CQC Building on strong foundations: shaping the future of health and care quality regulation

NHS Providers' response

ABOUT NHS PROVIDERS

NHS Providers is the membership organisation and trade association for the NHS acute, ambulance, community and mental health services that treat patients and service users in the NHS. We have over 220 members – more than 90% of all NHS foundation trusts and aspirant trusts – who collectively account for £65 billion of annual expenditure and employ more than 928,000 staff.

INTRODUCTION

NHS Providers welcomes the opportunity to input into the development of CQC's forthcoming five year strategy by commenting on the strategic choices set out in *Building on strong foundations: shaping the future of health and care quality regulation*. CQC has made significant progress in developing and implementing a new quality regulatory regime and inspection model over the last three years within an ambitious timescale. Despite some initial slippage to its initial commitments, it has now inspected over 60 per cent of NHS foundation trusts and trusts and is in a position to review and adapt its operating model to ensure it is responsive to changing context in the NHS, adds value and is sustainable in the long term.

Rather than answering the specific questions within the engagement document, our submission concentrates on five key areas which are of particular importance to our members:

1. The changing landscape and context of the NHS
2. Moving to co-regulation
3. Improving inspections
4. Taking the local context into account
5. Use of resources

Our evidence is based on our regular dialogue with CQC and our members, as well as a dedicated member engagement event held in partnership with CQC on 18 November 2015 to discuss the above issues in detail.

When considering how CQC should develop its regulatory model it is important to remain mindful of the fundamental role of quality regulation assigned to CQC, which is one of setting minimum, national quality standards and identifying where services fall below those standards through a risk based and proportionate approach. The primary responsibility for the quality of care delivered to patients and services users appropriately lies with provider boards and their staff.

CHANGING LANDSCAPE

CQC is right to recognise that the health and care landscape is changing and that regulation needs to respond accordingly. Its strategy engagement document and recent *State of Care* report highlight the complex and challenging environment in which NHS providers are currently operating, including extreme financial constraint alongside the need to deliver unprecedented efficiency savings and develop new models of care. However CQC helpfully highlights the significant level of improvement which is already underway despite these challenges. The regulatory framework should not act as a barrier to this. It must be risk-based and proportionate, enabling providers to innovate and make improvements to patient care.

Working with national partners

The coming together of Monitor and the NHS Trust Development Authority as NHS Improvement from 1 April 2016 and the fact that NHS Improvement will be developing its new operating model over the same period that CQC is developing this strategy, offers a unique opportunity for the two organisations to work together and review the overall regulatory framework to ensure it is fit for purpose and adds value. While the two organisations will continue with their current statutory remits, they will be able to review how they implement their functions to avoid over-burdening providers with unnecessary regulatory requirements, and instead focus on creating the conditions to support and enabling trusts to make improvements. There remains a need to build consensus about the role of regulation, the role of guidance and the role of improvement support. This needs to be a shared view between the national bodies and the sector.

The newly established National Quality Board also offers an opportunity for all national partners to develop a single shared view of "quality" in the NHS, which could be a helpful underpinning to quality regulation.

Registering and regulating new care models

The publication of the *Five year forward view*, of which the CQC is a co-author, signalled a shift towards managing whole health systems across populations, rather than focussing on individual institutions.

CQC's strategy will clearly need to consider how it regulates the new care models as outlined in the *Five Year Forward View* as well as potential changes to commissioning and provision from the development of devolution-deals. Although there are only two legal forms which secondary care organisations can take – foundation trust, or NHS trust – we expect to see developments in the functions which FTs and trusts seek to deliver in partnership with others. CQC's *State of Care* report acknowledged that it is already starting to see changes to registrations as a result of the *Five year forward view* vanguard programme, with some hospital trusts registering as providers of care homes for instance. In this context ensuring clear lines of accountability will become essential as the rest of the sector, outside of the vanguard programme, begins to develop new care models. The CQC will need to ensure it can operate a regulatory regime and inspection model that is fit for purpose as structures in the sector evolve.

USE OF DATA AND CO-REGULATION

CQC is proposing to develop and extend its current *Intelligent Monitoring* into a more comprehensive surveillance model – 'CQC Insight', combining numerical data with feedback from people who use services. Alongside this CQC is considering adopting an approach of co-regulation, where it will support providers to assess and share evidence on their own quality of care against CQC's key questions.

NHS Providers has previously raised some concerns about the effectiveness of CQC's intelligent monitoring system in measuring risk to safety and quality, and therefore we welcome CQC's commitment to developing and improving how it uses data. CQC should work with the sector to review the data it currently uses and jointly identify an agreed set of quality measures and regulatory triggers to adopt going forwards. There is some difficulty in sectors such as community and mental health where there are currently no agreed national indicators and we welcome CQC's commitment to work with others to ensure these are developed. We would be happy to assist in this process if helpful.

Our members also continue to raise concerns about the burden of receiving data requests from multiple national bodies. Creating a nationally shared data set based on a single definition of quality, which all national bodies have access to, would help alleviate this pressure.

The concept of co-regulation and what it would mean in practice requires more thought and we would welcome the opportunity to consider this in partnership with CQC in more detail. At our recent engagement event, many members struggled with the term 'co-regulation' which they felt was somewhat contradictory, and may also not inspire confidence in the public. Some members also understood the term to mean 'joint regulation' between different regulators whereas our understanding is that the focus on co-regulation is about exploring the development of more self assessment by providers in the system, and this may prove a more useful term to consider.

Our members have been clear that they would not want co-regulation to result in additional reporting burdens over and above what is already required, and some members queried whether a co-regulatory approach would prove sustainable for CQC or whether the weight of assuring additional information provided would prove equally costly all round. However many of our members would also welcome a move to a CQC model which mirrors more closely how boards currently assure themselves of quality.

Members would greatly welcome the opportunity to develop local relationships with CQC based on a relationship manager model where a consistent CQC representative could develop local knowledge and relationships (with external CQC representatives still undertaking appropriately scaled inspections). Many of our members suggested these local relationships could be developed, in collaboration with local/regional NHS England and Monitor/TDA representatives. Investing in local relationship management will ensure CQC is able to develop a fuller understanding of the trust which it is regulating. As this was one of the strongest themes emerging from the engagement event we held, we would welcome the opportunity to discuss how this could work in more detail, for example capitalising on monthly meetings that are already taking place at a local level, which would also enable CQC to develop a clearer understanding of the local health economy challenges and dynamics.

INSPECTIONS

As mentioned above, CQC have made significant progress in implementing a new comprehensive inspection model over the last three years within an ambitious timescale. However we have had on-going concerns about the long-term sustainability of this model and its effectiveness and therefore welcome the opportunity to shape how it is adapted going forwards.

NHS Providers has raised concerns about the long term sustainability of the comprehensive inspection model due to the burden it places on both CQC and providers. The resources CQC needs to carry out comprehensive inspections and the management time that NHS providers spend preparing and hosting inspections makes it important for this resource intensive element of the current operating model to deliver value for all concerned. We have received consistent feedback from our members who have felt that comprehensive inspections rarely highlight areas of concern of which their board was not already aware. A move to focus on areas of risk during an inspection, once CQC has a baseline through an initial comprehensive inspection, will therefore be welcome as it may offer more value than comprehensive inspections being undertaken on a three/five yearly basis.

Re-inspections

The timing around re-inspections should also be a consideration for CQC when developing its new approach. An organisation that requires improvement, but is improving fast would benefit from a re-inspection sooner rather than later and should receive an updated rating based on the improvements made. A transparent and consistent approach to re-inspection is also key to a proportionate and risk-based regulatory approach. Feed back suggests that re-inspections do not always target those services which were considered a concern during a comprehensive inspection and are not always focussed on reviewing agreed action plan. We would welcome plans set out by colleagues at CQC to define the 'maximum time' for each element of the process including time between inspection and publication of the report and between inspection and re-inspection.

Appeals process

The current inspection model relies on interpretation and judgement, which our members do not feel is always consistently applied. NHS providers take seriously the findings of CQC's inspections, however the reputational damage of a poor inspection report, however rare, should not be underestimated and while concerns around quality and safety should not go unsaid, there is a need for a fair, consistent and objective process to challenge and appeal a decision taken by CQC including before the publication of their report. This is lacking in the current inspection process. Although there is a process for providers to provide comments on the factual accuracy of the report prior to publication and request a review of their overall rating (once their inspection report has been published), to date the ratings review process has not been sufficiently transparent and we have concerns about the extent to which factual accuracy challenges are addressed.

TAKING THE LOCAL CONTEXT INTO ACCOUNT

NHS Providers has consistently argued for CQC to take the local context into account when it inspects institutions as there are some issues that affect quality within local health economies which extend beyond the control of any individual provider. We therefore welcome CQC's recent work on evaluating the quality of care in a local area, representing an acknowledgement of this.

However, while we and our members are keen to see CQC take account of wider considerations within the local health economy, we remain conscious of the fact that legal accountabilities in the system remain organisationally based and believe it is essential to maintain these clear lines of accountability nationally, and to local populations.

CQC sets out three options for how it could assess the quality of care for specific populations and across local areas:

1. Improving its current inspection approach to assess how well providers are working in partnership in and across their organisations to deliver person centred care.
2. Continuing to undertake thematic assessments on the quality of care for specific populations across areas, such as recent assessments of dementia care.
3. Taking a more radical shift by going beyond its existing provider-based approach and assessing the quality of care in a place.

When considering whether to take a more radical approach to assessing quality of care in a place we would encourage CQC to consider the following:

- There would be little value in CQC taking a more radical approach without assessing the impact of commissioning decisions. By doing this CQC's place-based inspections wouldl support a more strategic and system-level approach to quality improvement. Ultimately commissioners need to be held to account for their role in enabling the provision of high quality care across a local health and care economy.
- CQC will therefore need to consider what regulatory levers are available to it to make recommendations for whole local health and care economies. It currently does not have any legal duties relating to commissioners or local authorities.
- Given CQC is moving to a full-cost recovery model, we are keen to emphasise that it would not be appropriate for providers to cover the costs of any additional resource required for more radical quality in a place inspections.

Rather than taking the radical approach proposed in one step change, there is potential to use existing mechanisms to take more account of local circumstances and what affects quality of care and agree shared actions. For example, we would encourage CQC to be explicit about recommendations which require the input of other partners in the local health economy in their inspection reports and use quality summits more effectively as a forum for getting shared agreement and commitment to improvement plans at local health economy levels. The feedback we receive from members suggests that they are not currently working as well as they could. We would therefore encourage CQC to work with us, NHS Improvement, NHS England, Public Health England and the Local Government Association to jointly discuss how to develop the role of quality summits and ensure they are used effectively. We would also welcome more involvement from CQC in the newly established success regime for local health economies that are facing significant sustainability challenges.

For the reasons outlined above, we would envisage a rebalancing of CQC's activities to maintain organisational inspection alongside better insights into quality in a place and the wider factors which may impact the performance of any one provider, rather than a wholesale shift.

USE OF RESOURCES

While CQC may have a legal remit to encourage 'the efficient and effective use of resources in the provision of health and social care services' as set out in the Health and Social Care Act 2008, this is a fundamental change for CQC which has to date solely focussed on assessing the quality and safety of services.

We particularly welcome the early discussions we have been able to have with CQC and our members on this issue and recognise CQC is at an early stage in developing its approach, and keen to engage with the sector to get this new measure right. It will be important for CQC to articulate what the purpose of the new use of resources measure will be and how it will

benefit patients, service users and providers. Our members are keen to ensure CQC scopes its role in assessing use of resources in collaboration with NHS Improvement. It will be essential to be open and transparent about how a use of resources rating relates to Monitor's existing Risk Assessment Framework, and the value for money indicators within this, and to the on going work by Lord Carter to support trusts to enhance their productivity. It will be important for CQC to stipulate how the new measure would be used by the national bodies either for regulatory purposes or as an improvement tool for trusts – and to avoid the risk of double jeopardy or over-regulation. We welcome the commitments we have received to date that CQC and NHS Improvement colleagues do fully intend to align these measures.

We also understand that CQC plans to keep the use of resources rating separate from the existing quality ratings for trusts, sites and some services. While we understand CQC's rationale and agree that there is a logic to keeping the assessments separate in the pilot phase, and to ensure quality ratings remain comparable over the years, our members were unsure of the 'added value' of a completely discrete and separate assessment, and felt in the longer term, potential integration with the existing model (for instance, the well led domain) could be worth considering.

CQC is also currently developing an approach for NHS acute trusts only and plans to pilot this approach from 1 April 2016. We would strongly urge CQC to start developing sector specific approaches for the specialist, community, mental health and ambulance sectors as soon as possible to avoid the inappropriate application of an acute-focussed model and allow these sectors a longer lead in time to develop appropriate measures and data where necessary. We would be happy to assist with this process wherever possible. We would also urge CQC to take some time to properly reflect on its pilot phase, in collaboration with providers, and making the necessary changes before fully implementing the process.

We would welcome continued engagement with CQC on the development of this measure to clarify how the new use of resources measure would be defined and assessed. This includes whether a use of resources assessment would require an onsite inspection visit and whether providers or CQC would have capacity to support that alongside the existing inspection model; how CQC might skill up its existing teams or recruit additional capacity to undertake a use of resources assessment; and what might be the impact of making public a range of ratings for quality and a separate rating for use of resources. Members also flagged a need for CQC to engage with the public in developing the measure to ensure it proves meaningful and helpful, assuming the public would be a primary audience for this information.

We shall be responding to the detail set out in CQC's current signposting document *Delivering cost effective care in the NHS* separately and look forward to engaging in the development of CQC's use of resources assessment framework.

CONCLUSION

When developing its regulatory model CQC will need to realistically consider the constraints on its own capacity and ensure that inspectors are fully supported and trained up to deliver any new requirements placed on them to consider new aspects.

NHS Providers benefit from a constructive working relationship with the senior leadership team at CQC and with colleagues throughout the organisation. We look forward to continue engaging with them throughout the development of their five year strategy and would welcome the opportunity to facilitate more engagement on this with our members.

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