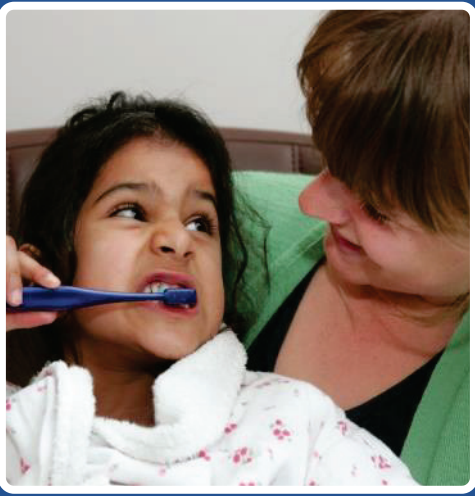
Care Quality Commission

# Shaping the future

CQC's strategy for 2016 to 2021

## What our strategy means for the health and adult social care services we regulate



Enter

# Foreword

**Andrea Sutcliffe**
Chief Inspector of Adult Social Care

**Professor Sir Mike Richards**
Chief Inspector of Hospitals

**Professor Steve Field**
Chief Inspector of General Practice

We have set out in our **accompanying strategy** our ambition for CQC over the next five years. We will focus on four priorities to deliver this – encourage improvement, innovation and sustainability in care; deliver an intelligence-driven approach to regulation; promote a single shared view of quality; and improve our efficiency and effectiveness.

In responding to our strategy consultation, care providers, the public and other stakeholders have been broadly positive about the changes CQC has made over the last three years. However, we cannot stand still. We know that there are still improvements to be made and these will have to be delivered with fewer resources.

This document signals how we will build on the strong foundations of our current approach across the sectors we regulate. We will soon complete comprehensive inspections of all services we rate. By using the baseline information that comes from this, and in particular ratings, we have an opportunity to improve and refine our key functions of registration, monitoring, inspection, rating, enforcement and national reporting in line with our new priorities.

Inspections will continue to be central to our assessments of quality, but we will complement this by developing our information and insight model to more effectively target our resources where the risk to the quality of care provided is greatest and where quality is likely to have improved.

People's health and social care needs are changing. Providers are meeting this challenge by changing the ways they deliver services, by breaking down the boundaries between hospital care, primary medical services and adult social care services, and by turning to new models of care and technology to efficiently deliver person-centred care. We will adapt our approach, and work collaboratively, within CQC and with providers and partners across health and social care towards a single shared vision of high-quality care.

People who use services, their carers and families remain central to all aspects of our work. We will continue to encourage and enable them to tell us about their experiences of care by working with our partners, including organisations that represent the public, and we will improve our ability to analyse what they tell us through the use of technology.

To help us implement the strategy, we will work with providers and their staff, with partner organisations, and with the public, people who use services and their families and carers. We will continue to learn from the completion of our current inspection programme this year, and consult where appropriate on changes we plan to make to our core methodology. This means that we can be confident that our work over the next five years responds appropriately to the challenges and opportunities that lie ahead.

# New models of care

### Summary of what we will do

- Learn alongside providers who offer new care models or use new technologies, to encourage innovation by flexibly and effectively registering and inspecting such new models.
- Build our capability to assess the quality of care from the perspective of people using services, particularly where services are organised by pathways or for particular groups of people across organisational boundaries.

We recognise that the way care is delivered is changing. The way CQC monitors, inspects, rates and reports on care providers will change to reflect new models of care and other changes in service structures. Innovative ways of organising health and social care are currently being tested, including through devolution – for example through the NHS *Five Year Forward View* vanguard programme and other initiatives, such as increasing access to primary care funded by the Prime Minister's Challenge Fund.

A central focus for many of these models is integrating services to improve how people experience care. This is achieved by making sure services are more joined-up and person-centred – for example, by encouraging better working between hospitals and care homes, or bringing together GPs and community-based services into a single organisation.

We will continue to assess individual services. At the same time we will do more to assess quality from the perspective of different groups of people and, where relevant, seek to understand their experiences of care across multiple services. As providers organise themselves in different ways we will increasingly tailor our inspections to changing models – making sure that we have the right combination of expertise on our inspections and that we register, report and rate at a level that is meaningful to the provider and the public.

We will build our capability so that we can inspect new models of care – for example, where care is organised by pathways and for particular groups of people, and where it crosses organisational boundaries. We will work alongside providers and partners such as NHS Improvement, NHS England, the Association of Directors of Adult Social Services and the Local Government Association, and learn from those providers that explore and offer new models. We have allocated an inspector to each of the vanguards across the country so that we can learn alongside them.

We will strengthen our assessment of how well providers work with others to share information and coordinate care, and assess how well providers deliver care for specific populations groups.

New models of care will be expected to deliver care that meets fundamental standards. We want to work closely with providers to understand what good and outstanding looks like in these new models.

# Registration

### Summary of what we will do

- Take a more robust approach for higher-risk applications and a more streamlined approach for those that are lower-risk, for example by considering the track record of a provider and the people who will be using the service.
- Use a flexible approach that supports new ways of providing health and care services, such as integrated care models that cut across organisational boundaries.
- Make sure the person ultimately responsible for care can be held accountable for quality – for example, we want to register a provider at a corporate level if it delivers care through a number of subsidiary provider organisations.

We will develop a more flexible approach to registration: an approach that is appropriate for how providers structure themselves now, as well as for future changes in ways of working and innovation in models of care.

A flexible approach means that we will focus resources where risk is the greatest. By 2020, all new registrations will be risk-assessed against set criteria. This will determine the process for the registration – for example whether we need to carry out an interview or a site visit. These criteria might include the nature of people using the service, the provider's track record on quality and whether individuals are professionally registered or subject to scrutiny by other bodies. Some applications, such as a change to an existing home-care agency branch office address, will be treated as an administrative change that providers can make through our more streamlined online process.

Where providers are delivering care through new, integrated and innovative approaches we will work with providers themselves, and with partners across health and social care, to understand their approach and how they are organised. This will help us determine the most efficient and appropriate ways of registering their services and how we will regulate them going forward.

We will also strengthen the link between registration and inspection by coordinating work between teams and sharing information more effectively.

We will move our registration processes online. This will allow us to set out clearly in one place, which providers deliver which services where and to whom – a digital register.

We will improve the way we request information from those registering with us by using a consistent framework, based around our five key questions that we ask each service: is it safe, effective, caring, responsive and well-led? We will

work with newly registered providers and managers to embed the key questions at the heart of their understanding of high-quality care.

We will consider whether we register providers at the right level when they are part of wider groups or organisations. This includes corporate groups, chains and federations. Our current approach is to register the body that directly runs local services, though we know these can be subsidiaries of larger companies or groups. So it may be the leadership of the parent company or group that is ultimately accountable for matters of quality in their services.

Where we find shortcomings, it is vital that we can hold leaders to account where we think this will protect people from poor care and ensure the improvements we need to see are made. Our enforcement powers only relate to providers that are registered with us. So we want to ensure that providers are registered at the level where ultimate accountability for quality sits.

# Our plans for hospitals

**Summary of what we will do**

- Focus our inspections on core services (for example critical care, surgery), particularly those that require improvement or are inadequate and extend the intervals between inspections for those that are good or outstanding.
- Update core service ratings on the basis of smaller, focused inspections and make more use of unannounced inspections.
- Hold an annual review of each provider to determine where to focus our inspection activity for the year ahead.
- Expect providers to describe their own quality against our five key questions, and feed this information into the annual review.
- Produce shorter reports, more quickly, that make clear how we have come to our decisions.
- With NHS Improvement, give a new rating of how efficiently and effectively NHS trusts and foundation trusts use their resources.
- Develop approaches to inspect services that cross our current core service boundaries, like cancer and mental health services in an acute hospital.

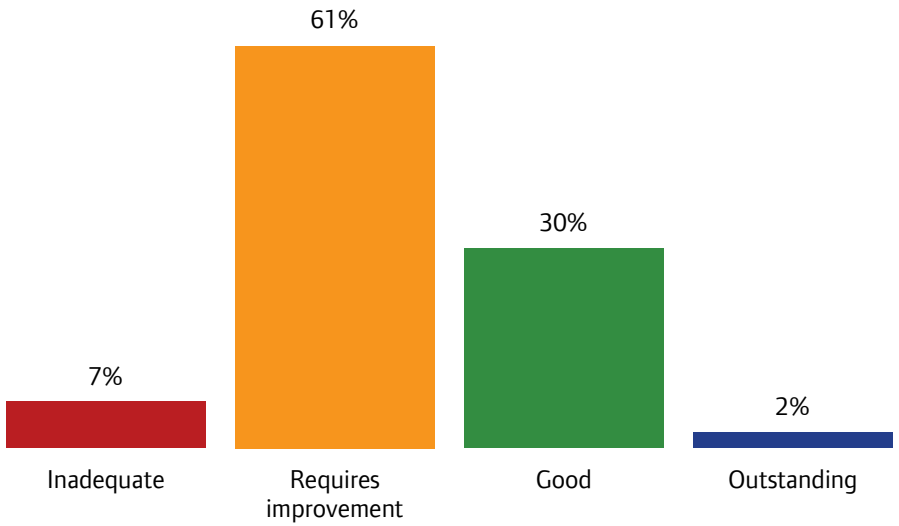
**For all sectors, we will keep the experience of people who use services, their carers and families at the heart of everything we do and ensure that equality and human rights remain embedded in our approach.**

## Context

This section sets out how our functions of monitoring, inspection and reporting will evolve for acute, mental health, community and ambulance NHS trusts and independent healthcare services.

By the end of March 2017, we will have carried out comprehensive inspections of all acute, mental health, community and ambulance NHS trusts and independent hospitals, and all standalone substance misuse services. For the first time we will have a wealth of baseline information about the quality of all of these services across England. We already have a baseline for NHS trusts, where we have found a wide variation of quality across England, including good and also some outstanding practice. However, we have rated 61% of NHS trusts and foundation trusts as requires improvement, while 7% are inadequate. This

**Ratings: NHS trusts and foundation trusts (May 2016)**




demonstrates the need for continued oversight of quality by an independent regulator that can take action where necessary and encourage improvement.

During 2016/17, we will continue inspecting the independent sector to get an equivalent baseline picture of the quality of care for these services. We will use this baseline, and the insight that comes from it, to significantly improve and evolve our approach and the impact we have. We will continue to work with independent sector providers to improve the availability and quality of data about these services.

We also need to consider how we can work more efficiently – including with partners such as NHS Improvement and NHS England – as any changes will have to be delivered with fewer resources. The challenge of doing more, for less, but better, is one we share with providers.

We recognise the challenges that the sector faces: the financial pressures, recruitment issues and moves to develop innovative and efficient models for delivering care. We are committed to working with the sector to develop an approach that recognises these issues and is flexible enough to accommodate the changing environment. We also want to hear about people's experiences of care, both good and bad. Where people have concerns we want to be clear that they can raise them with us – this applies whether they are using the service themselves, have friends or families using services, or are members of staff.

To help us meet this challenge we want to build on the strong foundations of our comprehensive inspection programme and develop our future approach to inspecting hospitals to deliver a model that:

- takes account of the variations in quality that we have found
- uses a provider's own view of quality alongside information from other sources, particularly what people using services say
- incorporates an assessment of how efficiently and effectively acute NHS trusts and foundation trusts use their resources
- recognises and encourages improvements in quality
- is flexible to accommodate new and innovative models of care delivery
- is costed, rigorously evaluated and efficient in its use of CQC's funding and its impact on providers
- uses information more effectively in our work with both NHS and independent providers.

This development will build on the strong foundations of our comprehensive inspection programme and evolve over the next five years. While we will maintain comprehensive inspections for newly registered providers, and those we are most concerned about, we will move to a more targeted and tailored approach focused on core services. Our inspections will be smaller and more frequent, with a maximum interval between them based on previous inspection findings, our ratings and wider intelligence about the quality of care of providers. Where appropriate, we will adapt this approach for those services we do not currently rate, such as independent ambulances.

## Efficient and effective use of resources

CQC has committed to a shared view of quality with NHS Improvement and other key system partners. We will work with NHS Improvement to develop a methodology for assessing efficiency and use of resources for NHS trusts and foundation trusts, beginning in the acute sector. We will ensure that both the quality and the use of resources assessments are clear, meaningful and relevant to providers and the public. Ratings should give providers an incentive to improve performance on both quality and use of resources and neither should override the other.

Development and testing of the assessment approach is underway, led by NHS Improvement. We will consult publicly on the model later in 2016/17, including on how the use of resources rating is brought together with CQC's existing quality ratings.

## Monitor

We are committed to developing a single shared view of quality across providers, commissioners and regulators. This will ensure that providers can use the same information required by regulators and commissioners to assure themselves of the quality of services they provide. We will be working closely with the National Quality Board, in particular with NHS Improvement, NHS England and the National Institute for Health and Care Excellence, to define what good quality care looks like using the five key questions we ask of each service: is it safe, effective, caring, responsive and well-led? We will also work with NHS Improvement to develop an approach to assessing and rating efficiency and use of resources for NHS trusts and foundation trusts, alongside our five key questions on quality.

With our partners, we will bring together a common information set that is accessible to all. This will mean that providers only have to share information once, minimising duplication and reducing their administrative burden.

We will look at how we can work more effectively with our partners by using each other's information, such as accreditation schemes. We also recognise the importance of developing good relationships with providers and commissioners (including NHS England, clinical commissioning groups and local authorities), as well as statutory groups that represent the public, such as the Healthwatch network, foundation trust councils of governors and complaints advocacy organisations. Spending more time on relationship management will enable us to have a shared ongoing understanding of local issues and areas of risk. We also want to develop a more mature relationship with providers so that they are open and transparent with us and feel that they can highlight challenges as they occur.

We will improve the provider information request (PIR) submitted before a comprehensive inspection so it becomes an electronic submission, able to be updated regularly. We will expect providers to give their view of the quality of care they are providing against our five key questions, as part of annual reporting processes, including what has changed over the year, their plans for improvement and examples of good practice. This will help us decide what and when to inspect alongside the other intelligence we hold. We will explore this further with providers including whether some, if not all, of the information can be shared with commissioners and the public. We will also explore with providers how we can make this a core expectation of our regulatory relationship so that each provider's view of the quality they provide is transparent.

We will adopt a targeted and tailored approach to plan future inspections, using providers' regulatory history, our new insight model, information from providers and local knowledge to determine the scope of inspection (for example, which core services to review). We will develop a set of 'triggers', which will prompt us to investigate further, where we believe the quality of a service is poor or follow up where improvements are being made.

Through our new insight model, we will improve the information we have about local services and our ability to analyse and use this information to inform our inspections – for example, using information from our outlier programme and the metrics from our current 'Intelligent Monitoring' programme that correlate most highly to our inspection ratings. Our insight model will give our inspectors more timely information about providers' performance at core service and key question level, as well as overall provider level.

We will make improvements to our key lines of enquiry (KLOEs) and our assessment of core services so that we continue to assess aspects of quality that are most closely linked to good outcomes for patients.

## Inspect

We will have a targeted approach to inspection that focuses our efforts both on areas of risk and where quality is most likely to have changed or improved. Although we will retain large-scale comprehensive inspections where we believe these are needed, we will move to a targeted and tailored approach focused on core services in most cases. This will mean more frequent inspections on a smaller scale and a greater reliance on unannounced or short notice visits. We will develop a regulatory plan for each organisation, based on the information we hold in our insight model – a combination of the existing baseline rating and ongoing data, information from a range of sources and local knowledge. Evidence from our work so far shows that a good predictor of the overall quality of care a provider delivers is how well-led they are.

For NHS trusts and foundation trusts we will carry out an annual inspection which, as a minimum, will be an inspection of how well-led they are and of one core service. We may also carry out an inspection to follow up a concern and to review ratings, where appropriate, including where care has improved.

We will prioritise the inspection of core services that have been rated inadequate or requires improvement. However we will also re-inspect a percentage of core services that have been rated good or outstanding to ensure quality is maintained. We will test and confirm the maximum interval within which all trust core services will be inspected as we develop our approach.

Where we have not rated independent providers (for example, standalone substance misuse services), we will use the findings from our previous inspections, along with our insight model (where available), information from providers, and local intelligence to determine our regulatory activity.

We will continue our regular visits to all places where people are subject to the Mental Health Act (MHA), and will use what we find to help inform our regulatory activities.

We will consider joint inspections where appropriate, for example, inspecting with NHS Improvement when making an assessment on the effective use of resources.

We will retain the ability to carry out comprehensive inspections where necessary – for example, where we have systemic or significant concerns, such as services in special measures. Where specific concerns about a provider are raised, we will also continue to carry out responsive, focused inspections (or MHA visits where appropriate). We will inspect newly registered services within 12 months to award a baseline rating.

The overall size of inspection teams will be considerably smaller by focusing on fewer core services. The roles in each team will depend on the scope of the inspection. Teams will include specialist advisors, Experts by Experience and MHA Reviewers (where appropriate), but they may contribute only to part of an inspection. The views of people using services and the public will continue to be an important source of information for our inspections.

We will work with new care models, such as hospital chains, and make sure our approach will be flexible enough to accommodate them. We will also target areas that we have not previously inspected to improve our understanding of their quality of care. These may be areas that are known to be at risk of poor quality, or that affect a large percentage of the population using services, and cross our current core service boundaries – for example, people with mental health needs in acute hospital settings, or people diagnosed with cancer.

## Rate and report

In some cases, the information we hold will confirm the existing rating for a core service. Our smaller-scale inspections will review and, where appropriate, change the ratings for the core services we inspect. This may lead to a change in the overall rating for a provider. Factors we will consider in making changes to a providers' overall rating include:

- the findings of inspections carried out that year
- a review of leadership and governance within the organisation
- our insight model and other information we have gathered through local relationships.

We will produce shorter reports more quickly and that are more accessible to the public and will more clearly identify the evidence we gathered to inform our assessment. We will make clear in our reports where we are requiring that action be taken and where we are making a recommendation.

In 2016/17, we will start to publish the new assessments of the efficient and effective use of resources in NHS trusts and foundation trusts alongside our existing quality ratings, working together with NHS Improvement. We will also be developing options to combine these ratings from 2017/18, and consult on our proposed approach later in the year.

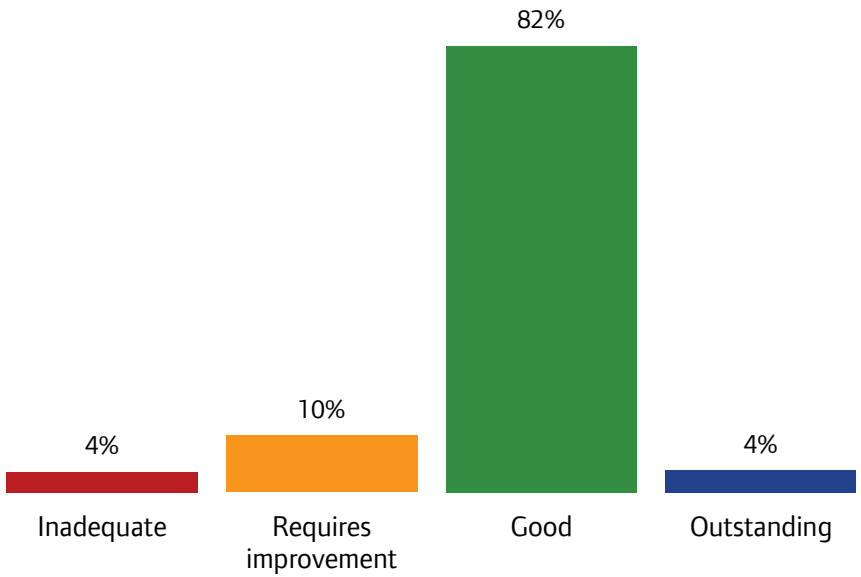
# Our plans for primary medical services

**Summary of what we will do**

- Work with partners to reduce duplication for GP practices and dental providers, agreeing jointly what action should be taken by whom where there may be risks of poor quality care.
- Agree a data request with the General Medical Council and NHS England so that GP practices only need to provide a single description of their quality based on the five key questions.
- Move to a maximum interval of five years for inspecting GP practices rated good and outstanding – subject to general practices providing accurate and full data, and our confidence that quality has not changed significantly.
- Focus on areas where there may be emerging risks, or where we need to understand more about innovative models of care, for example independent doctors or digital health providers.
- For federations and other new care models, focus on how well-led they are at corporate level, and consider inspecting a sample of locations, alongside looking at local area data to understand potential risks.
- For urgent and emergency care – including out-of-hours and NHS 111 services – inspect related services at the same time and strengthen how we work with our hospital inspection teams.
- Continue our current approach to joint inspections, such as the multi-agency work with HMI Prisons, HMI Constabulary, Ofsted and HMI Probation for children's services and in the criminal justice system, and look for opportunities to develop future joint inspection programmes.

**For all sectors, we will keep the experience of people who use services, their carers and families at the heart of everything we do and ensure that equality and human rights remain embedded in our approach.**

**Ratings: Primary medical services (May 2016)**




## Context

This section sets out how our functions of monitoring, inspection and reporting will evolve for GPs, dentists, urgent care, out-of-hours and 111 services, independent doctors and digital health services and inspections of children's services and of health and justice services.

By the end of 2016/17, we will have carried out comprehensive inspections and rated all GP practices, urgent care centres, out-of-hours and 111 services. We will have built on the initial round of inspections of dental practices we carried out in 2013/14, and inspected 20% of them. And we will have worked with partners to deliver a programme of reviews and inspections of children's services and health and justice services, and started comprehensive inspections of independent doctors.

For the first time, we will have a baseline of information that tells us about the quality of all general practices, urgent care centres, out-of-hours and 111 services across England. It is reassuring that so far we have found that the majority of practices (86%) are good or outstanding. However, we also have rated 4% as inadequate (affecting 600,000 patients) and 10% as requires improvement.

We will build on the aspects of our current approach that have worked well and driven improvements in the quality of care. We will rebalance our resources to focus on those areas where there may be unidentified or emerging risks, or where we need to understand more about innovative models of care – for example independent doctors, digital health care (such as online consultation services), some urgent care and new, more integrated care services.

We will invest in building local relationships and partnerships to help us move to a more intelligence-driven and targeted and tailored methodology, and also to ensure that collectively we have a better understanding of local issues and priorities. We also want to hear about people's experiences of care, both good and bad. Where people have concerns we want to be clear that they can raise them with us – this applies whether they are using the service themselves, have friends or families using services, or are members of staff.

The services we regulate are also going through a period of rapid change. We need to deliver a dynamic model that is both responsive to variations in the

quality of care and flexible to the new organisations that provide it, such as models that integrate both primary medical care and community health services, including those now emerging through the *Forward View* vanguard programme. We must ensure that we add value to the system, and work in the most cost-effective way possible.

We want to continue to encourage improvement and innovation in services. Crucially, we must strike the right balance between focusing on improving quality of care within a provider, such as an individual GP practice, and driving improvement across local and national systems – for example, the care of people with diabetes that needs to be coordinated across a number of services. We must ensure that we are also focusing on the priorities that matter most locally to the public and people who use services.

We recognise the challenges that services face over the next five years. We are committed to working more consistently with our partners to reduce unnecessary regulatory duplication experienced by services. This will be driven by our Regulation of General Medical Practice and Dental Practice Programme Boards, which provide a forum for regulatory bodies to tackle these issues together.

The next phase of regulation will evolve over the next five years. We will continue to carry out comprehensive assessments of quality, with comprehensive inspections being one element of a wider range of ways of working with services. We will move to a more targeted and tailored approach, with maximum intervals between inspections based on previous ratings (for those services we rate). We may inspect earlier than planned, depending on what our ongoing monitoring of wider intelligence (our insight) about a service is telling us.

We are currently piloting our approach to the regulation of independent doctors. We will publish our assessment framework and approach to regulating these types of services during 2016/17. We are currently developing our approach to regulating the provision of digital health care.

We will continue to deliver our joint health and justice services inspection work. Alongside delivering our children's inspection programmes (covering looked after children and safeguarding, joint targeted area inspections with Ofsted and special educational needs and disability), we will also consider how we can further embed assessing child safeguarding arrangements into our wider inspection activity.

We aim to begin implementing aspects of our new approach from April 2017, after we have completed our programme of comprehensive inspections. We will be co-producing and testing elements of our new model with patients and the public, and with partner organisations including NHS England, the General Medical Council, the Royal College of General Practitioners and the British Medical Association.

## Monitor

For general practice, we will develop a single shared view of quality with providers, people who use services, and our partners, including NHS England, the General Medical Council, and the National Institute for Health and Care Excellence. We will structure a common framework according to the five key questions we ask of each service: is it safe, effective, caring, responsive and well-led? This framework will use consistent and transparent measurements to drive improvements at provider and local level and across the system.

We will introduce our insight model, which brings together all of the national and local intelligence we hold on practices, to support our decision making. This new model for ongoing monitoring will identify where good care has been maintained or improved, as well as where care has deteriorated. The development of our insight model will support an increase in the maximum interval between inspections for good and outstanding practices.

Our insight will be flexible to the changing provider landscape and new models of care. We will make improvements to our key lines of enquiry (KLOEs) and population groups, so that they continue to assess aspects of quality that are most closely linked to outcomes for patients, for example for people with mental health needs.

We will analyse general practice data across local areas, such as across clinical commissioning groups (CCGs). This will help us understand patterns in data that may not show up at individual practice level.

To underpin our monitoring we will enable GP practices to share up-to-date information with CQC and other regulators and expect them to describe their view of the quality of care they are providing against our five key questions, as part of annual reporting processes, including what has changed over the year, their plans for improvement and examples of good practice. We will explore this further with providers, and see whether some, if not all, of the information can be shared with commissioners and the public. We will also explore with providers how we can make this a core expectation of our regulatory relationship so that each provider's view of the quality they provide is transparent. We are working closely with NHS England and the General Medical Council to align our information requests and develop more integrated systems, so that we reduce unnecessary duplication.

We are currently piloting a GP Practice Leadership Assessment Tool (developed with the King's Fund) to evaluate if it will help practices and CQC to assess leadership and culture within a practice and identify areas for improvement.

In consultation with NHS England, CCGs and other partners, we will carry out a regular review to identify which providers are posing an enhanced risk, what actions should be taken, and who should take them. This knowledge will complement our insight and inform the development and delivery of the local area inspection plans.

Inspection teams will have dedicated time for strengthening local relationships and gathering local intelligence for their portfolio of providers. Depending on the level of risk or potential improvement that is flagged, inspectors will respond, using a range of interventions, which may include carrying out an inspection.

We will identify annual activity for dental services by reviewing the information we hold, including what providers tell us, and involving commissioners and other regulators, where possible. Developing a shared view of quality is a central feature of our monitoring and inspection activity. We will do this by building on the partnership work between system regulators and commissioners arising from the Regulation of Dental Services Programme Board.

As the data currently available for out-of-hours and urgent care services is more limited, we will continue to be more reliant on inspectors gathering local information.

## Inspect

For general practice, the frequency and scope of each inspection will be based on the current level of concern that we have about a service, or their potential for improvement. We will inspect services that we have most concerns about more frequently than those where we have least concerns. Our level of concern will be based on previous ratings and up-to-date monitoring information. We will inspect a service earlier than planned if our insight identifies a level of concern that warrants it, or if we think quality has improved. With more effective monitoring information, more of our inspection activity will be unannounced. Our inspection programme will include a mix of focused, comprehensive and population or pathway assessments, reflecting national and local priorities.

We will inspect all newly registered locations within 12 months to award their baseline rating. Services rated inadequate will be inspected every six months, and those rated requires improvement at least every year.

For general practice, we will move to a maximum interval between inspections of five years for practices rated good and outstanding. This will be subject to practices providing accurate and full data, which is available to CQC and partner organisations, and also to CQC remaining assured that the quality of care has not changed significantly since the previous inspection.

We will carry out comprehensive inspections of all newly registered providers, and those that have been rated as inadequate. For other services, we may carry out a comprehensive inspection or an inspection focused on areas of concern or potential improvement, or with a particular focus on a population group or theme.

A core principle of our inspection approach is using specialist inspection teams and clinical expertise. This will continue to form an important element of our model. We will tailor the size and composition of the teams to suit the focus of the inspection and the nature and size of the service.

We will ensure that the level at which we inspect will be flexible to the type of provider. For many providers, this will remain at service level. For general practice, our approach for federations and other new care models will be informed by the structure and governance of the organisation. This could include inspecting a sample of locations, based on previous ratings and ongoing monitoring information. We may also focus on how well-led organisations, such as federations, are at a corporate level. For dental services, where appropriate (for example, large dental corporate providers), our assessment will be at headquarters level, with inspections of a sample of locations.

We will continue to inspect a proportion of registered primary care dental locations every year. Our current programme of inspections will provide a more comprehensive evidence base to identify the impact of our approach and how we can improve it. This will build on the findings of the Regulation of Dental Services Programme Board.

We will develop our model for regulating urgent care so that it can respond to the changes in national policy (for example changes to commissioning arrangements). Our approach will also be flexible to the changing models that deliver urgent care. Our Hospitals and Primary Medical Services inspection teams will collaborate more strongly to understand the quality of urgent care within a local area. This will build on our current urgent and emergency care

pilot, which is testing an approach for assessing care within an area and how providers coordinate care to produce a seamless experience for people who use services. Our future approach to inspecting care across pathways and populations will be informed by our findings.

As integrated out-of-hours and NHS 111 services are continuing to increase, we will continue to carry out inspections of both elements at the same time. We will also test joint inspections with commissioners. We will continue to inspect and rate at provider level.

## Rate and report

We will continue to publish data, inspection reports and ratings for general practice and urgent care services. For many GP providers this will continue to be at practice level. An overall rating will normally only be updated on the basis of evidence from inspection.

We will develop consistent principles for the level at which we provide ratings for larger GP practices, federations, corporate providers and new care models such as the *Forward View* vanguards. The right level will reflect the different models of care, and will be meaningful for people who use services and that particular provider.

Our inspection reports will be concise and will highlight key findings, changes in quality since the previous inspection and areas for providers to address. We will produce reports more quickly, supported by data published at the most meaningful level for a provider and for the public.

# Our plans for adult social care

**Summary of what we will do**

- Improve the information we have about local services and our ability to analyse and use this to inform our inspections – including expecting providers to describe their own quality against the five key questions.
- Respond to risk and potential improvements in quality through timely inspections.
- Once we have access to better information about services we will work with partners to agree and introduce longer intervals between inspections for services rated good and outstanding.
- Update ratings on the basis of inspection, and clarify where services are good with outstanding features and where services that require improvement are not meeting fundamental standards.
- For corporate providers, improve our local activity by better understanding the head office leadership and how this impacts on quality through culture and policies.

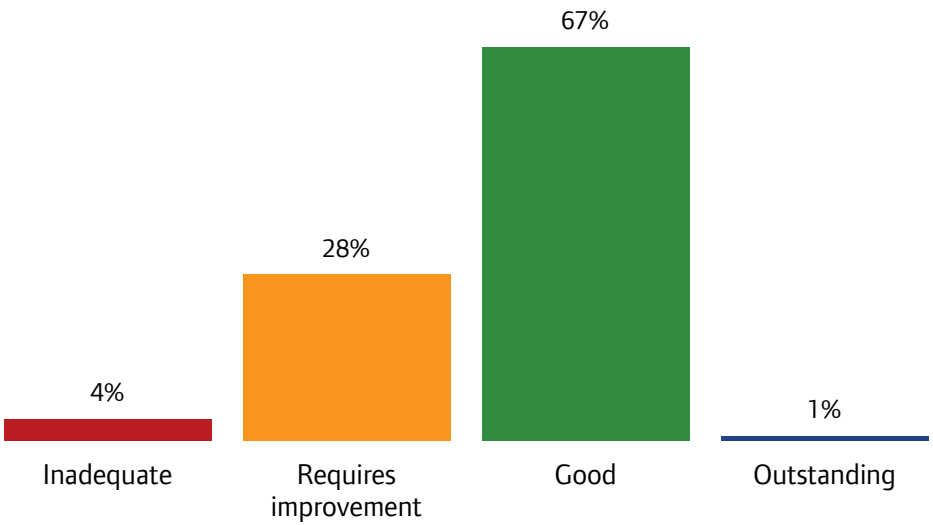
**For all sectors, we will keep the experience of people who use services, their carers and families at the heart of everything we do and ensure that equality and human rights remain embedded in our approach.**

## Context

This section sets out how our functions of monitoring, inspection and reporting will evolve for adult social care.

By the end of 2016/17 we will have a comprehensive understanding of the quality of adult social care services across the country, following the introduction of our new approach in October 2014. So far we have found that the majority of services (68%) are rated as good or outstanding. However we have found that 4% are rated inadequate and 28% requires improvement. This understanding will give us a strong foundation from which to build and deliver the commitments set out in our strategy for 2016 to 2021, which we will start to develop from this year, alongside people who use services, providers, commissioners and other partners.

**Ratings: Adult social care (May 2016)**




The adult social care sector is large with over 25,000 locations, many of which are run by small providers. The financial pressures that the sector faces are well known, as are the difficulties in recruiting and retaining staff. In these circumstances, it is more important than ever that the quality regulator is on the side of people using services, identifying good practice, encouraging improvement in providers and holding them to account where they do not meet expectations.

In meeting this challenge, we want to be clear that we will build on what we have done over the last two years. The way we regulate will be different in 2020 and our approach will continue to evolve. We will draw on our understanding of the current quality of care, making better use of information from providers, people who use services, their carers and families and others, and focusing our efforts both where risks of poor care are greatest, and where we see significant improvements. We want to hear about people's experiences of care, both good and bad. Where people have concerns we want to be clear that they can raise them with us – this applies whether they are using the service themselves, have friends or families using services, or are members of staff.

## Monitor

Although we do respond to risk now, the quality and availability of information is currently limited in adult social care and this is an important focus of improvement for us over the next few years. As more data and information become available, we will have a more comprehensive and sustained picture of the quality of care in individual services. This will allow us to respond more quickly and plan our inspections more proactively in response to possible risks to people, or where there has been significant improvement for people using services. This will give greater confidence that the regulator knows what is happening in local services throughout the year. We will encourage people who use services, their families and carers, as well as staff and other professionals, to pass information to us about the quality of care.

Through our new insight model, we will improve the information we have about local services and our ability to analyse and use this information to inform our inspections. We will also improve the provider information return

(PIR) so providers can describe their own quality based on the five key questions we ask each service (is it safe, effective, caring, responsive and well-led?), as part of annual reporting processes. This will include information to indicate what has changed over the year, their plans for improvement and examples of good practice. We will explore this further with providers, including whether some, if not all, of the information can be shared with commissioners and the public. We will also explore with providers how we can make this a core expectation of our regulatory relationship so that each provider's view of the quality they provide is transparent. Information will be submitted online and providers will be able to update it as and when they need to.

We will encourage more people to share their experiences of care with us and improve our ability to analyse what they tell us through the use of technology. This will help us to understand and respond better to the views of people using services – this is particularly crucial where people are looked after in their own homes, as we are less likely to be able to meet with them.

In order to promote a shared view of quality, we will work with local authorities and clinical commissioning groups to develop more consistent quality frameworks and expectations on providers, based on our five key questions. We will seek a common dataset that we can all access, so that providers only have to share information once, minimising duplication and reducing their administrative burden. We will improve our understanding of the quality of services delivered in people's own homes by requiring providers to share their call monitoring data – in particular, numbers of missed or late visits, length of stay and how many different carers are visiting individuals.

We will make improvements to our key lines of enquiry (KLOEs) so that they continue to assess aspects of quality that are most closely linked to outcomes for people. And we will monitor providers within a framework, based on our five key questions and KLOEs.

We will also continue to monitor the financial sustainability of the most difficult to replace providers of adult social care through our existing Market Oversight function.

## Inspect

We will continue to inspect and rate all adult social care locations, asking whether the current rating is still accurate, so people using services can be confident that our judgements remain timely and appropriate. Where we inspect large providers with more than one location, we will improve our understanding of the effectiveness and impact of the overall leadership at head office. We know that the leadership can have an important bearing on quality through the culture it sets, its policies and procedures and how it monitors and ensures continuous improvement.

The length of time between inspections will be determined by the rating of the service and the likelihood of quality having changed. We will inspect all newly registered locations within 12 months to award their baseline rating. Services rated as inadequate will be inspected every six months, and those rated as requires improvement every year. Over the course of the strategy, we will move to longer intervals between inspections for services rated good and outstanding as we have access to better information, and in 2016/17 we will start to work with our partners and people who use services to agree appropriate timescales.

Where our monitoring activity suggests there has been a significant improvement or deterioration in the quality of care, we can and will inspect sooner.

Our inspections will always focus on the experience of people using services and they will also involve talking with, and observing, people using the service and staff. Our specialist inspection teams – particularly for services delivering poorer care or where we have concerns – will continue to benefit from Experts by Experience and specialist advisors.

Our inspections will be most resource intensive where the risk to people using services is greatest. Therefore, inspecting an inadequate service will normally be a longer inspection with a bigger team, compared to when we return to a good service where the information available suggests the rating remains accurate.

## Rate and report

Given the currently limited availability of information about adult social care services, we will only change a rating on the basis of evidence from inspection, and this could be a comprehensive or focused inspection.

We will be clearer when services are good with outstanding features and where the rating of requires improvement does and does not entail a breach of regulations.

Drawing on information from our insight, from services and from our inspectors, our reports will be shorter and quicker to produce and publish, so that people using services will get to know our judgements more quickly and will be empowered to make choices about care using our information. We will work with national and local partners to share examples of good practice to encourage improvement.

# Enforcement

### Summary of what we will do

- Continue to use the full range of our enforcement powers, such as restrictions or closure of services, fixed penalty notices or prosecution where we find poor care below the fundamental standards, to make sure people's rights are protected and those responsible are held to account.

Where providers are failing to deliver the quality of care we expect, we will continue to take enforcement action against providers and individuals, to secure improvements in services and protect people using services from potential or actual harm. Where people are exposed to significant harm or risk of significant harm, we will take urgent enforcement action to prevent them being exposed to further risk. If appropriate, we will hold the provider to account using our powers to prosecute where fundamental standards have been breached.

We will continue to follow our enforcement policy and use the full range of our powers, from fixed penalty notices, to criminal prosecution, to closure or restrictions on services. We will share information about our enforcement action so that the public and good providers can be confident we are tackling poor care.

We will seek changes in the regulations so that we can share information during enforcement action we are taking, rather than at the conclusion.

We will review and adapt our current approach to special measures in all sectors, to ensure it is enabling services, commissioners, regulators and other stakeholders to act quickly and decisively where the quality of care is most poor.

## About CQC

**The Care Quality Commission is the independent regulator of health and adult social care in England.** We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

## Our role

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

## Our values

**Excellence** – being a high-performing organisation.
**Caring** – treating everyone with dignity and respect.
**Integrity** – doing the right thing.
**Teamwork** – learning from each other to be the best we can.

## Our statutory objectives

Our strategy is based on our main statutory objectives, which remain the guiding reason for doing what we do. These are: to protect and promote the health, safety and welfare of people who use health and social care services by encouraging improvement of those services; encouraging the provision of those services in a way that focuses on the needs and experiences of people who use those services; and encouraging the efficient and effective use of resources in the provision of those services.

## How to contact us

Call us on **03000 616161**
Email us at **enquiries@cqc.org.uk**
Look at our website **www.cqc.org.uk**

Write to us at **Care Quality Commission**
**Citygate, Gallowgate, Newcastle upon Tyne, NE1 4PA**

Follow us on **Twitter @CareQualityComm**

Read more and download this report in other formats at **www.cqc.org.uk/ourstrategy**

Please contact us if you would like this report in another language or format.

CQC-331-052016