Cheshire LMC response to the *Better regulation, better care: Consultation on improving how we assess and rate providers.*

The full consultation document is available **HERE**.

Context of the Consultation

- CQC is rebuilding and improving its regulatory methods after recognising previous issues.
- Feedback from stakeholders and findings from three independent reviews (by Penny Dash, Mike Richards and the Care Provider Alliance) have shaped the proposals.
- There is a need to adapt regulation to evolving health and care services, including integrated local models of care.
- The consultation aims to work in partnership with providers, the public, and other stakeholders to ensure the approach is workable and effective.

Purpose of the Consultation

The consultation is seeking feedback on:

- Updates to the assessment frameworks and guidance.
- Proposed changes to methods for inspecting, assessing and awarding ratings.

Key Aspects of the New Approach

- Sector-specific assessment frameworks to better reflect differences across health and care sectors.
- Clear rating characteristics published to guide consistent rating decisions for the five key questions.
- Reframed quality statements as supporting questions, like previous KLOEs, to clarify what "good" looks like.
- Four new Chief Inspectors will lead implementation using specialist expertise in each sector.
- Continued commitment to:
    - Improved clarity in reporting
    - Greater consistency in regulatory decisions
    - More timely assessments
- Stronger use of data and new insights to ensure assessments reflect current evidence and people's experience.

Part 1: Improving the Assessment Framework

- The assessment framework underpins how the CQC judges the quality of regulated services and supports other key functions such as registration, enforcement, joint inspections, and local authority assessments.
- The current framework is built around:

    - **Five key questions** (safe, effective, caring, responsive, well-led)
    - **Quality statements** describing expectations of high-quality care
    - **'I' statements** reflecting what matters to people using services
- The single assessment framework introduced in 2024 aimed to simplify processes and ensure consistency across healthcare and adult social care.

Why Changes Are Needed

Feedback from independent reviews and stakeholders highlighted the need to:

- Clearly define expectations across all rating levels (not just "good")
- Provide better sector-specific clarity on quality and safety
- Make the framework easier to understand and use.

What Will Stay the Same

- The five key questions remain the structural basis for assessments.
- The fundamental standards in legislation continue to underpin quality and enforcement.
- Local authority assessments are not part of this consultation but will be aligned later.

What Is Proposed

1. Describing our expectations of quality for all our rating levels

- **Reintroduce rating characteristics** for each rating level (outstanding, good, requires improvement, inadequate), developed collaboratively and applied flexibly rather than as a rigid checklist.
- **Replace current quality statements** with a new set of **supporting questions**, similar to previous KLOEs, to give a clear structure and make expectations transparent to providers and the public.

Consultation Question 1

To what extent do you agree that we should publish clear rating characteristics of what care looks like for each rating as part of our new assessment frameworks?

Answer: ***Agree***

2. Clearer Sector-Specific View of Quality and Safety

- Feedback has highlighted the need for clearer expectations of what "good" looks like across different sectors of health and care.
- CQC regulates a wide variety of services (e.g., hospitals, GP and dental practices, care homes, home care, ambulance services), each with distinct contexts and needs.
- The CQC proposes to re-introduce sector-specific assessment frameworks that:

    - Better reflect the differences between sectors
    - Clearly articulate standards for quality and safety
    - Are developed in partnership with providers, people using services, and stakeholders
- These frameworks will:
    - Maintain consistency through shared core elements (e.g., five key questions and regulatory links)
    - Include sector-specific content where necessary
    - Support integrated assessments of care pathways across sectors, as care models become more complex and joined up.
- Supporting guidance will set out relevant evidence sources and standards for each sector.
- For services that CQC cannot legally rate (e.g., dental providers), frameworks will clarify how compliance with regulations is judged.
- Registration processes will be aligned with the updated assessment approach to ensure continuity between approval and ongoing regulation.
- Draft frameworks will be published for co-production and refined based on feedback from this consultation.

Consultation Question 2

To what extent do you agree with our proposed approach to developing assessment frameworks that are specific to each sector?

Answer: ***Agree***

Consultation Question 2a

Do you have any comments or suggestions on how we should develop sector-specific assessment frameworks?

Answer:

Assessment frameworks should be developed collaboratively with appropriate expertise from each sector. In general practice, this must include meaningful consultation with GP leaders, specifically Local Medical Committees (LMCs) and the BMA's General Practitioners Committee (GPC) to ensure that expectations are realistic, deliverable, and reflective of the realities faced by frontline GPs. This engagement is essential to build confidence and trust in the regulatory process.

We would expect CQC inspectors to be in regular communication with LMCs in their regions so that local issues can be addressed early on and providing practices with a way to give constructive feedback about their experiences.

We would welcome the publication of more detailed supporting guidance for general practice that shows the key standards and sources of evidence that CQC will consider as this will help to clarify expectations in some areas. Prompt practical guidance from CQC (with input from

the General Practitioners Committee) for emerging issues where there may be uncertainty will be vital in supporting practice to reach expectations.

A rigid, "one size fits all" assessment framework that overlooks the local context and the roles of different organisations within new care models is unlikely to be effective. Flexibility is therefore critical to ensure fairness and accuracy as is regular review of the frameworks based on feedback from providers and patients where appropriate.

As integrated neighbourhood care models emerge, it would be more effective to inspect services "at scale", with a reduced reliance on individual practice inspections and a greater focus on how care is delivered collaboratively across networks. This will also help to reduce unnecessary burden, duplication of effort and pressure on individual practices.

3. Making Assessment Frameworks Simpler and Clearer

Proposals include removing duplication, improving consistency and simplifying language.

Consultation Question 3

To what extent do you agree with our proposed approach to making our assessment frameworks clearer and removing areas of duplication?

Answer: ***Strongly agree***

Consultation question 3a

Do you have any comments on the content of our current single assessment framework, or suggestions for how we should make our assessment frameworks simpler and clearer?

Answer:

Over reliance on patient feedback and unrealistic patient expectations (when general practice is currently under immense pressure) may influence ratings in ways that do not reflect clinical appropriateness. For example, unnecessary referrals may occur at patient request despite community-based care being more appropriate and cost-effective. It is therefore important that a balanced approach is taken to reviewing patient feedback and complaints.

A single framework is unlikely to fully capture the complexity of all services CQC regulates. The administrative burden on individual GP practices in preparing for inspections is disproportionately higher than for larger Trusts. Therefore, a more flexible and balanced approach is needed to account for this.

Providers should be able to demonstrate how they meet quality statements through pre-submitted examples, rather than relying solely on evidence sought on the day of the

inspection. Supportive guidance from CQC could provide greater clarity for practices on the type of examples that could be submitted as evidence.

Practices should be permitted to focus on a smaller number of broader quality statements to showcase innovation, collaboration, and excellence. Local intelligence from ICBs and relevant datasets could be incorporated to ensure that a more selective approach still meets regulatory standards.

Part 2: CQC Judgements and Award Ratings

Current approach

- CQC rates health and care services to provide an independent view of quality: **safe, effective, caring, responsive, well-led**.
- Ratings are based on inspectors' professional judgement, evidence, and people's experiences.
- Ratings are: Outstanding, Good, Requires Improvement, Inadequate.

Why change is needed

- The scoring system introduced in 2024 was meant to:
  - Improve consistency and transparency
  - Allow ratings to be updated more quickly
- But feedback showed scoring is:
  - Too complex
  - Not transparent
  - Limits appropriate professional judgement

Proposed improvements

1. **Simplify the rating approach**
   - Remove detailed scoring under each key question (no quality statement scoring).
   - Stronger emphasis on expert inspector judgement.
2. **Streamline inspections**
   - Faster, clearer reports that focus on improvement. Maintain strong and effective relationships with providers.
3. **Clarify how and when ratings are updated**
   - Review frequency of assessments and rating changes.
4. **Possible changes under consultation**
   - Reintroduce overall Trust-level ratings
   - Remove overall ratings for individual hospital locations within Trusts.

What will stay the same

- Services will still receive:
  - Ratings for all five key questions
  - Overall rating based on those key question ratings
- Same aggregation principles and use of professional judgement

- Services that legally cannot be rated (e.g. primary care dental) will still have regulations met/not met judgements.

Overall goal

- A simpler, clearer and more flexible system that provides trusted information to the public and drives improvement in care.

Consultation Question 4

To what extent do you agree that we should award ratings directly at key question level with reference to rating characteristics?

Answer: ***Agree***

Consultation question 4a

Do you have any comments or suggestions on our proposed approach to awarding ratings?

Answer:

A simplified approach is welcomed. All ratings should be accompanied by a clear, evidence-based rationale. Inspectors and their teams should take proportionate and pragmatic approaches to assessments. We would expect them to have a thorough understanding of the sector they are inspecting, as well as the wider context and external factors which have an impact on a provider's ability to deliver safe, high-quality care. GP practices should retain the right to appeal ratings, supported by an independent review process to ensure transparency and fairness.

Supporting Inspection Teams and Improving Reporting

Improving inspection delivery

- Focus on timelier and expert-led inspections.
- Strengthen relationships with providers through respect, trust and continuity.
- Ensure providers have a clear CQC contact, especially large organisations like NHS trusts.

Better technology and data use

- Replace outdated IT systems to better support CQC staff and providers.
- Redevelop the provider portal and registration systems to be simpler and more accessible.
- Improve how regulatory data and insights are shared to support quality improvement.
- Co-design digital systems with users to ensure safety, usability and accessibility.

Role in AI-enabled care

- CQC will not regulate AI products directly but will assess how AI is used in services.
- Developing a clear policy position on AI focusing on quality, safety and equity (due spring 2026).
- Engage widely with stakeholders to shape this position.

Developing a skilled workforce

- Four chief inspectors leading specialist teams across key sectors.
- Invest in staff expertise, regulatory skills and relational skills.
- Expand joint working with Experts by Experience and external specialist advisors (e.g., clinicians) for high-quality, credible assessments.

Clear and impactful inspection reports

- Co-design new report format that is:
    - Structured, consistent and easy to use
    - Clear about performance against the assessment framework
    - Useful for both the public and providers
- Include:
    - Detailed reasoning behind judgements
    - Highlights of good practice
    - Areas needing improvement, including inequalities and unwarranted variation.

Consultation question 5

Do you have any comments or suggestions for how we should support our inspection teams to deliver expert inspections, impactful reports and strong relationships with providers?

Answer:

Inspection teams should include individuals with a broad range of relevant experience, ensuring that assessments are balanced and do not place disproportionate emphasis on one aspect of the inspection.

To build trust and strengthen relationships, inspectors should proactively engage with Local Medical Committees (in the case of general practice). This would support effective feedback across regions and allow emerging issues to be identified and addressed early on.

It is essential to consider the impact that inspections have on staff wellbeing and service delivery in general practice, which differs significantly from that of larger Trusts. Providing practices with sufficient time to submit information in advance and adopting a more supportive approach would be welcomed. Inspection teams should acknowledge the wider pressures facing general practice, including rising demand, workforce shortages, increasing patient expectations and prolonged underfunding. We would expect Inspection teams to engage professionally and compassionately with providers to better understand how they are trying to meet the required standards.

Examples of good practice should be celebrated, with learning shared across the wider system. Inspection reports should be timely, factual and clearly supported by evidence. Registration systems must be more user friendly.

Following Up Assessments and Updating Ratings

- CQC aims to deliver more dynamic, flexible and up-to-date regulation.
- Earlier scoring systems were intended to support more frequent rating updates, but operational issues delayed progress.
- A new assessment approach will include clearer planning for when and how ratings are updated.

Two main types of inspections

1. **Routine planned inspections**
    - Broad review of quality across all five key questions
    - Typically, every 3–5 years, depending on service type and performance trends
2. **Rapid response inspections**
    - Triggered by immediate concerns or risks
    - Focus on specific risk areas, not full framework coverage

How ratings will be updated

- Ensure evidence is current, avoiding reliance on outdated findings.
- Consider:
    - Improvement or deterioration in quality
    - Enforcement action where significant failings occur
    - Other intelligence e.g. reviews and complaints
- Large providers: priority given to services with lower previous ratings.
- Frequency schedule will factor in:
    - Time since last assessment
    - Emerging risks or signs of improvement

Inspection approach

- Both announced and unannounced inspections will continue.
- Care homes typically unannounced; revisit if registered manager absent.
- Trust-level Well-Led inspections usually announced to ensure key staff availability.

Consultation question 6

To what extent do you agree with the approach to following up assessments and the principles for updating rating judgements?

Answer: ***Agree***

Consultation question 6a

Do you have any comments on our proposed approach?

Answer:

We support ratings being updated based on current evidence to avoid reliance on outdated findings. Routine inspections of GP practices should not take place within five years of the last inspection, unless emerging risks or significant concerns have been identified.

For practices that consistently achieve a "Good" or "Outstanding" rating and where no concerns have been raised, a full site visit should not always be necessary. In most cases, any additional information required could be requested digitally rather than through a full on-site inspection.

As small independent businesses, GP practices must be given sufficient notice of inspection dates and be mindful of the spikes in pressure that practices face at certain times of the year. Where key staff are on planned leave or service delivery would be significantly impacted by workforce shortages, alternative dates should be offered without detriment to the practice.

A balanced approach should be taken when reviewing patient complaints, ensuring that local intelligence and performance data are also considered to maintain a fair, considered approach and to avoid skewed ratings.

CQC must also improve the speed of rating reviews where practices can clearly show swift action was taken during or directly after the inspection to address concerns.

Potential Changes to Ratings for NHS Trusts and Independent Hospitals

- CQC is reviewing how it rates complex providers such as NHS trusts and independent hospitals.
- Currently, NHS trusts receive:
    - Multiple levels of ratings (from service-level to trust-level)
    - A single trust-level rating only for the Well-Led key question
    - No trust-level ratings for safe, effective, caring or responsive
- CQC recognises challenges with this current model, particularly how well a single Well-Led rating reflects overall trust performance.
- The consultation seeks feedback on:

1. Reintroducing an overall quality rating for NHS trusts
2. Reintroducing trust-level ratings for all 5 key questions

- Location-level ratings (e.g., for individual hospitals) may be removed because:
    - Aggregated hospital ratings can mask variation between services
    - Care is increasingly delivered across different sites, not confined to one location
    - However, patients still value local hospital ratings → further engagement is planned
- CQC will continue gathering feedback on:
    - How service ratings should be structured within trusts
    - Whether assessing services by location or pathway is more meaningful.

Consultation Question 7a

To what extent would you support reintroducing an overall quality rating for NHS trusts and Trust-level ratings for all five key questions?

Answer: ***Don't support***

Consultation Question 7b

To what extent would you support no longer aggregating hospital-level ratings into an overall location rating?

Answer: ***Not support at all***

Consultation Question 7c

Do you have any comments to support your views, or suggestions for how we should award ratings for NHS trusts and independent hospitals?

Answer:

It is essential for both providers and patients to understand how individual hospitals are performing. Performance can vary significantly between hospitals within the same Trust, and Trust-level ratings alone may be misleading.

Hospital-level ratings support patient choice and shared decision-making at the point of referral. They can also provide valuable insights to support the safe and appropriate shift of services from hospitals into the community, with alignment of funding to deliver care closer to home.

The use of single aggregated ratings, however, is too simplistic and cannot adequately capture the complexities of delivering healthcare. An overall 'requires improvement' or 'inadequate' rating could conceal areas of excellent care, possibly in a specialty or service more relevant to the individual patient seeking information on care that is relevant to them. Equally, an overall 'good' or 'outstanding' rating might conceal areas of poor care in another area.

If Trust-level ratings were introduced without hospital-level ratings, a parallel approach should apply in primary care. Where general practices operate at scale, or within new integrated models of care, the neighbourhood model should be assessed rather than inspecting and rating each practice individually.

The negative impact of single aggregated ratings is well-known. Many GP practices report difficulty in recruiting staff to practices with poor CQC ratings and this is likely to lead to poorer outcomes for patients.

Measuring the Impact on Equality

The CQC's draft equality and human rights impact assessment considers how proposals may affect different groups and aims to identify risks and good practice.

Consultation question 8

We'd like to hear what you think about the opportunities and risks to improving equality and human rights in our proposals. Do you think our proposals will affect some groups of people more than others (for example, those with a protected equality characteristic such as disabled people, older people, or people from different ethnic backgrounds)?

Please tell us if the impact on people would be positive or negative, and how we could reduce any negative effects.

Answer:

CQC must ensure that information is available in different formats and is accessible to everyone. Feedback from individuals from the groups you have highlighted, and any relevant representative groups should inform decision making around language used and the approach taken to reduce inequalities.

Consultation question 9

Do you have any other comments on our work, things we should consider, or suggestions for how we could improve?

Answer:

Consideration of vexatious complaints from patients that can trigger CQC inspections needs appropriate consideration as it can cause significant distress for practice staff.