFR - HC - effective - E1.1
AFR - HC - effective - E1.3
AFR - HC - effective - E1.4
AFR - HC - effective - E1.5
AFR - HC - effective - E1.6
AFR - HC - effective - E1.6, E1.7
AFR - HC - effective - E1.7
AFR - HC - effective - E2.1
AFR - HC - effective - E2.2
AFR - HC - effective - E2.3
AFR - HC - effective - E2.4
AFR - HC - effective - E3.1
AFR - HC - effective - E3.3
AFR - HC - effective - E3.7
AFR - HC - effective - E4.1
AFR - HC - effective - E4.2
AFR - HC - effective - E4.3
AFR - HC - effective - E4.4
AFR - HC - effective - E4.5
AFR - HC - effective - E5
AFR - HC - effective - E5.1
AFR - HC - effective - E5.2
AFR - HC - effective - E5.3
AFR - HC - effective - E5.4
AFR - HC - effective - E5.5
AFR - HC - responsive - R1
AFR - HC - responsive - R1.3
AFR - HC - responsive - R2
AFR - HC - responsive - R2.1
AFR - HC - responsive - R2.10
AFR - HC - responsive - R2.11
AFR - HC - responsive - R2.2
AFR - HC - responsive - R2.3
AFR - HC - responsive - R2.4
AFR - HC - responsive - R2.6
AFR - HC - responsive - R2.7
AFR - HC - responsive - R2.9
AFR - HC - responsive - R2.9, R2.10, R2.11
AFR - HC - responsive - R3
AFR - HC - responsive - R3.1
AFR - HC - responsive - R3.1, R3.8
AFR - HC - responsive - R3.2
AFR - HC - responsive - R3.3
AFR - HC - responsive - R3.6
AFR - HC - responsive - R3.7

AFR - HC - responsive - R4
AFR - HC - responsive - R4.3
AFR - HC - responsive - R4.5
AFR - HC - responsive - R5
AFR - HC - responsive - R5.3
AFR - HC - responsive - R5.7
AFR - HC - safe - S1
AFR - HC - safe - S1.12
AFR - HC - safe - S1.3
AFR - HC - safe - S1.5
AFR - HC - safe - S1.6
AFR - HC - safe - S1.7
AFR - HC - safe - S1.8-11
AFR - HC - safe - S2
AFR - HC - safe - S2.1
AFR - HC - safe - S2.2
AFR - HC - safe - S2.3
AFR - HC - safe - S2.4
AFR - HC - safe - S2.5
AFR - HC - safe - S2.6
AFR - HC - safe - S3
AFR - HC - safe - S3.1
AFR - HC - safe - S3.2
AFR - HC - safe - S3.3
AFR - HC - safe - S3.4
AFR - HC - safe - S3.5
AFR - HC - safe - S3.6
AFR - HC - safe - S3.7
AFR - HC - safe - S4
AFR - HC - safe - S4.3
AFR - HC - safe - S4.6
AFR - HC - safe - S5
AFR - HC - safe - S5.1
AFR - HC - safe - S5.2
AFR - HC - safe - S6
AFR - HC - safe - S6.2
AFR - HC - safe - S6.4
AFR - HC - safe - S6.5
AFR - HC - well-led - W1
AFR - HC - well-led - W1.2
AFR - HC - well-led - W1.4
AFR - HC - well-led - W2
AFR - HC - well-led - W2.3
AFR - HC - well-led - W2.4
AFR - HC - well-led - W2.5

AFR - HC - well-led - W3
AFR - HC - well-led - W3, W3.3
AFR - HC - well-led - W3.5
AFR - HC - well-led - W3.6
AFR - HC - well-led - W3.8
AFR - HC - well-led - W4
AFR - HC - well-led - W4.1
AFR - HC - well-led - W4.2
AFR - HC - well-led - W5
AFR - HC - well-led - W5.1
AFR - HC - well-led - W6
AFR - HC - well-led - W6.1
AFR - HC - well-led - W6.2
AFR - HC - well-led - W6.3
AFR - HC - well-led - W6.5
AFR - HC - well-led - W6.7
AFR - HC - well-led - W7
AFR - HC - well-led - W7.1, W7.2
AFR - HC - well-led - W7.2
AFR - HC - well-led - W7.3
AFR - HC - well-led - W7.4
AFR - HC - well-led - W7.5
AFR - HC - well-led - W8
AFR - HC - well-led - W8.3
AFT - End of life - responsive (HC R2,9, R2.10, R2.11, ASC R3)
AFT - Info gov - safe (HC S4, ASC S1.6)
AFT - Medicines - safe (HC S3, ASC S4.6)
AFT - Personalisation - caring (HC C2.3, C2.4)
AFT - Personalisation - effective (HC E3.7)
AFT - System lead - effective - (HC E4, ASC E5)
AFT - System lead - well-led (HC W2.5, W4.4, W7.4, ASC W5.1, W5.2)
AFT - Technology - effective (HC E1.3, ASC E4.5)
C - Comments on problems in services/care
C - CQC - Aims/goals of org
C - CQC - bureaucracy/burden/doubt methods
C - CQC - Communication
C - CQC - criticise current practice
C - CQC - criticism of current practice
C - CQC - expertise of inspectors
C - CQC - internal issues
C - CQC - negative general view
C - CQC - Positive comment
C - CQC - positive general view
C - CQC - provider fees concern
C - CQC - question expertise/value

C - CQC - ratings and inspections general
C - CQC - reference to bad practice
C - CQC - regulation for other groups
C - CQC - Relationship with patient groups
C - CQC - Remit
C - CQC - Scope of work
C - CQC - Staff wellbeing/retention
C - CQC - transparency/trust
C - Health/social care integration
C - Health/social care parity
C - LD - current quality of care
C - NHS - care quality issues
C - NHS funding issues
C - NHS funding/policy
C - NHS policy - early intervention/prevention
C - NHS quality issues
C - NHS/ASC funding issues
C - NHS/ASC quality issues
C - Social care funding
C - Suggestion - CQC governance
CP - Consultation - readability/accessibility
CP - Consultation documentation - comment/criticism
CP - Criticism
CP - Further discussion/consultation
CP - Question - comment/criticism
CP - Refer to informal consultation
CP - request from respondent
CP - Support
CS - Acc - Issue - burden/bureaucracy
CS - Acc - Issue - Data/intelligence
CS - Acc - Issue - enforcement
CS - Acc - Issue - feedback from people who use services
CS - Acc - Issue - informing the public
CS - Acc - Issue - Self reporting
CS - Acc - Issue - should not replace CQC regulation
CS - Acc - Issue - standards/confidence
CS - Acc - Issue - third party evidence
CS - Acc - Issue - unaccredited
CS - Acc - Issue - understanding provider context
CS - Acc - Overall sentiment - 0 negative
CS - Acc - Overall sentiment - 1 sceptical/doubtful
CS - Acc - Overall sentiment - 2 neutral
CS - Acc - Overall sentiment - 3 constructive criticism
CS - Acc - Overall sentiment - 4 positive
CS - Acc - Overall sentiment - none expressed

CS - Acc - Positive/opportunity - accountability
CS - Acc - Positive/opportunity - improving services
CS - Acc - Positive/opportunity - more targeted
CS - Acc - Positive/opportunity - patient/public confidence
CS - Acc - Positive/opportunity - reduce duplication
CS - Acc - Positive/opportunity - sharing best practice
CS - Acc - Positive/opportunity - transparency
CS - Acc - Query/suggestion
CS - Acc - Reference to accreditation body
CS - Annual inspection - comments on staffing
CS - Annual inspection - concerns
CS - Annual inspection - positive
CS - Annual inspection - query/suggestion
CS - AS - Issue - aggregation of ratings
CS - AS - Issue - core services more important
CS - AS - Issue - CQC capacity
CS - AS - Issue - implementation
CS - AS - Issue - inspection trigger
CS - AS - Issue - specialist expertise of inspectors
CS - AS - Negative/risk - burden/bureaucracy
CS - AS - Negative/risk - effectiveness
CS - AS - Overall sentiment - 0 negative
CS - AS - Overall sentiment - 1 sceptical/doubtful
CS - AS - Overall sentiment - 2 neutral
CS - AS - Overall sentiment - 3 constructive criticism
CS - AS - Overall sentiment - 4 positive
CS - AS - Overall sentiment - none expressed
CS - AS - Positive/opportunity - all services need inspection
CS - AS - Positive/opportunity - benefits providers
CS - AS - Positive/opportunity - consistency of standards across services
CS - AS - Positive/opportunity - improving services
CS - AS - Positive/opportunity - patient/public confidence
CS - AS - Positive/opportunity - place-based
CS - AS - Positive/opportunity - shared learning/best practice
CS - AS - Positive/opportunity - support enforcement
CS - AS - Positive/opportunity - support separation/no aggregation
CS - AS - Suggestion - additional services should be included under core services
CS - AS - Suggestion - implementation
CS - AS - Suggestion - other additional services
CS - AS - Suggestion - ratings should be aggregated
CS - Caveat - data/information sources
CS - Issue - CQC capacity
CS - Issue - data/information sources
CS - Issue - depends on implementation

CS - Issue - efficiency
CS - Issue - feedback from people who use services
CS - Issue - funding
CS - Issue - inspection/assessment method
CS - Issue - inspections
CS - Issue - Inspections (proportionality
CS - Issue - Inspections (resources for)
CS - Issue - quality of all services
CS - Issue - staff feedback/wellbeing
CS - Issue - supporting providers
CS - Issue - timing(s)
CS - Issue - unannounced inspections
CS - Mat/gyn - 0 - Negative
CS - Mat/gyn - 1 - Sceptical/doubtful
CS - Mat/gyn - 2 - Neutral
CS - Mat/gyn - 3 - Constructive criticism
CS - Mat/gyn - 4 - Positive
CS - Mat/gyn - consider overlap in inspections
CS - Mat/gyn - Issue - data collection/analysis
CS - Mat/gyn - Issue - duplication/burden
CS - Mat/gyn - Issue - Equity
CS - Mat/gyn - Issue - Feedback from service users
CS - Mat/gyn - Issue - implementation
CS - Mat/gyn - Issue - inspection frequency
CS - Mat/gyn - issue - outcomes not clear
CS - Mat/gyn - necessity of inspections
CS - Mat/gyn - Negative - Equality/gender issues
CS - Mat/gyn - No sentiment expressed
CS - Mat/gyn - Positive - Separate inspections
CS - Mat/gyn - Query/suggestion
CS - More information/clarity needed
CS - Negative/risk - burden/bureaucracy
CS - Negative/risk - comments on robustness
CS - Negative/risk - existing inspection approach
CS - Negative/risk - not flexible/ignores key services
CS - Outpatients - consider overlap in inspections
CS - Outpatients - Issue - data collection/analysis
CS - Outpatients - Issue - feedback from people who use services
CS - Outpatients - Issue - inspection frequency
CS - Outpatients - Issue - inspection/assessment method
CS - Outpatients - Issue - necessity of inspections
CS - Outpatients - Issue - transparency
CS - Outpatients - Negative/risk - burden/bureaucracy
CS - Outpatients - New approach - support
CS - Outpatients - New approach - support with caveat

CS - Outpatients - Overall sentiment - 0 negative
CS - Outpatients - Overall sentiment - 1 sceptical/doubtful
CS - Outpatients - Overall sentiment - 2 neutral
CS - Outpatients - Overall sentiment - 3 constructive criticism
CS - Outpatients - Overall sentiment - 4 positive
CS - Outpatients - Overall sentiment - none expressed
CS - Outpatients - Suggestion - accreditation/avoid duplication
CS - Outpatients - Suggestion/query
CS - Overall sentiment - 0 negative
CS - Overall sentiment - 1 sceptical/doubtful
CS - Overall sentiment - 2 neutral
CS - Overall sentiment - 3 constructive criticism
CS - Overall sentiment - 4 positive
CS - Overall sentiment - none expressed
CS - Positive/opportunity - improving services
CS - Positive/opportunity - more targeted
CS - Positive/opportunity - shared learning/best practice
CS - Positive/opportunity - thorough
CS - Query/suggestion
CS - Query/suggestion - other
CS - Query/suggestion - reinspection
CS - Query/suggestion - targeting
CS - Query/suggestion - timing/frequency
CS - TLR - Issue - comments on what included
CS - TLR - Issue - comparability
CS - TLR - Issue - consistency
CS - TLR - Issue - CQC/NHS I joint working
CS - TLR - Issue - depends on implementation
CS - TLR - Issue - different services or locations
CS - TLR - Issue - feedback from people who use services
CS - TLR - Issue - flexibility
CS - TLR - Issue - frequency of rating
CS - TLR - Issue - granularity
CS - TLR - Issue - how ratings are used
CS - TLR - Issue - informing public/patients
CS - TLR - Issue - link between ratings and quality improvement
CS - TLR - Issue - measuring/rating
CS - TLR - Issue - morale
CS - TLR - Issue - need more detail
CS - TLR - Issue - NHS vs private ratings
CS - TLR - Issue - Oversimplification
CS - TLR - Issue - prefer existing approach
CS - TLR - Issue - prefer simple rating system
CS - TLR - Issue - problem
CS - TLR - Issue - proportionality

CS - TLR - Issue - rating changes
CS - TLR - Issue - rating individual services
CS - TLR - Issue - reflect context
CS - TLR - Issue - reports
CS - TLR - Issue - robustness of inspections/regulation
CS - TLR - Issue - safeguarding
CS - TLR - Issue - staff feedback/wellbeing
CS - TLR - Issue - standards/confidence
CS - TLR - Issue - suggestion/change
CS - TLR - Issue - support risk-based assessment
CS - TLR - Issue - supporting complexity/NMCs
CS - TLR - Issue - supporting providers
CS - TLR - Issue - system gaming
CS - TLR - Issue - takeovers/mergers
CS - TLR - Issue - transparency/clarity for providers
CS - TLR - Issue - use of resources
CS - TLR - Issue - weighting
CS - TLR - Negative/risk - rating shelf-life
CS - TLR - New approach - support
CS - TLR - Overall sentiment - 0 negative
CS - TLR - Overall sentiment - 1 sceptical/doubtful
CS - TLR - Overall sentiment - 2 neutral
CS - TLR - Overall sentiment - 3 constructive criticism
CS - TLR - Overall sentiment - 4 positive
CS - TLR - Overall sentiment - none expressed
CS - TLR - Positive/opportunity - accountability
CS - TLR - Positive/opportunity - Current ratings clear
CS - TLR - Positive/opportunity - improved performance
CS - TLR - Positive/opportunity - sharing best practice
CS - TLR - Positive/opportunity - transparency/clarity
CS - TLR - Query/suggestion
CS - TLR - Requirement to improve
CS - Transparency/duty of candour
CS - Triggers and decision-making
CS - Unannounced - 0 - Negative
CS - Unannounced - 1 - Sceptical/doubtful
CS - Unannounced - 2 - Neutral
CS - Unannounced - 3 - Constructive criticism
CS - Unannounced - 4 - Positive
CS - Unannounced - Caveat
CS - Unannounced - Caveat - depends on implementation
CS - Unannounced - Caveat - feasibility
CS - Unannounced - Caveat - key ppl not there
CS - Unannounced - Caveat - risk losing patient voice
CS - Unannounced - Caveat - timing(s)

CS - Unannounced - Negative
CS - Unannounced - Negative - anxiety/disruption
CS - Unannounced - No sentiment expressed
CS - Unannounced - positive
CS - Unannounced - Positive - business as usual
CS - Unannounced - Positive - consistency
CS - Unannounced - Positive - mitigates other risk
CS - Unannounced - Positive - more accurate
CS - Unannounced - Positive - prevents gaming system
CS - Unannounced - query/suggestion
I - Issue - accountability
I - Issue - burden/bureaucracy
I - Issue - consistency/clarity
I - Issue - coordination/transition
I - Issue - CQC capacity/ability
I - Issue - CQC responsiveness
I - Issue - CQC systems
I - Issue - data management
I - Issue - enforcement
I - Issue - feedback from others
I - Issue - feedback from people who use services
I - Issue - identifying risks/concerns
I - Issue - implementation/outcomes
I - Issue - inspection/assessment method
I - Issue - integration
I - Issue - priority/focus
I - Issue - staff engagement/wellbeing
I - Issue - transparency
I - Issue - working with others
I - Negative/risk - inequality between services
I - Overall sentiment - 0 negative
I - Overall sentiment - 1 sceptical/doubtful
I - Overall sentiment - 2 neutral
I - Overall sentiment - 3 constructive criticism
I - Overall sentiment - 4 positive
I - Overall sentiment - none expressed
I - Positive/opportunity - access to Insight reports
I - Positive/opportunity - alignment with NHS Improvement
I - Positive/opportunity - co-production
I - Positive/opportunity - inspection approach
I - Positive/opportunity - reduce burden/bureaucracy
I - Positive/opportunity - sharing best practice
I - Positive/opportunity - targeted monitoring
I - Query/suggestion
I - Suggestion - implementation

I - Suggestion - learn from previous experience
LD - Issue - burden/bureaucracy/cost
LD - Issue - current provision
LD - Issue - family members
LD - Issue - feedback from people who use services
LD - Issue - flexibility
LD - Issue - funding/commissioning
LD - Issue - importance of inspections
LD - Issue - innovation/new models
LD - Issue - locality/community proximity
LD - Issue - measuring/rating
LD - Issue - parity between services
LD - Issue - previously registered services
LD - Issue - priority/focus
LD - Issue - residence size
LD - Issue - residence/service type
LD - Issue - staff feedback/wellbeing
LD - Issue - supporting/involving providers
LD - Negative/risk - clarity/complexity
LD - Negative/risk - CQC role/remit
LD - Negative/risk - guidance rationale
LD - Negative/risk - outcomes
LD - Overall sentiment - 0 negative
LD - Overall sentiment - 1 sceptical/doubtful
LD - Overall sentiment - 2 neutral
LD - Overall sentiment - 3 constructive criticism
LD - Overall sentiment - 4 positive
LD - Overall sentiment - none expressed
LD - Positive/opportunity - bespoke registration
LD - Positive/opportunity - clarity/detail
LD - Positive/opportunity - CQC effectiveness
LD - Positive/opportunity - fair/appropriate
LD - Positive/opportunity - improving services
LD - Positive/opportunity - KLOEs
LD - Suggestion - inspection method
LD - Suggestion - other
LD - Suggestion - priority/focus
LD (non-Q4) - Issue - Bed numbers
LD (non-Q4) - Issue - Personalisation
NM - Depends on implementation/too early to tell
NM - Issue - accountability
NM - Issue - Barriers to NMC within NHS
NM - Issue - CQC has no direct impact on NMC development
NM - Issue - CQC staff/inspectors
NM - Issue - data collection/analysis

NM - Issue - feedback from people who use services
NM - Issue - Need more detail/guidance
NM - Issue - need more engagement
NM - Issue - penalties/incentives
NM - Issue - Regular monitoring
NM - Issue - Responsiveness to system
NM - Issue - role of risk (provider risk taking)
NM - Issue - staff feedback/wellbeing
NM - Issue - timing
NM - Issue - transparency
NM - Need more detail/hard to say
NM - Negative/risk - burden/bureaucracy
NM - Negative/risk - Complex providers/ways of working - comments
NM - Negative/risk - impact on ASC
NM - Negative/risk - Over-simplification
NM - Overall sentiment - 0 negative
NM - Overall sentiment - 1 sceptical/doubtful
NM - Overall sentiment - 2 neutral
NM - Overall sentiment - 3 constructive criticism
NM - Overall sentiment - 4 positive
NM - Overall sentiment - none expressed
NM - Positive/opportunity - clarity of guidance
NM - Positive/opportunity - CQC/NHS Improvement alignment
NM - Positive/opportunity - Enablement
NM - Positive/opportunity - Flexibility
NM - Positive/opportunity - less complex
NM - Positive/opportunity - more targeted
NM - Positive/opportunity - reduce burden/bureaucracy
NM - Positive/opportunity - support principles
no theme
O - Contains multiple responses
O - Duplicate
O - Duplicate response
O - Easy-read response
O - Email/letter
O - No comment
O - Personal details
O - Quote
O - Refer to CQC guidance/documents
O - Refer to other correspondence
O - Refer to other document/evidence
O - Refer to other question
O - Refer to other regulator
O - Refer to previous comment(s)
O - Respondent's context

O - Respondent's experience
O - Unsure/don't know
O - Webinar/event
PIR - Issue - accountability
PIR - Issue - clarity/consistency
PIR - Issue - data accuracy/review
PIR - Issue - data collection/analysis
PIR - Issue - data management/security
PIR - Issue - enforcement
PIR - Issue - feedback from people who use services
PIR - Issue - flexibility
PIR - Issue - focus/priority
PIR - Issue - identifying risks/concerns
PIR - Issue - inspection frequency
PIR - Issue - other sectors
PIR - Issue - PIR acronym
PIR - Issue - relationship development
PIR - Issue - reliability of ratings
PIR - Issue - timings
PIR - Issue - understanding provider context
PIR - Negative/risk - accountability
PIR - Negative/risk - burden/bureaucracy
PIR - Negative/risk - need/purpose
PIR - Negative/risk - self-reporting
PIR - New approach - monitor/review
PIR - New approach - support
PIR - Overall sentiment - 0 negative
PIR - Overall sentiment - 1 sceptical/doubtful
PIR - Overall sentiment - 2 neutral
PIR - Overall sentiment - 3 constructive criticism
PIR - Overall sentiment - 4 positive
PIR - Overall sentiment - none expressed
PIR - Positive/opportunity - clarity/consistency
PIR - Positive/opportunity - communication
PIR - Positive/opportunity - evidence/data
PIR - Positive/opportunity - improving services
PIR - Positive/opportunity - reduced burden/bureaucracy
PIR - Positive/opportunity - relationship development
PIR - Positive/opportunity - self-assessment
PIR - Positive/opportunity - transparency
PIR - Query/suggestion
PS - Acute care/hospital
PS - Adult social care (ASC)
PS - Ambulance services
PS - Cancer services

PS - Children's services
PS - Community care/district nurse
PS - Dentistry
PS - Diagnostic imaging
PS - General practice (GP)
PS - General practice (GP) / primary care
PS - Gynaecology
PS - Hospice/end-of life care
PS - Independent sector
PS - Learning disabilities
PS - Maternity care
PS - Mental health
PS - Other
PS - Out-of-hours/111
PS - Outpatients
PS - Pharmacy
PS - Substance misuse
R - Reporting
R - Social care - Comments on quality
R - Social care - Prefer different approach
R - Social care - problem with ratings
RM - Inspections - Issue
RM - Issue - accountability
RM - Issue - communication/ongoing interaction
RM - Issue - consistency/clarity
RM - Issue - CQC capacity/ability
RM - Issue - CQC responsiveness
RM - Issue - CQC staff/inspectors
RM - Issue - enforcement
RM - Issue - engagement meetings
RM - Issue - Experts by Experience
RM - Issue - feedback from people who use services
RM - Issue - identifying risks/concerns
RM - Issue - leadership/strategy
RM - Issue - provider parity/equality
RM - Issue - regulation of GPs
RM - Issue - re-inspect on request
RM - Issue - relationship development
RM - Issue - supporting providers
RM - Issue - transparency
RM - Issue - working with others
RM - Negative/risk - bureaucracy/burden
RM - Negative/risk - CQC organisational issues
RM - Negative/risk - too close to providers
RM - Overall sentiment - 0 negative

RM - Overall sentiment - 1 sceptical/doubtful
RM - Overall sentiment - 2 neutral
RM - Overall sentiment - 3 constructive criticism
RM - Overall sentiment - 4 positive
RM - Overall sentiment - none expressed
RM - Positive
RM - Positive - Increased contact
RM - Positive/opportunity - co-production
RM - Positive/opportunity - CQC reputation
RM - Positive/opportunity - increased contact
RM - Positive/opportunity - reduced burden/less intrusive
RM - Positive/opportunity - sharing good practice
RM - Positive/opportunity - supporting providers
RM - Query/suggestion - Burden on one part of service
RM - Suggestion - existing model
RM - Suggestion - implementation
WL - Comments on management culture
WL - Data/evidence
WL - Issue - accountability
WL - Issue - clinical versus management responsibility
WL - Issue - Look at leadership beyond provider
WL - Issue - Qualities of good leadership
WL - Management - incentives/penalties
WL - More information/clarity needed
WL - Negative
WL - Negative - duplication
WL - Negative - Methods ineffective
WL - Positive
WL - Positive - Accountability
WL - Positive - Complements inspection approach
WL - Positive - Will help managers/leaders
WL - Suggestion

Appendix 3: Breakdown of responses to closed questions by respondent category

Table A-0-1: Responses to Q1a by overall respondent category

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Total
Carer of someone who uses health or social care services	1	5	5	3	1	15
CQC Expert by Experience		2	3	1		6
CQC staff member	5	19	13	3		40
Health or social care commissioner	1	1	3			5
Local authority	1	12	3	3		19
Member of a foundation trust council of governors					1	1
Member of a local Healthwatch or local Healthwatch staff	1	9	2			12
Member of an overview and scrutiny committee						0
Member of the public/person who uses health or social care services	4	18	16	4	3	45
Other		7	8	1		16
Parliamentarian						0
Provider trade body or membership organisation		15	5	3		23
Provider/professional: I work at or am associated with a CQC-registered health or social care service	11	98	38	15	11	173
Researcher/student			2			2
Staff member of an arm's length body or other regulator		3	2	1		6
Voluntary or community sector representative	1	9	5	3		18
Total	**25**	**198**	**105**	**37**	**16**	**381**

Table A-0-2: Responses to Q2a by overall respondent category

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Total
Carer of someone who uses health or social care services	3	10	2	1		16
CQC Expert by Experience		3	1	2		6
CQC staff member	11	20	7	1	1	40
Health or social care commissioner	2	2	1			5
Local authority	6	12		1		19
Member of a foundation trust council of governors				1		1
Member of a local Healthwatch or local Healthwatch staff	1	9	2			12
Member of an overview and scrutiny committee						0
Member of the public/person who uses health or social care services	13	13	10	6	3	45
Other	3	5	3	4		15
Parliamentarian						0
Provider trade body or membership organisation	3	14	2	3	1	23
Provider/professional: I work at or am associated with a CQC-registered health or social care service	42	84	26	16	8	176
Researcher/student			1			1
Voluntary or community sector representative	2	9	4	3		18
Staff member of an arm's length body or other regulator	2		2			4
Total	**88**	**181**	**61**	**38**	**13**	**381**

Table A-0-3: Responses to Q10a by overall respondent category

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Total
Carer of someone who uses health or social care services	5	6	2			13
CQC Expert by Experience	3	1	1		1	6
CQC staff member	8	11	10	4		33
Health or social care commissioner		3	1			4
Local authority	2	4	4			10
Member of a foundation trust council of governors					1	1
Member of a local Healthwatch or local Healthwatch staff	4	5		1		10
Member of an overview and scrutiny committee						0
Member of the public/person who uses health or social care services	18	10	6		4	38
Other	4	6	1			11
Parliamentarian						0
Provider trade body or membership organisation	2	6	8	1		17
Provider/professional: I work at or am associated with a CQC-registered health or social care service	21	58	37	7	10	133
Researcher/student			1			1
Voluntary or community sector representative	4	5	2	1		12
Staff member of an arm's length body or other regulator		1	1			2
Total	**71**	**116**	**74**	**14**	**16**	**291**

Table A-0-4: Responses to Q11a by overall respondent category

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Total
Carer of someone who uses health or social care services	1	4	3	2	1	11
CQC Expert by Experience	1	2	1	2		6
CQC staff member	5	14	10	3	1	33
Health or social care commissioner		2	1	1		4
Local authority	1	3	6	1		11
Member of a foundation trust council of governors			1			1
Member of a local Healthwatch or local Healthwatch staff	1	7	2			10
Member of an overview and scrutiny committee						0
Member of the public/person who uses health or social care services	7	9	8	6	7	37
Other	3	5	3	1		12
Parliamentarian						0
Provider trade body or membership organisation	4	9	4			17
Provider/professional: I work at or am associated with a CQC-registered health or social care service	34	57	22	11	10	134
Researcher/student			1			1
Voluntary or community sector representative	3	4	4	1	1	13
Staff member of an arm's length body or other regulator	1	1	1			3
Total	**61**	**117**	**67**	**28**	**20**	**293**

Appendix 4: List of organisations responding

The below list of organisations reflects how these were entered by respondents.

Action on Hearing Loss
Action on Smoking and Health
ADASS and LGA
Age UK
Agincare
Akari Care
Alzheimer's Society
Anglian Community Enterprise
ARCO – Associated Retirement Community Operators
Association of Independent Healthcare Organisations
Barchester Healthcare
British Dental Association
Bedford Hospital NHS Trust
Berkshire Healthcare Foundation Trust
Bethphage
Black Health Agency
Black Swan International Limited
BLM
Boars Tye Residential Home
Boots UK
Bourntree Field Nursery Health and Wellbeing
Bradford District Care Foundation Trust
British Medical Association
British Pregnancy Advisory Service (BPAS)
British Red Cross
Broadham Care Ltd
BSI Group
Buckinghamshire Healthcare NHS Trust
BUPA UK
Burton Hospitals NHS Foundation Trust
Camphill Families and Friends
Camphill Village Trust
Cardiomyopathy UK
Care England
Care Homes Of Distinction Ltd
Care Management Group
Care Right Now CIC
Central London Community Healthcare NHS Trust
Certitude
CGL
Charing Healthcare
Cheshire and Wirral Partnership NHS Foundation Trust

Chesterfield Royal Hospital NHS Foundation Trust
Cheswold Park Hospital (Riverside Healthcare Limited)
Child Health Alliance
Choice Care Group
Christie NHS Foundation Trust
Civil Service Pensioner's Alliance
Classic Care Homes Devon
Clydesdale and Yorkshire Bank PLC
Consensus
Court Street Medical Practice
Cumbria Partnership NHS Foundation Trust
Cygnet Health Care
DAC Beachcroft
Danshell Group
Dementia UK
Derbyshire County Council, Direct Care Service, Transformation, Quality and Compliance Team
Devon County Council
Dimensions UK Ltd
Disabilities Trust
Dorset HealthCare University NHS Foundation Trust
Durham County Council Adult and Health Services
East Midlands Public and Patient Involvement Senate (East Midlands Health Science Network)
East Sussex County Council
East Sussex Healthcare NHS Trust
Eden Futures
Essex & Herts Air Ambulance Trust
Eternity Care LLP
EveryLIFE Technologies
Excelcare holdings
Finefutures Ltd
Foresight Centre at GE Healthcare Finnamore
Four Seasons Healthcare
Francis Taylor Foundation
Freeways
Fylde and Wyre CCG
Gateshead Health NHS Foundation Trust
General Dental Council
General Medical Council
Gloucestershire Care Services NHS Trust
Greater Western Hospitals NHS Foundation Trust
Hampshire County Council
Harrogate and District NHS Foundation Trust
Hartlepool Borough Council Audit and Corporate Governance Committee
HC One of a Kind
Healthcare Quality Improvement Partnership (HQIP)

Health Foundation
Healthwatch Birmingham
Healthwatch Cambridgeshire
Healthwatch Coventry
Healthwatch Cumbria
Healthwatch East Sussex
Healthwatch Enfield
Healthwatch England
Healthwatch Lincolnshire
Healthwatch Norfolk
Healthwatch Sheffield
Healthwatch Wandsworth
Healthwatch Worcestershire
Heritage Care
Hertfordshire Partnership NHS Foundation Trust
hertfordshire.gov.uk Health and Community Services
Hesley Group
HFH Healthcare
Home from Home Care
Home Group
Hospice UK
Hull and East Yorkshire Hospitals NHS Trust
Human Tissue Authority
IICLtd
Independent Doctors Federation
Independent Healthcare Sector Complaints Adjudication Service
International Communities of Sunderland (ICOS)
James Paget University Hospitals NHS Foundation Trust
Jiva Healthcare Limited
John Taylor Hospice
Joint Thinking Initiative
Kent County Council
Knowsley Council
Lancashire Care NHS Foundation Trust
Lancashire County Council
Lancashire Teaching Hospitals NHS Foundation Trust
Leeds and York Partnership Foundation trust
Leeds Teaching Hospitals NHS Trust
Leicester City Council
Leicestershire County Council Health Overview and Scrutiny Committee
Lighthouse Healthcare
Linkage Community Trust
Local Healthwatch (a number of organisations, names not specified)
London Borough of Barnet
London Borough of Newham
London Care Partnership

LOROS
Marie Curie
Medical Defence Union
Mencap and the Challenging Behaviour Foundation
Millennium Care Services Ltd
Mind
Moorfields Eye Hospital NHS Foundation Trust
National Autistic Society
National Care Association
National Care Forum
National Deaf Children's Society
National Federation of Women's Institutes (NFWI)
National Institute for Health and Care Excellence (NICE)
National Council for Palliative Care
NELFT
Newcastle upon Tyne Hospitals NHS Foundation Trust
NHS Clinical Commissioners
NHS Confederation
NHS Digital
NHS Employers
NHS England - Equalities and Health Inequalities Unit (Nursing Directorate)
NHS Litigation Authority
NHS Partners Network
NHS Providers
North of England Commissioning support (NECS)
Northamptonshire Healthcare NHS Foundation Trust
Northumberland Tyne and Wear NHS Foundation Trust
Norwood
Notting Hill Housing
NSFT
Nuffield Health
Nursing and Midwifery Council (NMC)
OLGA (Older Lesbian, Gay, Bisexual & Trans Association)
Oxleas NHS Foundation Trust
Parliamentary and Health Service Ombudsman
Patient council WAHT
Pi Ltd
Plymouth Hospitals NHS Foundation Trust
Portland College
Precious Homes
Prior's Court Foundation
Priory Group
Provide
Public Consultation Group: Speak Out Group – My Life My Choice
Purple Balm Ltd
Quality Compliance Systems

Radis Community Care
Real Life Options
Regency Care at Home Ltd
Registered Nursing Home Association
Relatives & Residents Association
Rotherham Hospice
Royal Berkshire Hospital
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Midwives
Royal College of Nursing
Royal College of Ophthalmologists
Royal College of Paediatrics and Child Health (RCPCH)
Royal College of Physicians
Royal College of Physicians of Edinburgh
Royal College of Psychiatrists
Royal College of Surgeons of England
Royal Marsden NHS Foundation Trust
Royal Masonic Benevolent Institution Care Company
Royal Wolverhampton NHS Trust - West Midlands Quality Network Group
Shelford Group
Shopmobility South Gloucestershire
Skills for Care
Social Care Institute for Excellence (SCIE)
Society of Radiographers
Solent NHS Trust
South Essex Partnership University NHS Foundation Trust
South London and Maudsley NHS Trust
South Staffordshire and Shropshire Trust
South Western Ambulance Service NHS Foundation Trust
Southern Derbyshire CCG
Southern Health NHS Foundation Trust
Speak Out Group – Saheli Women's Project
St Catherine's Hospice, West Sussex
St Helens and Knowsley Teaching Hospitals NHS Trust
St John Ambulance
St Luke's Hospice, Sheffield
St Peter's Hospice Bristol
Stockton on Tees Borough Council
Stoke City Council
Sue Ryder
Surrey and Borders Partnership NHS Foundation Trust
Surrey Community Development Trust Transform Housing and Support
Surrey County Council
Sussex Community NHS Foundation Trust
Sussex Health Care

Together for Short Lives
Tracscare
Turning Point
UKHCA
United Kingdom Accreditation Service
University Hospitals Bristol NHS Foundation Trust
Voluntary Organisations Disability Group (VODG)
Walsingham Support
West Hertfordshire Hospitals Trust
Wiltshire People 1st with members of the Speaking Up Group
Wirral University Teaching Hospital NHS Foundation Trust
Witham Parliamentary Constituency
York LGBT Forum