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?

We agree with the publication of clear rating characteristics to make it easier for charitable hospices to understand what inspectors are looking for during inspections, and to understand why they received a rating.

Accompanying such characteristics with case studies to show what was done and how to achieve an improved rating would be welcome. It would help hospices to understand what the CQC is assessing. However, this would need to be accompanied by the introduction of sector specific frameworks that would take into account the differences between services.

We support the introduction of a charitable hospice framework given their unique service delivery model of delivering holistic palliative and end of life care in the community with both statutory and charitable funding. Failing that we would support a broader palliative and end of life care framework, given its difference from other forms of care.

The CQC would need to work with Hospice UK and the charitable hospice sector to ensure that such frameworks would be fit for purpose for use withing the sector. Such engagement would also help build confidence in the CQC's ability to assess the sector.

Consultation question 2: To what extent do you agree with our proposed approach to developing assessment frameworks that are specific to each sector?

We support the introduction of a charitable hospice framework given their unique service delivery model of delivering palliative and end of life care in the community. Failing that we would support a broader palliative and end of life care framework, given its difference from other forms of care.

The hospice operating model is unique. Hospices deliver highly specialist palliative and end of life care in their inpatient units, outpatient buildings and in people's homes. This is reliant on specialist staff. Many also provide generalist healthcare services, such as community nursing. These specialist and generalist palliative and end of life care services are the government's statutory responsibility to provide.

Alongside these healthcare services, some charitable hospices provide social care for people with a palliative care need. The majority also deliver additional services that ensure holistic needs are met. These include bereavement and carer support, financial and emotional support, living well services and compassionate communities.

Whilst there are some hospices run by the NHS, the majority of hospices in England are independent charities, with Hospice UK having 158 members who are independent hospices along with Marie Curie and Sue Ryder. On average, 40% of the care and support provided by charitable hospices is funded by government sources. The rest is reliant on charitable donations.

Such a unique operating model does not fit neatly into existing assessment categories, and should be assessed under it's own specific framework taking into account the multiple and varied services that are provided, as well as the way they are funded.

Failing this a broader palliative and end of life care framework should be developed to take into account the different types of care that are provided when care is not curative. Hospices would benefit from a framework focused on what they do and deliver, with inspectors who understand these services, instead of a framework that is focused on other types of care.

Consultation question 2a: Do you have any comments or suggestions on how we should develop the sector-specific assessment frameworks?

To make a hospice or palliative and end of life care assessment framework functional and effective, it would need to be created with the support and input of the sector. Consultation on what the framework should look like would need to include visiting hospices and speaking directly to hospice staff about what is needed in a sector-specific framework.

We would also wish to see the inspectors for this framework, undergo specialist training specifically for it. The training would need to take into account the operational model of charitable hospices, including the variety of clinical and non-clinical services they provide, along with the funding arrangements of NHS contracts and grants, plus charitable funding. This training would also need to include and understanding of non-curative care and support. It would include understanding the quality outcomes, such as was the palliative and end of life care proactive. The holistic understand of palliative and end of life care would also need to be recognised, in how it provides social, psychological, spiritual, emotional and financial support.

Any new framework would need to be accompanied by further transparency in how ratings are agreed, for example by publishing who are on the panels that make the final rating decisions. Such transparency would ensure everyone had confidence in the scoring system and help minimise variation in approach across the sector.

Consultation question 3: To what extent do you agree with our proposed approach to making our assessment frameworks clearer and removing areas of potential duplication?

We agree with this proposal to make things clearer and remove duplication, due to the positive effects it will have on smaller organisations. Many hospices are small organisations, who may lack the funding for specialist quality teams. This means under the current assessment framework, staff can struggle with understanding what evidence the CQC is looking for.

For example, in some smaller hospices, the lead clinician might be covering many roles, including evidence gathering for the CQC. Making the assessment frameworks clearer will speed up the process for these staff, while removing duplication will help organisations submit a higher quality of evidence.

Along with making the frameworks, providing a single point of contact with the same inspector(s) would support hospices. This would mean that inspectors would get to know the organisation and operating model, and develop a deeper understanding of what evidence is needed and not needed. This experience and strong working relationships with hospices would help avoid duplication. Inspectors and hospices would be able to have open conversations about what evidence is needed. Providing a single point of contact would also enable inspectors to have specialist training in the charitable hospice sector.

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?

We recommend making the portal for uploading evidence easier to use. Hospice staff have commented that the portal does not always work, and that it is not clear what evidence is needed. Simplifying the portal and providing clearer instructions, along with examples of evidence, would streamline the process for hospice staff and allow them to provide a higher quality of evidence.

This also applies to what data is needed for the evidence, and how it is asked for. Simplifying how data is asked for with clear timelines, and how data is to be presented well in advance would make it easier for staff to collate and provide it.

Consultation question 4: To what extent do you agree that we should award ratings directly at key question level with reference to rating characteristics?

We support the intention of simplifying the ratings process and strengthening the role of professional judgement. However, we have concerns that this simplification may come at the expense of the granular clarity and detailed feedback that the scoring system provides. While it was complex, the detailed feedback it provided was of benefit to hospices.

Granular and actionable feedback is essential, as it allows the sector to understand exactly which elements of their service need attention and prioritisation. This detailed insight is also vital for developing and sharing best practice for the future.

Ultimately, we believe removing the scoring system is of benefit to hospices in simplifying how they will be rated. We also support strengthening the professional judgment of inspectors, accompanied by training to ensure they understand the needs of the hospice sector. Yet this should be accompanied by the requirement to provide granular feedback that is focused on how the hospice can take targeted action to improve within each of the wider rating categories.

Consultation question 4a: Do you have any comments or suggestions on our proposed approach to awarding ratings?

Simplifying ratings is positive in making the scoring process easier to understand for both staff and patients. However there remains a need for granular feedback to help hospices understand what they can do to improve the quality of their care.

This does not need to be scores. The rounded assessment of evidence along with detailed narrative feedback for each quality statement should be provided to hospices to help them understand what drove their rating.

The reporting should remain structured and transparent. A risk of simplification is that qualitative feedback will become unstructured and less beneficial in terms of fixing problems and sharing best practice. Strong guidance for inspectors on how qualitative guidance should look would help deliver providers with actionable feedback.

Finally, this approach should be tested with the hospice sector through a pilot to understand how it will work, and ensure it maintains clarity and supports improvement before a full implementation.

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?

To effectively support inspection teams, it is essential that inspectors receive comprehensive training specifically focused on the charitable hospice sector. This should include a deep understanding of the unique nature and operational context of hospices, as well as detailed knowledge of the relevant regulatory framework. Having inspectors who are well-versed in the hospice sector will ensure that assessments are relevant and appropriately tailored.

Wherever possible, deploying the same inspectors to particular hospices can help build meaningful relationships, leading to a greater understanding of local circumstances and continuity in the inspection process. Familiarity with the local area and ongoing engagement with providers by inspectors will contribute to more insightful and constructive inspections. For instance, it is important that inspectors do not approach hospice inspections with the same criteria or expectations as acute hospitals, as this can result in irrelevant or unhelpful assessments.

We would also welcome clear timeframes to receive the rating and feedback post inspection.

Consultation question 6: To what extent do you agree with the approach to following up assessments and the principles for updating rating judgements?

We support this approach. Some hospice providers have not been reviewed since 2016 and there is a need for a more consistent and timely inspection schedule. This is not only to ensure ratings and inspection information is up to date to ensure patients can chose their provider with all the relevant information, but also to ensure providers are aware of changing standards and requirements in inspections.

We support the suggested cycle of reviewing providers every 3 to 5 years, as this would help ensure that services are monitored and rated regularly, while also allowing sufficient time for meaningful improvements between inspections.

Consultation question 6a: Do you have any comments on our proposed approach?

We would welcome further detail on the inspection intervals, and exactly how urgent inspections will be carried out. Details on urgent inspections would help hospices understand their purpose, what exactly they are looking for, and how hospices can best engage with them if they happen.

In the assessment of care homes, unannounced inspections are currently carried out but the CQC will return to speak to the registered manager if they are not available on the day of inspection. We would support the introduction of this approach for hospices, including the addition of speaking to the senior leadership and multi-disciplinary team, including people such as the medical director. This would balance the need for the CQC to get an accurate picture on inspections of an average day, but allow the manager and medical director to have the time and space to speak to the CQC, instead of having to find the time in what will already be a busy day.