Clarifying how we define registered providers and improving the structure of registration

Objectives for today

To share our current thinking and seek your views on:

1. How and why we propose to clarify the definition of a provider
2. The practical implications of a revised definition of a provider
3. Changes to how we plan to structure our register

What is the problem we are trying to solve? (1)

Our current approach to registration inhibits our effectiveness and our ability to deliver our statutory duties and strategic ambitions

Register

- **Limited visibility of links between entities and lines of accountability**
- **Register does not reflect public understanding of 'brands' or services they use**
- 'One size fits all' with a focus on buildings that is increasingly irrelevant

Monitor

- **Limited visibility of provider strengths and weaknesses across all its services**
- **Localised focus**
- CQC Insight compromised by poor quality of contextual data

What is the problem we are trying to solve? (2)

Our current approach to registration inhibits our effectiveness and our ability to deliver our statutory duties and strategic ambitions

Inspect & Rate	• **Limited scope to target inspections & duplication of effort** • **Cannot rate at corporate/federation/chain HQ level** • Limited understanding of nature and scale of services in some models
Enforce	• **Systemic failings cannot be met with appropriate action; localised and duplicative approach** • Market Oversight function not fully supported
Independent voice	• **Can't inform people how local service fits into a wider organisation and what the quality of that organisation is** • State of Care is not as clear as it could be on market trends

Overview of consultation proposals

We propose to:

- develop our register so it properly informs the public about provider ownership and answers the **what, who, where, when** questions
- clarify who is required to register with us so that we can
  - ✓ hold to account all of those who are accountable for quality
  - ✓ make sure they improve quality across their services
- improve our understanding of large and complex organisations so we can take a more targeted and responsive approach to regulation
- display the history of a service where they come under new ownership, new contracting arrangements or if there is an administrative change such as change of address and be able to take more account of this history in registration decisions

How and why we propose to clarify the definition of a provider

Our current approach (1)

- Section 10 of the Health and Social Care Act (2008) requires that any person ‘carrying on’ a regulated activity must be registered with CQC
- Until now this was the legal entity that has ongoing direction and control of the regulated activity and which delivers the service day-to-day.
- Where providers are subsidiaries within wider groups, this means rather than registering the group as a whole, we have in most cases registered:

  1. the entity that is directly above the location in an organisational structure, and
  2. each provider individually

Our current approach (2)

- Scale of impact (all regulated health and social care services in England):
  - 31,000 providers delivering services across 49,000 locations.
  - Estimate 2,340 of these providers are part of 390 wider groups.
  - They run 11,400 locations (includes approx. a third of all care homes beds

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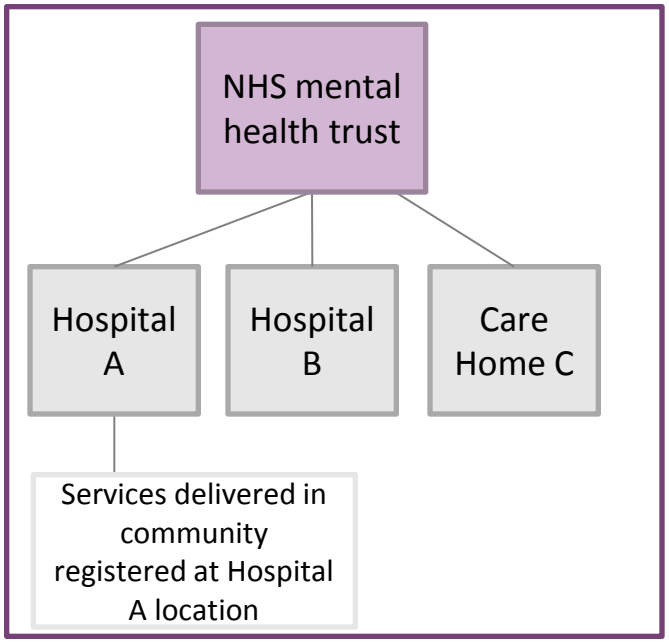
Examples of current approach

Entity registered with CQC	Entities above registration	Locations as a condition of registration	Not on register: do not fit our definition of location for that service

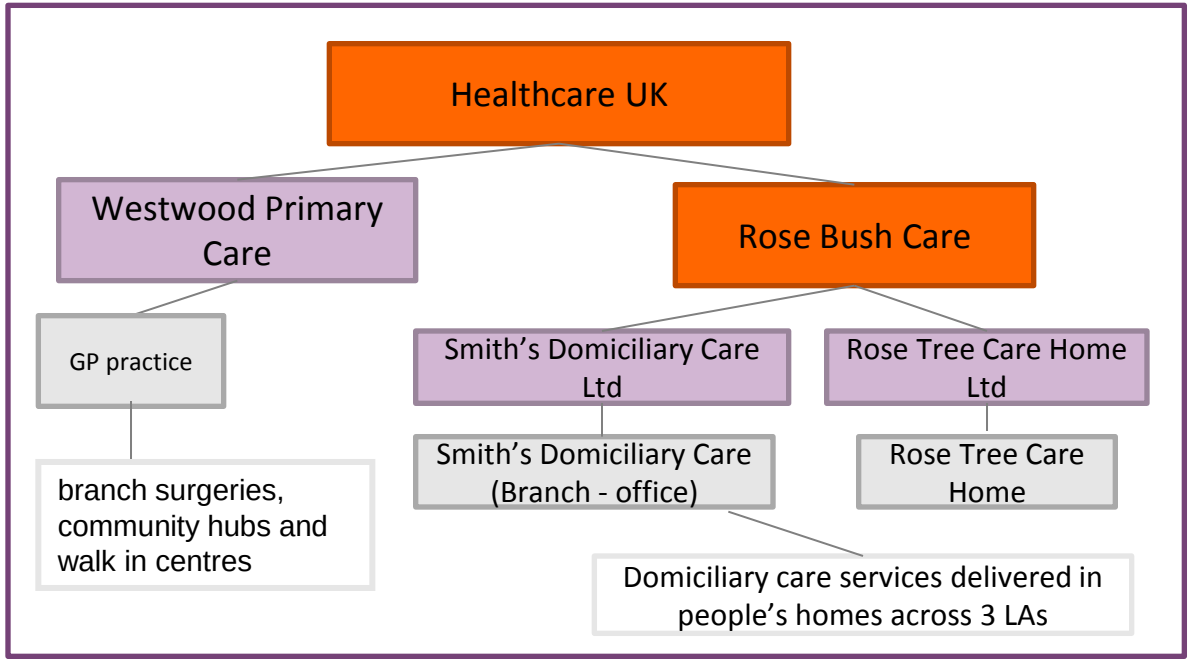
Our current approach allows us to understand providers and deliver our operating model more effectively in some organisational forms and services than others.

Example A: NHS Trusts can be registered as a single entity, enabling CQC to understand links between the Trust's locations, and to take action at Trust level where needed



Trust delivers community mental health services from local area teams, one in each of the five CCG areas it services.
People won't be able to find them as they are not deemed locations so aren't on the register.

Example B: Healthcare UK and Rose Bush Care are not registered, although these entities may well direct or control the quality and safety of Smith's Domiciliary Care, Rose Tree Care Home and Westwood GP Federation.



GPs have formed new legal entity with one patient list, so they only register one practice as a location. Community hubs serve same patients so are branches. Community services are also delivered at the hubs, but location rules require all of these to be registered at community trust headquarters. Community hubs do not appear on our register at all. Westwood Primary Care only pays fees for one location.
DCA rated Inadequate but is expanding taking on contracts across several local authorities. We are not aware of extent of services or expansion as provider has not set up new office (location). Fees based on number of offices.

Defining who is accountable for the quality of care (1)

Entities that exert **significant influence over quality and safety** rather than equity holders where the focus is more purely financial. So where they:

- Manages and delivers assurance and auditing systems or processes that assess, monitor and drive improvement in the quality and safety of the delivery of regulated activity and to which entities delivering that activity are accountable.
- Has the right to require providers of regulated activity to submit consolidated annual budgets in advance for approval.
- Has the right of veto such that entities providing regulated activity will only be entitled to carry on their business in accordance with financial plans that have been signed off.
- Directly develops and enforces common policies on matters such as staffing levels, clinical policy, governance, health and safety, pay levels and procuring supplies that must be adhered to by entities providing regulated activity.

List continues on the next slide

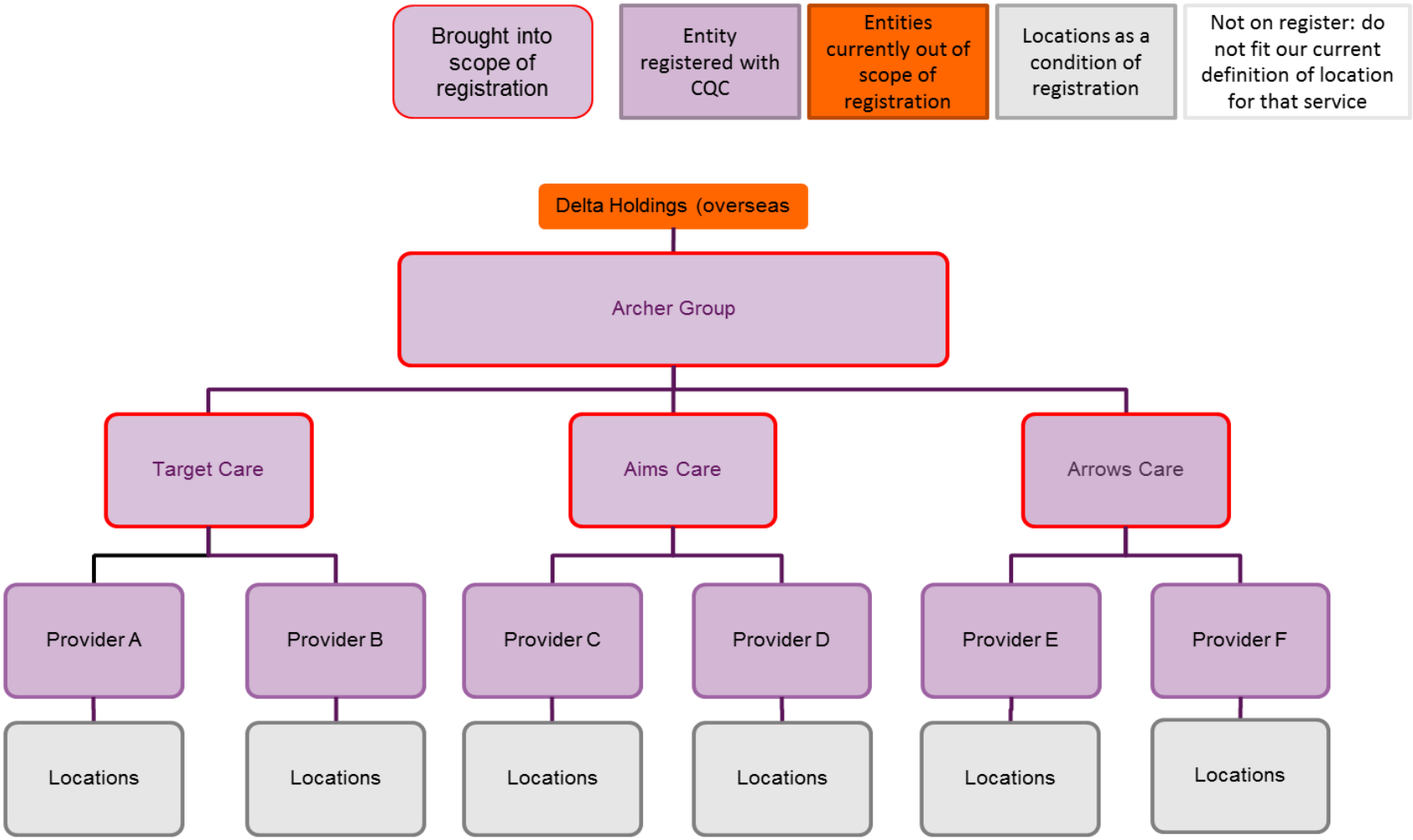
Defining who is accountable for the quality of care (2)

Where they:

- Have the right to make employment decisions concerning:
  - People who work or are seeking to work in support of the delivery of regulated activity
  - People who run or who seek to run individual care settings that deliver regulated activity
  - Board membership where the board is responsible for holding to account services or entities delivering regulated activity.

- **Providers in England only.** However, we will require providers to inform us of overseas owners and will use this information to link together what we know about providers with common ownership and publish this on our website.

What might this look like in practice?



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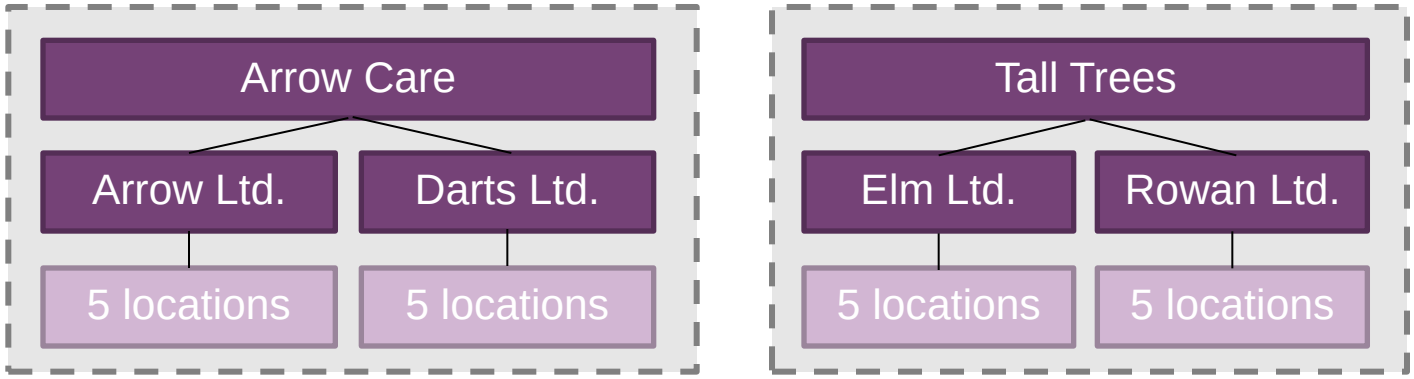
The practical implications of a revised definition of a provider

Context

- In developing our new approach to registration, providers and colleagues in Market Oversight have highlighted that our approach has the potential to have a significant impact on the market
- This is not necessarily a bad thing, as the impact might be to improve quality of care and to prevent poor providers carrying on a regulated activity or expanding their provision
- Here we set out some scenarios which, in the new approach, CQC will have an opportunity to influence and to explore the level of influence and control CQC should have over certain types of transaction

New approach

Registered provider | Locations | Known ownership and management relationships

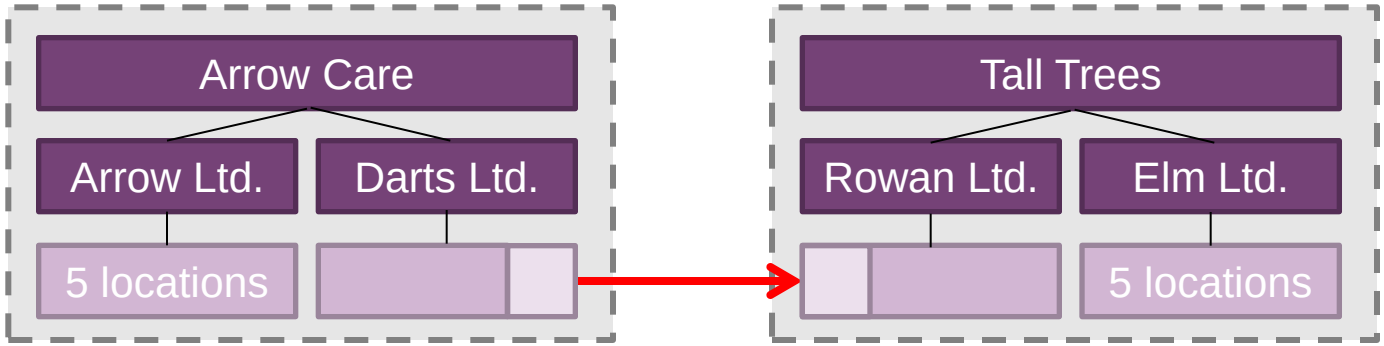


In the new approach to registration:

- All providers in the dark purple boxes will be registered
- We will know that Arrow Care and Tall Trees are ‘guiding minds’ of two providers each, and be able to hold them to account for care
- We can potentially understand these structures as ‘blocks’ of registration and will be able to take this into account when making decisions throughout our operating model
- **We need to make decisions about the level of scrutiny and influence CQC should have over changes between and within these structures.**

Sales and acquisitions (1)

Registered provider | Location for sale | Locations | Known ownership and management relationships



Darts Ltd sells one location to Rowan Ltd

•At present, we only consider Rowan Ltd in deciding whether to agree to them taking on the new locations

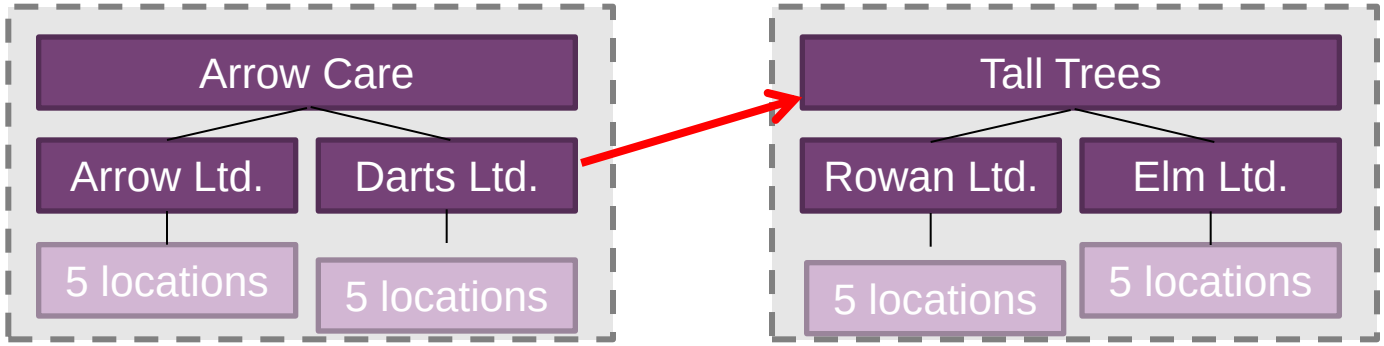
Questions for discussion:

1.In future, to what extent should we consider the roles and quality of Tall Trees and Rowan in reaching a decision?

2.Where movement takes place within one organisational structure, should we require notification (rather than *application*) only?

Sales and acquisitions (2)

Registered provider | Location for sale | Locations | Known ownership and management relationships



Arrow Care sells a provider (Darts Ltd) to Tall Trees

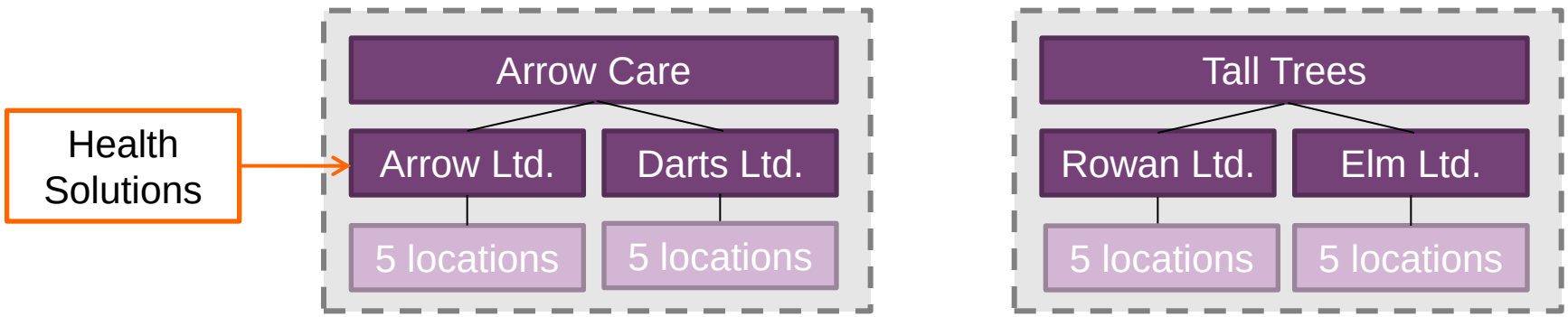
- At present, we would not know about this change, but in our new approach we would

What level of oversight of the sale and acquisition of providers should CQC have?

1. Require Tall Trees to **apply** to take over Darts Ltd. Would increase oversight but would increase the burden and potentially impact the market
2. Require Tall Trees to **notify** us of the change. Would require no assessment and minimal (unqualified) increase in the burden

Management contracts (1)

Registered provider | Operating company | Locations | Known ownership and management relationships



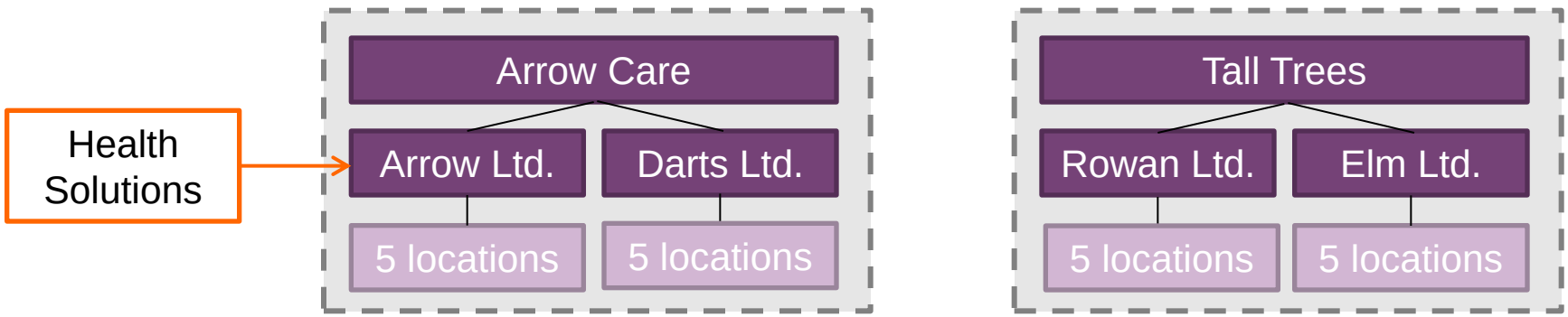
Arrow Care is a financial company with no care experience. They appoint Health Solutions, an operating company, to manage and direct the care delivery

•At present, we have no regulatory relationship with Health Solutions, as this arrangement occurs through an existing provider vehicle

Our new approach will bring Health Solutions into scope of registration

Management contracts (2)

Registered provider | Operating company | Locations | Known ownership and management relationships



Arrow Care then decide to change the operating company, and appoint Tall Trees to manage and direct care delivery, through a management contract

- At present, we would not know about or influence this arrangement, even if we have concerns about Tall Trees' existing providers

What level of oversight of changes to management contracts should CQC have and should this be same as our oversight of sales/acquisitions?

Changes to how we plan to structure our register

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- Register does not reflect public understanding of 'brands' or services they use
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Monitor

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How will we solve the problem? (1)

Develop a flexible way of registering and controlling provider services appropriate to the kind of service

1. **Increase granularity** by defining a core set of information ('fundamental attributes') which allows us to answer basic questions:

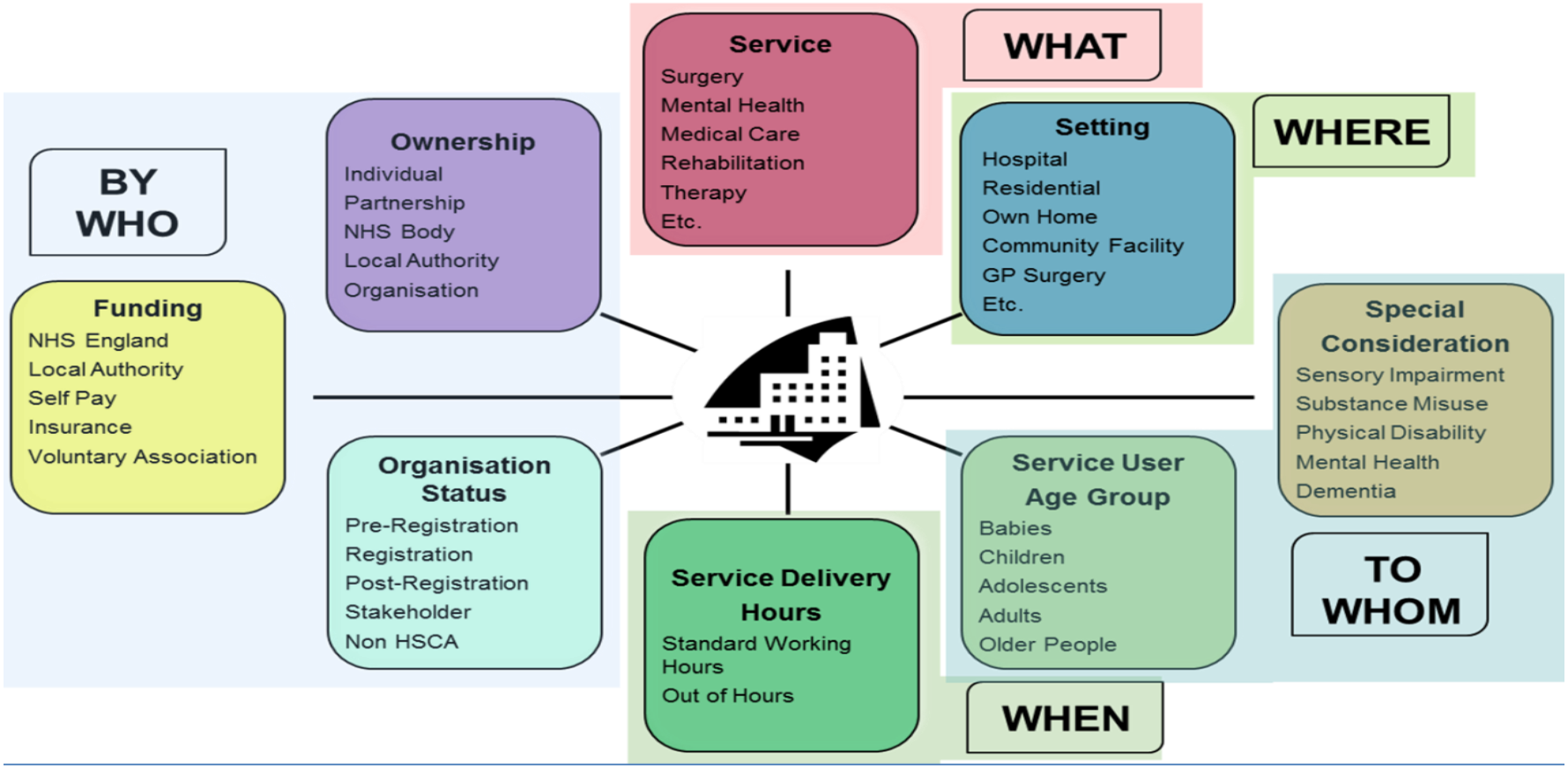
    - **WHAT TYPE** of services are provided? (aligned to core services and services in inspection)
    - **WHO** is the service for?
    - **WHERE** is the service provided? (setting e.g. hospital ward, people's homes) + address(es)/ geography)

2. **Combine these attributes** to understand what 'blocks' of service delivery make up a provider.

How will we solve the problem? (2)

3. **Only control regulated activity by buildings where this makes sense for the kind of service**
   - Develop other restrictive conditions for other types of services if this is the most appropriate regulatory mechanism
   - Review/update policy on use of restrictive conditions (at registration)
   - Keep other information up to date through more effective and consistent use of statement of purpose

What might this look like in practice?



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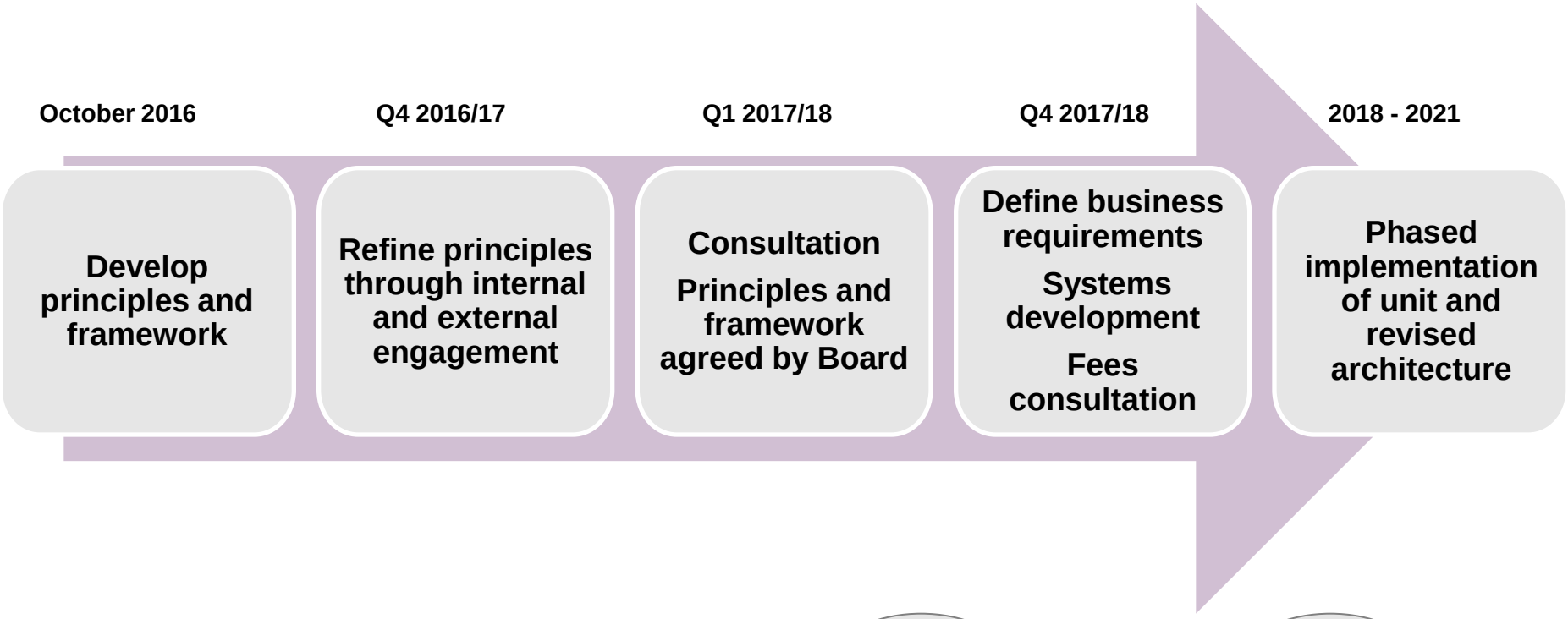
High level timeline



Next phase of inspections timeline

Assess some evidence at HQ level

Well-led and increased activity at provider level

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Thank you!