The Health Committee accountability hearing: Care Quality Commission

Submission from the Foundation Trust Network (October, 2013)

1. INTRODUCTION

1.1. The Foundation Trust Network (FTN) is the trade association and collective voice for NHS foundation trusts and those working to achieve foundation trust status. We have 215 member organisations providing care across the acute, mental health, ambulance and community services. We welcome the opportunity to contribute to the Committee’s annual review of the Care Quality Commission (CQC).

2. SUMMARY

- FTN fully supports a strong and effective quality regulator, which is independent of government.
- The role of CQC in providing authoritative and robust judgements about the quality of care is fundamental to supporting public confidence in the NHS and ensuring quality retains parity with financial scrutiny within the regulatory sphere.
- CQC has faced a year of significant challenge and change.
- We support the principles driving CQC’s new proposed regulatory approach including more proportionate and risk based regulation and more skilled inspection teams.
- FTN has formed a constructive working relationship with CQC’s new leadership team.
- We are committed to working closely with the regulator to achieve the best possible outcome from the new quality regulation regime.
- We welcome CQC’s engagement with our members to shape the new regulatory model.
- Significant progress has been made to rebuilding confidence in the CQC and its regulatory approach.

However, we have concerns about:
- The timeframe for the ambitious scale of change proposed in the NHS acute sector and the delays for other providers. In particular, this risks:
  - Undue pressure on CQC to roll out the new regulatory approach;
  - Delays to inspecting non-acute services through the phased introduction of this approach in different sectors disadvantaging mental health, community and ambulance sector members;
  - Potential delays to aspirant trusts in securing foundation trust status.
- How regulatory judgements will be apportioned across a pathway of care in a regime which remains primarily institutionally focussed.
- The impact on the ‘fair playing field’ of different processes developing for different types of provider in a more competitive market.
- The development of different agencies with parallel responsibilities for quality, enforcement and failure and risks of duplication. Greater consideration is needed of the relationship between resourcing and quality by CQC and Monitor.
• **Whether the new regime will increase regulatory burden and costs for providers.** We appreciate CQC needs time to test and cost the impact of its new proposals, but it is vital that the overall burden is reduced in line with a more risk based approach.

3. **COMMENTS**

3.1. The past year has been one of significant challenge and change for the CQC. Following publication of the Francis public inquiry and events at Winterbourne View and University Hospitals Morecambe Bay NHS FT, CQC’s regulatory approach has been subject to considerable scrutiny. This has prompted significant changes in the CQC’s personnel (both its leadership and other staff) and the development of a new regulatory model, with the first wave inspections of acute trusts under this regime taking place from September 2013.

3.2. The scale of change is considerable, and at times has been disruptive to providers, and to the operation of the CQC. Given our members’ limited experience of the new regulatory model to date, we cannot comment on its operation. Our response therefore focuses on how CQC is responding to the challenges of reform, and highlights key themes we believe it must address to become an effective quality regulator. We also highlight areas the government and Department of Health should address, including ensuring clarity about CQC’s purpose and remit, and how that relates to those of other oversight bodies.

4. **CQC RELATIONSHIP WITH GOVERNMENT**

4.1. Much of the pressure for CQC reform stems from the government’s response to the Francis Inquiry and Winterbourne View. Government’s role is to set the overall regulatory framework. However, we are concerned that some aspects of the regulatory model (such as the Chief Inspector model and summary ratings) have been developed with limited supporting evidence alongside ambitious time scales for the introduction of the new regulatory model.

4.2. Independence from government is vital to ensuring a robust and effective quality regulatory regime. We welcome the Secretary of State’s recent announcements that he is bringing forward amendments to the Care Bill to relinquish some of his powers to intervene in CQC’s operational decisions.

4.3. In setting expectations for CQC, government, the sector and the wider public need to keep in mind that primary responsibility for the standards of care provided to patients lies with the provider boards. The regulator’s role is to identify and take early action within organisations with systemic issues with the quality of care, and to ensure the regulatory model supports robust local governance. Unrealistic expectations of what CQC can do risk it being set up to fail.
5. REBUILDING CONFIDENCE IN QUALITY REGULATION

5.1. FTN and its members support the operation of an effective and proportionate system of quality regulation to ensure that the care provided to patients meets designated standards of quality and safety at all times, wherever they are treated. The CQC has a vital role in creating and assessing these baseline standards, and in assuring patients and the public that any care provided will meet these standards.

5.2. Recent changes in the senior leadership at the CQC are likely to be a key part of rebuilding public confidence in the CQC. We particularly welcome the appointment of the new senior team at CQC, and their vision and approach to developing its new regulatory approach and assessments.

5.3. NHS providers must also have confidence in the approach and tools used by the regulator, particularly the accuracy and fairness of its assessments and judgements. While our members support in principle the role of CQC as a quality regulator, they have been critical about many aspects of its execution of this role historically, including the quality and knowledge of its inspectors. Embedding senior clinical leadership in the CQC and its inspection teams is therefore particularly welcome.

5.4. FTN has previously highlighted the need for CQC to change organisationally to improve its culture and approach to regulation. We welcome the steps taken so far which reflect a more collaborative and consultative approach to developing the new regulatory model.

5.5. Our members have participated in several dedicated CQC engagement events to discuss their proposals. We are pleased CQC has taken on board some areas of advice, including to publish their methodology in full and to expand the proposed surveillance data to include patient reported outcomes measures. We also welcome the CQC’s work to build a better understanding of the effectiveness and value of its work.

6. DEVELOPING THE NEW REGULATORY MODEL

6.1. CQC must learn from its experiences and those of previous quality regulators. This is fundamental to supporting confidence in the CQC and its regulatory approach, and reinforcing public confidence in NHS providers. FTN is considerably encouraged by CQC’s progress to date in developing a more open and transparent system of regulation that provides authoritative and robust judgments about the quality of care.

6.2. FTN welcomes CQC’s practical commitment to engaging with our members to develop detailed aspects of the new regulatory model, including more proportionate and meaningful assessments of quality. We support the principles driving CQC’s proposed new regulatory approach, which should result in a more proportionate and risk-based approach, together
with the clarification of new fundamental standards linked to registration. We also support the development of summary ratings and making this information publicly available.

6.3. We particularly welcome development of specialist inspection teams, making better use of peers as part of those inspection teams and inspection regimes more-tailored to the different types of service. Several of our members are providing practical support for this approach by releasing senior staff to participate in inspections. This will address previous criticisms of the capability of CQC’s generic inspectors. However, we note that there are shortages of skilled inspectors in some areas, such as governance, which CQC must address urgently.

6.4. We support the introduction of more risk-based and in-depth inspections, tailored to particular types of provider, with a balance between announced and unannounced inspections. However, important aspects of the CQC’s approach remain to be clarified for example:
   i. Whether inspections are regulatory-driven or quality improvement
   ii. The balance between routine and risk-based inspections
   iii. The length of time between inspections for outstanding providers.

6.5. A further important unresolved issue is how quality is assessed and regulated across care pathways in a regulatory system based on registration of individual organisations. This is particularly important with increased focus on providing bundles of care for individual patient pathways. Identifying and assessing the contribution of individual organisations to the overall outcome for patients will be challenging for the CQC, but is vital to making better sense of developing care models.

6.6. FTN welcomes CQC’s attempts to streamline the fundamentals of care with the adoption of five accessible and transparent questions, relating to the key dimensions of quality and form the basis of CQC’s new regulatory approach. However, clarification is needed on CQC’s approach and fundamental standards relate to the other standards that are being introduced (expected and high quality).

6.7. Establishing the wording for the standards to apply consistently to all settings will be challenging. Current guidance is too acute/social care focused and relates primarily to episodic care and our mental health, community and ambulance members have expressed disappointment at the language of ‘hospitals’ in recent CQC documentation. Sector-specific guidance is required, as well as focusing on the provision of care to people with long-term conditions and multiple care needs.

6.8. Clear guidance is required on how providers can evidence compliance with these fundamentals of care in registration requirements. This must include clear definitions and guidance to minimise the scope for interpretation and value judgements.
6.9. Significant guidance will also be required on how CQC will monitor and assess trusts’ compliance with the statutory duty of candour proposed in the Care Bill, which will form part of registration requirements. Guidance on how breaches will be identified and judgements made about any regulatory action that should follow will be vital.

7. USING DATA TO DRIVE INSPECTIONS AND ASSESSMENTS OF SERVICES

7.1. We welcome CQC’s decision to use existing data collections and indicators rather than to generate their own requirements and potentially duplicate data requests for its surveillance model. NHS England leads on development of national data sets, and we suggest that CQC should liaise closely with them to ensure that these also meet CQC’s needs.

7.2. Identifying the indicators to form the basis of CQC’s surveillance model will be complex. This must draw on the wide range of information already available about the quality of care, including patient reported outcomes (PROMs) data and morbidity indicators as well as mortality indicators. We welcome the use of local intelligence and soft data to enrich the quality of available information, but with provisos about verifying the quality and efficacy of that data.

7.3. We welcome amendments CQC has made to the surveillance data following feedback from our members including to publish its full methodology so that trusts understand the basis on which they will be judged. This will help to clarify what information is used to demonstrate compliance for the regulator.

7.4. However, some concerns remain. There are still no leadership/ governance indicators to identify whether the organisation is well led, and greater use could be made of Monitor’s quality governance framework in assessing this.

7.5. There is a particular need to develop appropriate national measures for monitoring risk and quality in mental health and community settings. Without such data, it makes it difficult to operate the CQC’s new regulatory model.

7.6. Our members would like to see a more collaborative approach with the CQC on the use of data, including giving trusts the opportunity to validate the accuracy of any data and provide more recent information before publication. There should be scope to contextualise data in the light of particular circumstances in the local health economy and any underlying factors. Furthermore, we believe there should be an appeals process so that trusts can challenge CQC judgements or present further evidence.

8. DEVELOPING RATINGS FOR SERVICES

8.1. FTN has consistently argued that the public should be the primary audience for ratings, and we are pleased that the CQC recently acknowledged this will be the case. We believe service
level ratings will be of most value to patients and the public. Ratings at any level will be insufficiently granular to inform commissioning or regulatory decisions.

8.2. Any ratings approach must be based on a clear and transparent methodology. Our members would like clarification of whether CQC ratings will take account of wider intelligence on performance against the three levels of standards, including assessments of other bodies such as the NHS Litigation Authority and professional bodies. Getting the language and terminology of rating right will be crucial. We suggest that CQC should include a narrative to support the overall rating to identify any factors affecting performance outside the provider’s control or highlight steps being taken to address any issues raised in the assessment.

9. REGULATING ALL TYPES OF PROVIDER

9.1. Ensuring the new regulatory approach is relevant to all types of provider is fundamental to building the confidence of regulated providers in the new system, and ensuring the public is assured about the standards of the services they use. Our members have previously criticised the CQC for being too acute or social care focused, causing particular problems for providers of community health, mental health and ambulance services.

9.2. The CQC is in danger of falling into the same trap with the appointment of Chief Inspectors of Hospitals, Social Care and Primary Care, and delaying the development of the new regulatory approaches for community, ambulance and mental health services until much later. We welcome CQC’s recent announcement that it will appoint a deputy chief inspector of hospitals with particular responsibility for mental health. This is especially important given CQC regulatory responsibilities under the Mental Health Act as well as the quality regulator.

9.3. Despite this, there is a danger of over-focusing on the regulation of hospital-based care, which ignores the trends to provide more care in community-based settings and for trusts providing a mix of types of services or care that is more integrated. Many acute trusts now also provide community services, while some mental health providers provide more community health services than mental health services. Members from integrated and specialist trusts participating in recent FTN/CQC engagement events highlighted how many aspects of the new regulatory and surveillance model did not apply to them.

10. TIMETABLE FOR IMPLEMENTATION

10.1. We have already highlighted the challenging timetables set for introducing the CQC’s new regulatory model. The first wave of acute hospital inspections is underway with the second wave expected early in 2014. It will take many months to complete new style inspections of all acute trusts. Furthermore, inspections of providers of non-acute services will not start until well into 2014.
10.2. There will inevitably be a time lag in establishing the new system of inspections across the whole of health and social care, particularly given the CQC's welcome approach of piloting the approach and revising this in the light of experiences. However, different approaches for different sectors raise fair-playing field issues particularly in the currently more competitive NHS environment.

10.3. Additionally, a good or excellent CQC assessment is expected to be a prerequisite for authorisation as a foundation trust. FTN is therefore significantly concerned that the protracted timetable for inspecting NHS trusts, particularly community health and ambulance service providers, will have a detrimental impact on the FT-pipeline.

11. CLARIFYING CQC’S RELATIONSHIPS WITH OTHER BODIES

11.1. There remains confusion about the responsibilities of different bodies for quality and driving improvement, with NHS England, NHS Trust Development Authority and Monitor all having an interest in this in addition to CQC. This lack of clarity is particularly burdensome for aspirant NHS trusts that are seeking FT status. The overlap of these oversight models raises questions of duplication and double or even triple jeopardy, as each body makes a judgement about a trust often on the same information.

11.2. We welcome the steps CQC is taking to build relationships with these other bodies and to coordinate action. It is particularly important that NHS England and NHS TDA coordinate any investigations or inspections with CQC to minimise the burden on trusts and potential disruption to care provision.

11.3. Particular care is needed to avoid overlap and duplication between Monitor and the CQC. While both are actively working to improve coordination, more could be done. For example, the Monitor licence already includes a fit and proper persons test for Board and senior managers, yet it is proposed to include this in CQC registration requirements. At a minimum, CQC and Monitor should use the same definitions and criteria in operating this test.

12. ENSURING QUALITY REGULATION REMAINS PROPORTIONATE

12.1. It is essential that CQC is held accountable for operating in the most efficient and cost effective way. We welcome the steps CQC is taking to better understand the costs and benefits of its regulatory role.

12.2. As well as considering its own costs, CQC must be mindful of the impact of its new approach on regulated organisations, particularly the impact of lengthier inspections on staff and the provision of care. A key factor in minimising the disruption to trusts will be ensuring that inspections teams have the right skills and training to operate in well-evidenced and effective way.
12.3. The new regulatory model will inevitably be more expensive to run. It is particularly important in the current financial environment that these costs are kept to a minimum as NHS trusts and foundation trusts meet the costs of CQC’s regulatory regime through regulatory fees. A balance must be struck between the complexity and costs of the regulatory regime, and the benefits it yields for the quality of care.