



NHS REGULATION AND OVERSIGHT

A time of transition



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KEY POINTS

- The results of this year's survey reflect the fact that the sector is in a period of transition as new regulatory and oversight frameworks are developed which support system working, and as NHS England and NHS Improvement align their activities.
- Trust leaders are optimistic that the new national structure will be more efficient and better placed to support system leadership through providing a more joined up perspective. However, the findings indicate that, under the new joint working arrangements with NHS Improvement, there will be a need for NHS England to rapidly develop and demonstrate its understanding of the provider sector. Trust leaders also see opportunity for the national NHS leadership to use this juncture to reset the culture towards one of improvement support and to focus on shared culture, values and behaviours.
- It is encouraging that most trusts reported a sense of stability in the level of regulatory burden over the last 12 months. This is in contrast to each of the previous four years in which we have run this annual survey when the majority of trusts have said that the burden had increased. There has also been an improvement in the proportion of trusts who agree that reporting requirements are proportionate to the level of risk they manage.
- However, trust leaders' experiences of the regulatory framework reflect a mixed picture. While there are promising indications of improvement in some areas, in other respects providers' experiences have worsened over the last year. This year, fewer respondents said that the overall regulatory framework of the NHS is working well than in previous years, and there has been no increase in the proportion of trusts who believe the regulatory framework offers value for money.
- Trusts continue to feel the tension between the current institutionally-focused regulatory model and policy ambitions to develop methods of oversight for local systems. They feel that the move to greater system working and system-level oversight risks blurring existing lines of accountability and placing additional regulatory burden on providers.
- Nonetheless, trust leaders are optimistic that it is possible to develop new models of oversight to hold systems to account for the collective performance of their component organisations. However, respondents also pointed out that without legislative change, systems will remain fundamentally voluntary arrangements and questions will persist as to how whole systems can be held accountable.
- Trusts continue to tell us that NHS Improvement's approach is generally one of performance management rather than of support, despite the national focus on becoming an improvement support agency
- Trusts that took part in Care Quality Commission (CQC) local system reviews found them valuable. However, trusts' hopes for CQC's revised regulatory approach for organisations have not yet been realised.

INTRODUCTION

This report outlines the findings from our fifth regulation survey, which was carried out in May and June 2019. The annual regulation survey explores NHS trusts and foundation trusts' experiences of regulation over the preceding 12 months and their views on the future of regulation, and trends over time.

The boundaries between organisations with regulatory and oversight roles such as NHS England and NHS Improvement are blurring. Locally too, traditional organisational responsibilities are changing, as providers, commissioners and their partners are asked to plan and deliver services collectively through local system partnerships. In this context, trusts are navigating a complex, evolving, and sometimes conflicting, regulatory framework.

NHS England and NHS Improvement have recognised that, as they expect local systems move towards greater integration, they must likewise commit to closer working. While the statutory framework means a formal merger between the two organisations is not currently possible, the two leadership teams have come together as the NHS Executive Group and a new integrated NHS England and NHS Improvement regional structure has been introduced. Seven NHS England and NHS Improvement regional teams, each led by a regional director (RD), are now responsible for the quality, financial and operational performance of all NHS organisations in their region, including both providers and commissioners. The regional teams are also playing a role in supporting the development of sustainability and transformation partnerships (STPs) and integrated care systems (ICSs).

CQC introduced its next phase inspection model in 2017, which was being implemented at the time of last year's survey. This year's survey offers an opportunity to understand how CQC's new approach to regulation and inspection is bedding in, in practice. CQC is also exploring how it can reflect the move to system working in its approach to regulation – last year, CQC completed its programme of local system reviews, which looked at how health and social care services are working together to support and care for people aged 65 and over. CQC also continues to develop its approach to working with STPs and ICSs.

As this report highlights, the changes taking place nationally and regionally represent a real opportunity for the regulators and national bodies to streamline their approaches and consider the culture, behaviours and processes that underpin the way in which they carry out their regulatory duties. There are indications that trusts are optimistic about potential impact of changes to the regulatory landscape. However, our findings show that turning national ambitions into tangible benefits at the frontline is challenging. As the regulators continue to adapt and implement new ways of working, it is more important than ever that they focus on ensuring regulation is proportionate, coordinated and offers value for money.

We are grateful to those trust leaders who responded to this survey and to the national bodies for working with us to develop the survey questions. We look forward to exploring the findings with the national bodies and regulators in the coming months.

About the survey

This survey was sent to all trust chairs, chief executives, company secretaries, finance directors, chief operating officers, strategy directors, medical directors and nursing directors in May 2019. In previous years we have surveyed chairs, chief executives and company secretaries only – this year we opened the survey to a wider group of trust leaders to reflect the changing nature of regulation and oversight in the NHS and seek a broader range of views.

This is the fifth time we have run this survey. As in previous years, it covers NHS trusts and foundation trusts' experiences of the regulatory regime over the past 12 months and looks forward to how the regulatory system is evolving and the impact this is having in practice. We have adapted some questions in this year's survey to reflect the changes in the regulatory landscape, but wherever possible, trends have been monitored over time to identify key changes in provider views on regulation.

We received responses from 116 NHS providers, representing over half (51%) of the sector. All regions and trust types were represented in the survey sample. Of the respondents:

- 69% were in segments 1 or 2 of the NHS Improvement single oversight framework, with the remaining 31% in segments 3 and 4
- six trusts were in quality special measures at the time of responding, three were in financial special measures, and two were in both quality and financial special measures.

Where we refer to the regulators and national bodies, we mean CQC, NHS Improvement and NHS England, as these are the main bodies our members interact with on a regular basis.

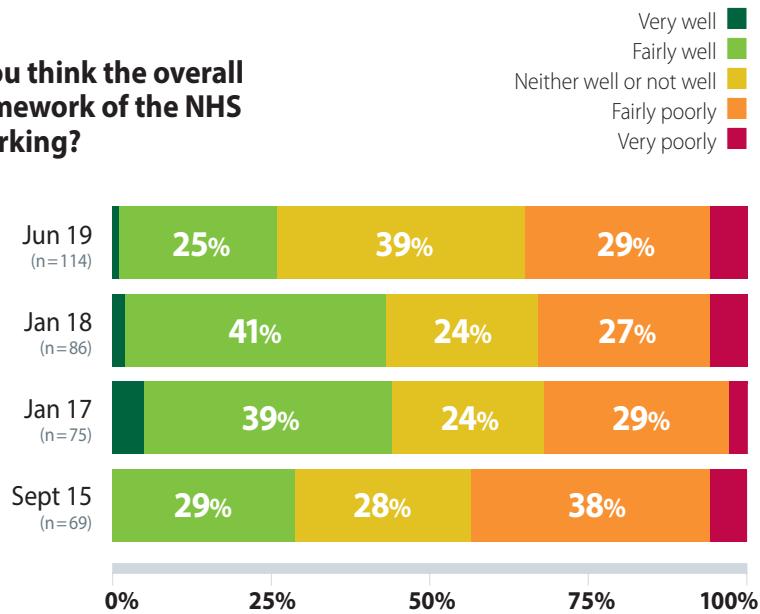
Due to a small sample size for some categories when splitting the data by trust type, they have been grouped for analysis into acute (acute, acute and community, specialist) and non-acute (ambulance, community, mental health).

OVERALL REGULATORY FRAMEWORK

Every year we ask trusts how they feel the overall regulatory system is functioning. Last year's survey results indicated that improvements reported by trusts in 2017 had stalled. This year's results suggest that earlier improvements are not being maintained consistently – while some responses indicate areas of improvement, others reveal that providers' experiences of some aspects of the framework have worsened over the last year.

This year, fewer respondents said that the overall regulatory framework of the NHS is working well (39% fairly well, 0% very well) than in previous years; in both 2017 and 2018, 44% responded that it was working well. As the national bodies undergo reorganisation and develop a new regulatory and oversight architecture there is a need to maintain a focus on ensuring the regulatory framework delivers value for money, places as little unnecessary burden on providers as possible and is proportionate to the level of risk that trusts are managing.

Figure 1
How well do you think the overall regulatory framework of the NHS is currently working?



Value for money

Only 8% of trusts surveyed this year said that they believe the regulatory framework offers good value for money. This is the same proportion as in 2018. Almost half (48%) said that the current regulatory system is poor value for money, a very similar proportion to last year (50%).

Trusts tell us that there continues to be misalignment and duplication between the regulators and national bodies, as well as with other organisations with oversight responsibilities. Trusts report that the level of regulatory requirements on them are not always proportionate to the level of risk they are managing, that the regulators could become more effective and efficient in their approaches, and that the regulators' interventions do not always add value. We explore these themes later in this report.

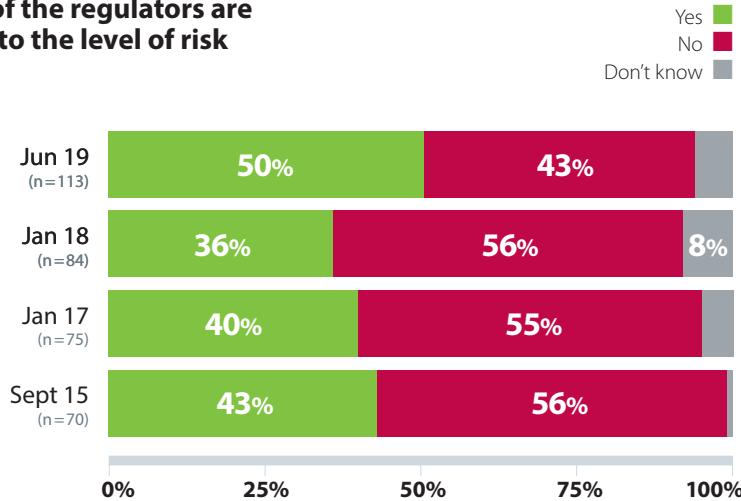
Regulatory burden

Every year we ask providers whether the overall regulatory burden experienced by their organisation has increased, stayed the same, or decreased over the last 12 months. In contrast to all previous years, when asked about the regulatory burden over the last 12 months, the most common response was that the burden had stayed the same (46%) and a smaller proportion (38%) said it had increased. In both 2017 and 2018 the majority (67%) of trusts said the burden had increased.

Similarly, there was a decrease this year in the proportion of trusts that agreed that the number of ad hoc requests from the regulators had increased over the last 12 months (45%). In the 2018 survey, 62% felt the number of ad hoc requests had increased, and in 2017, 69% said they had increased.

It is also encouraging that there has been an improvement in the proportion of trusts who report that the current reporting requirements are proportionate to the level of risk they manage – this year, 50% agreed that the requirements are proportionate, up from 36% in 2018.

Figure 2
Do you think the current reporting requirements of the regulators are proportionate to the level of risk you manage?



As in previous years, respondents highlighted that the expectations on them from the regulators are only one part of the oversight pressures they experience – trusts are also held to account by commissioners, professional regulators, local systems agreements and, in some areas, through devolution arrangements.

While the shifts in the trends this year indicate that efforts by the regulators to better coordinate their requests, interventions and communications to local organisations are

starting to have a positive effect on frontline providers, it is important to recognise that nearly half of trusts report that ad hoc requests have increased in the last year and over a third say the regulatory burden has increased overall. Given the impact that responding to regulatory requests has on trusts in terms of resource and staff time, it is essential that reducing and streamlining regulatory requests continues to be prioritised by the national bodies.

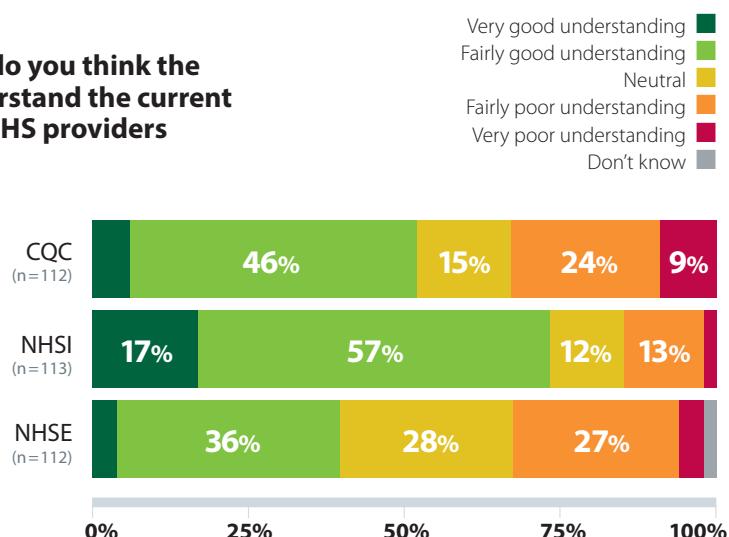
Regulators' understanding of local pressures

Each year we ask providers for their views on how well the regulators understand the pressures facing trusts. This understanding is essential in enabling the regulators to practice proportionate and responsive regulation and oversight that is appropriately tailored to the organisation and its circumstances.

The results this year suggest a decline in trusts' perception of CQC's understanding of local pressures, as only 52% said CQC has a good understanding, compared to 62% in 2018. Meanwhile, trust leaders' views on NHS Improvement's understanding of local pressures remained very similar to the previous year: 74% said NHS Improvement has a good understanding of the pressures facing the NHS this year, compared to 75% in 2018.

For the first time this year, we also asked providers for their view on NHS England's understanding of the pressures facing them. Only 39% of respondents said they think NHS England has a good understanding. This is not necessarily surprising given NHS England's role has not previously included oversight of the provider sector. However it does indicate that, under the new joint working arrangements with NHS Improvement, there will be a need for NHS England to rapidly develop and demonstrate its understanding of the provider sector – this is crucial for building trust with provider leaders, ensuring that the regulatory framework is realistic, adds value and does not hinder trusts' ability to improve care.

Figure 3
To what extent do you think the regulators understand the current pressures that NHS providers are facing?



OVERSIGHT AND REGULATION OF SYSTEMS AND NEW ORGANISATIONAL FORMS

3

This is the second year running that we have asked for trusts' views regarding the oversight and regulation of systems.

The NHS long term plan confirmed system working as the key driver of change within the sector with multiple expectations of STPs and ICSs forming to maximise the use of collective resource in a local system, and to improve, and integrate care. The long term plan also set out that regulatory frameworks will be realigned to support system working, with providers being held accountable to system wide objectives and goals, in addition to existing organisation-level accountabilities.

The plan states that:

- NHS England and NHS Improvement will work more closely with other regulatory bodies to set clear and consistent system-wide expectations and commit to keeping assurance and oversight proportionate.
- ICSs will agree system-wide objectives with the relevant NHS England and NHS Improvement regional directors, who have responsibility for oversight of health care in their regions, and be accountable for their performance against these objectives. ICSs will then have the opportunity to earn greater authority as they develop and perform.
- A new ICS accountability and performance framework will consolidate existing accountability arrangements and will provide a consistent and comparable set of performance measures, including the new 'integration index'.
- CQC intends to place greater emphasis on system-wide quality in its regulatory activity so that providers are held to account for their activity to improve quality across a local area.

Despite this shift in the operating environment, no changes have been made to the legislative framework underpinning the NHS. Clinical commissioning groups (CCGs), trusts boards and local authorities remain responsible and accountable for the commissioning and provision of services, underpinned by the Health and Social Care Act 2012. Crucially, STPs and ICSs have no legal status and derive their legitimacy from the statutory bodies which comprise them.

In terms of regulation and oversight of the provider sector as it stands, the 2012 Act aligned national bodies' responsibilities and regulatory frameworks to sectors and institutions. This has translated over time into NHS Improvement monitoring and assuring the performance of NHS trusts and foundation trusts through the single oversight framework (SOF), and NHS England carrying out a parallel assurance role for CCGs using the CCG improvement and assessment framework (IAF). However, in August 2019 NHS England and NHS Improvement published the new NHS oversight framework which brings together the previously separate approaches to provider and commissioner oversight, and reflects the priority of system working as set out in the long term plan. This new framework has superseded the SOF and the IAF.

All of the above serves to highlight that providers, their local partners, and the national bodies are continuing to navigate a complex environment, and developing new regulatory models to reflect the changes taking place locally will only grow as a priority.

New models of system oversight

As we saw last year, a significant majority (80%) of trusts continue to agree that NHS England and NHS Improvement need to develop new models of oversight to hold systems to account for the collective performance of their component organisations, as shown in figure 4.



If we are to move towards greater systems working, then regulatory oversight at systems level is essential.

When asked about the ways in which the existing regulatory framework discourages the development of effective system working and what changes could be made to the framework to stop this from happening, multiple respondents highlighted the conflict between regulatory frameworks focused on individual organisations and the drive towards greater collaboration and system working as a key issue, and commented on the need for clear and robust approach to regulation and monitoring at a system level. A number of trusts said setting individual control total has had a particularly negative impact on system working.



Still holds individual organisations to account without any view on the role played in the system - appreciate that this is due to the legal framework we currently operate in.



Financial control total approach encourages providers and commissioners to be in a transactional and adversarial relationship.



There is confused thinking over the role of STPs and ICSs in relation to oversight. NHS England and NHS Improvement appear to be looking to delegate oversight of local systems to STPs. However, (1) STPs are not statutory bodies (2) they are not resourced to manage performance (3) providers are members of STPs and indeed some are chaired by provider chief executives.

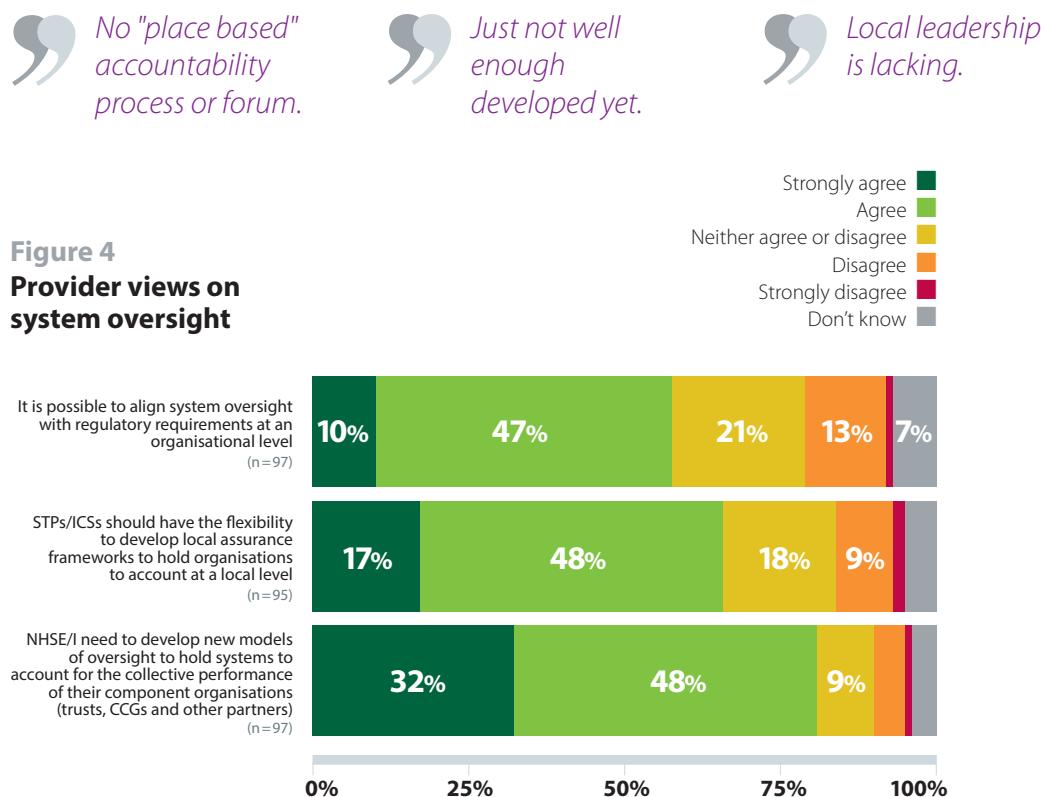
Oversight at a system level will impact individual organisational regulation. As a consequence of contributing to a system-level plan which commits to deliver services differently for the local population, some individual organisations may be disadvantaged or advantaged. The potential risks and gains need to be shared appropriately across organisations and monitored at a system level. Trusts facing performance issues will, in particular, need flexibility from the regulators to balance system responsibilities with requirements to improve organisational finance and performance (NHS Providers, 2019).

Despite continued support for new models of oversight at a system level, numerous respondents highlighted the complexity in trying to take a collaborative approach in a legislative framework set up for competition. At the moment, any regulatory intervention or enforcement action can only be taken at individual organisation level, as STPs and ICSs

are not statutory bodies. In addition, while the regulatory framework needs to adapt as system working develops further, it is important to bear in mind that there is a great deal of variability between local areas on their journey to becoming an ICS. There therefore needs to be flexibility in the application of regulation and oversight during any transition from national bodies regulating individual organisations to whole systems.

The variation in the maturity of local systems appears to be reflected in our findings around trusts' views on STPs/ICSs having the flexibility to develop local assurance frameworks to hold organisations to account at a local level. Nearly two thirds (65%) of trusts agreed they should have this flexibility, which is a similar proportion of respondents who agreed with this statement last year (61%). It is possible that those in agreement are part of more established and developed local partnerships, which could benefit from negotiating additional freedoms and flexibilities with the national bodies. In these cases, careful consideration needs to be taken by NHS England and NHS Improvement on which elements of oversight must remain at a national level, and which can be transferred to the regions or to local systems.

Trust leaders who disagreed that STPs/ICS should have such flexibility commented on local systems lacking the infrastructure and resources required to take on an assurance role and manage performance, which was a theme that emerged from last year's survey. Similarly to last year, some trusts also continued to express concern around the potential for conflicts of interest to arise if STPs/ICSs, which derive their decision making powers from the statutory bodies which comprise them, are holding those very organisations to account.



Aligning system oversight and the regulation of organisations

As we stressed in last year's report, it is crucial that oversight and assurance frameworks respond as local systems evolve to ensure that the oversight of systems does not simply create an additional layer of performance management, with no added value, or create multiple conflicting judgements or 'double jeopardy'. Ideally, any additional regulatory requirements at system level require a commensurate reduction in the existing regulation on individual organisations.

Over half (58%) of trusts who responded to our survey agreed it is possible to align system oversight with regulatory requirements at an organisational level. Achieving the required alignment still feels far off - numerous respondents highlighted that the regulatory bodies not coordinating their work as a key issue, which is increasing the burden of regulation on them as a result. Furthermore, only 20% of trusts agreed the regulators take the context of local system working adequately into account in their judgements of individual providers, with 51% disagreeing. A number of trusts commented that CQC and NHS Improvement could better reflect the context within which a trust is working in their assessments and reports.



If CQC were to develop a methodology to inspect systems we would be able to transform our services with greater pace.



CQC do not appear to take into account commissioning decisions and the scale of commissioning investment (or not) and its impact on the service delivered.



Huge burden of regulation not all pointing in the same direction.

More so than ever, trusts are feeling the tension between the current institutionally-focused regulatory model and policy ambitions to develop methods of oversight for local systems. Trusts feel that the move to greater system working and system-level oversight offers opportunities to promote and support collaboration across health and care, but also risks blurring well established lines of accountability, and placing additional regulatory burden on providers as they face organisational regulation and the development of a new system oversight framework.

Successful development of collective responsibility will depend in part on the relationships developed between trusts, CCGs, STP/ICS leaders and the new regional directors. It is essential that there are clear lines of responsibility, accountability and decision making.

NHS IMPROVEMENT

Since last year's survey, NHS Improvement has gone through a period of significant change. NHS England and NHS Improvement have entered joint working arrangements, resulting in changes in the senior leadership teams within both bodies, and have established seven new integrated regional teams. The two organisations have reinforced this joint approach through the development of a new NHS oversight framework, bringing together the SOF for providers and the CCG IAF. This signals significant change in the way local NHS organisations are held to account – reinforcing that collaboration across organisations and local health systems is now the national policy priority.

NHS Improvement's planning guidance for trusts reflects the expectations set out in the NHS long term plan for operational and financial planning to increasingly take place at a system level, through STPs and ICSs. For the first time this year, all STPs and ICSs have also been asked to agree a system control total, in addition to the process of setting organisational control totals for trusts.

NHS Improvement also made changes to the provider sustainability fund (PSF) this year – it established the financial recovery fund (FRF) and transferred £1bn of PSF into the urgent and emergency care tariff. The FRF is only available to providers in deficit who sign up to their control total.

With the NHS struggling to meet performance targets and facing ongoing financial challenges, the tendency among the national bodies has been to adopt a firmer grip over the NHS, leading to a top-down, performance management approach over organisations and, increasingly, over local systems.

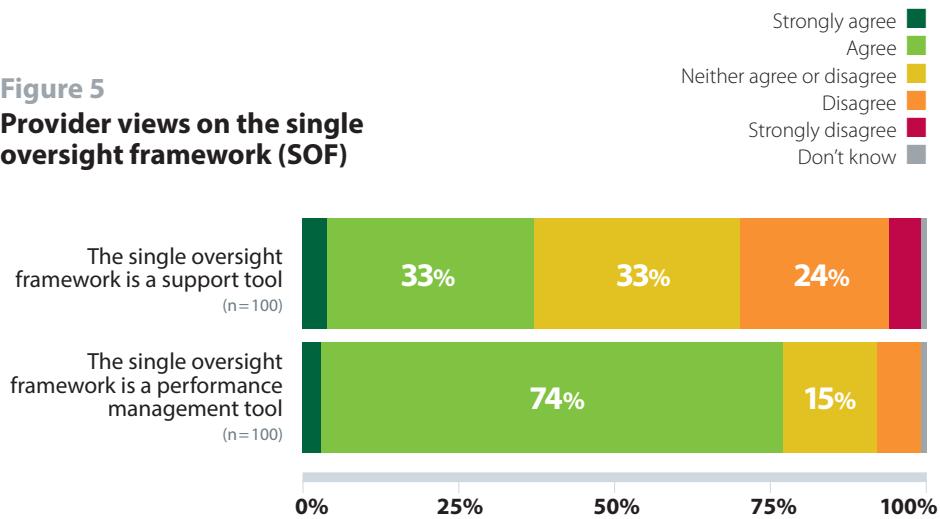
Despite this, NHS Improvement has continued this year to reposition its approach towards one which prioritises support and enabling sector-led improvement. As in previous years, our survey sought to identify whether this shift is being reflected in the experiences of trust leaders.

Provider views on the single oversight framework

We asked trusts to indicate whether they agreed with the statement "*the decision making for our segmentation in the single oversight framework is clear*". The majority of trusts agreed (67%) while 18% disagreed. There was a noticeable difference in opinions between sectors: non-acute trusts were more likely to agree that the decision making for segmentation is clear (78%) than acute trusts (61%).

We also asked trusts to indicate whether they agreed with the statement "*the single oversight framework is a support tool*" and with the statement "*the single oversight framework is a performance management tool*". 37% agreed that the framework is a support tool (29% disagreed) while 77% of trusts agreed it is a performance management tool (7% disagreed). They suggest that despite the commitment and national focus on improvement support, at the frontline, providers continue to primarily experience performance management, rather than support, from NHS Improvement. There were suggestions among respondents that NHS Improvement is still struggling to align its regulatory and improvement functions.

Figure 5
Provider views on the single oversight framework (SOF)



We understand the SOF but it's not yet about improvement is it?



Reasons for moving segmentation [were] unclear.

NHS Improvement's support offer

Given NHS Improvement's focus on helping the provider sector to achieve financial balance, it is disappointing that less than half of trusts (48%) agreed with the statement "NHS Improvement support adds value to the financial position of our trust". 28% said they 'neither agree or disagree' with the statement, while 22% said they disagreed.

Trusts regularly report that oversight and regulatory frameworks, along with support for improvement, tend to be more appropriate for the acute sector. The survey results this year suggest this view continues to persist, although there appears to have been some improvement since last year: in 2018, 51% of respondents agreed with the statement "NHS Improvement support has been appropriately tailored to our sector". This year, 58% agreed. However, it is telling that acute trusts were more likely than non-acute trusts to agree with the statement (68% vs 42%).

Balance between autonomy and support

There was also an improvement this year in the proportion of trusts that agreed with the statement "NHS Improvement strikes a good balance between respecting trusts' autonomy and support in its approach to overseeing providers". This year, 58% of trusts agreed with the statement, compared to 47% in 2018. Consistent with last year's results, views were more positive among non-acute trusts, who were more likely to agree that NHS Improvement strikes a good balance (67%) than acute trusts (53%).



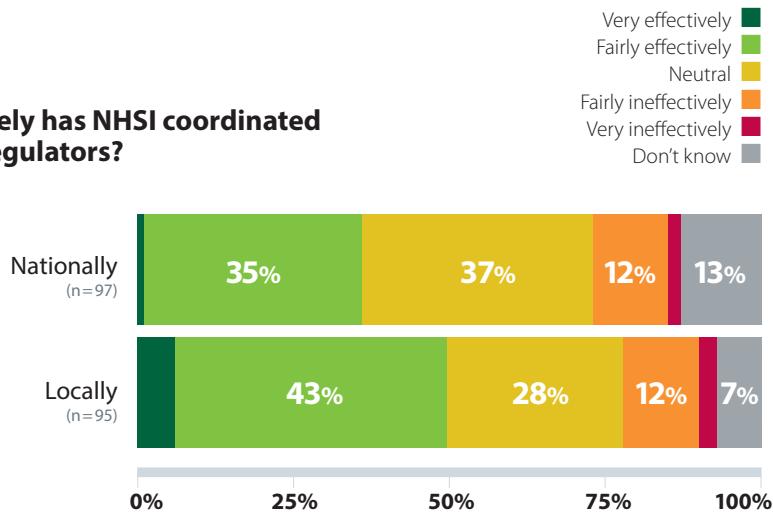
The local relationships with NHS Improvement are supportive, with links into the developing NHS Improvement support offer where appropriate.

NHS Improvement's coordination with other national bodies

This year we made changes to the way we ask trusts how well the regulators have coordinated with other national bodies. In previous years we have asked about coordination across the regulators generally – this year we asked for views on each regulator in turn.

Almost half of trusts (49%) told us they felt NHS Improvement had coordinated its activity effectively with other regulators at a local level. At a national level, only slightly more than a third of trusts (36%) said that NHS Improvement had coordinated effectively with other regulators. There was a large response to 'don't know' (37%).

Figure 6
How effectively has NHSI coordinated with other regulators?



NHS ENGLAND AND NHS IMPROVEMENT JOINT WORKING

In 2018, the NHS England and NHS Improvement boards published plans to increase joint working between the two organisations. As the national bodies continue to ask local health and care systems to move to more joined up ways of working, NHS England and NHS Improvement, broadly representing the commissioning and provider sectors respectively, recognised that they must do likewise.

The two leadership teams have been brought together through a new NHS Executive Group, while seven integrated NHS England and NHS Improvement regional teams have been introduced, each led by an RD. Each of these seven teams is responsible for working with local health systems, and their constituent CCGs and provider organisations, to provide oversight and support for improvements in quality, health outcomes and use of resources.

At the time of surveying, NHS England and NHS Improvement were developing their new joint working arrangements and there had been a period of change and uncertainty for providers. Since their appointment, and since we surveyed trusts, the RDs and their teams have been developing their operating models, processes and ways of working. They have carried out considerable work to engage local providers and partners in these activities. Our survey gives a snapshot of the aspirations and concerns trust leaders hold about the new model, but we recognise that the picture is likely to have shifted even over this short period of time.

Work is also underway within NHS England and NHS Improvement to identify which functions should sit with national teams and which should sit with the new regional teams, and which responsibilities should be held by the national executive directors and which should be delegated to the RDs. For the provider sector, it is essential that there is absolute clarity on lines of accountability and processes. This will ensure trusts are not subject to duplicative requests or interventions from both national and regional teams, that there is consistency in messages from both national and regional teams, and that processes are as efficient and easy to navigate as possible.



NHS England and NHS Improvement coming together feels encouraging but it is too early to say how that will affect the framework.

Expectations for NHS England and NHS Improvement joint working nationally

We asked trusts to share their views on the risks and opportunities of the closer working between NHS England and NHS Improvement. There is concern among some providers that in coming together, NHS England and NHS Improvement will become a very large, single central body with a lot of power. Some trusts suggested this could lead to a more centralised, top-down approach and a dilution of the autonomy of local organisations. A larger central body with an expanded remit may also find it more difficult to provide tailored and specific support to providers, and some respondents commented that the specific

provider-sector expertise within NHS Improvement is in danger of being lost. Respondents also warned about the loss of the valuable challenge and tension that has existed between the two bodies until now.

Trust leaders suggested that there is a danger that, despite the joint working arrangements, the two organisations will continue to operate as separate bodies, with ongoing duplication or misalignment of approaches and messages. A number of trust leaders believe that in the short term, the changes within the organisations are likely to have a negative impact – the focus on restructuring and reorganisation may undermine existing momentum around service change and impact negatively on staff morale, relationships and efficiency within the national bodies.

Some respondents suggested that it is just as critical for the two bodies to focus on culture change, shaping values and behaviours, as it is for them to focus on structural changes. This is seen as essential to moving away from a culture of performance management and monitoring to one of improvement through support. One respondent suggested that if there is a “*new culture that is built around doing the right thing for the system then there will be a real opportunity for improvement*”.

Respondents highlighted that bringing together NHS England and NHS Improvement offers the potential for more joined up thinking at the top of the national bodies, and gives them the opportunity to speak ‘with one voice’. A number of trust leaders believe the new structure will be much better placed to support system leadership through providing a more joined up perspective on system working and developing shared approaches between providers, commissioners and their local partners. Trust leaders also feel the joint working presents opportunities for efficiency savings through streamlining processes and providing greater clarity on roles.



Having a clear and consistent expectation set by regulators on both the provider and commissioner side would be beneficial.



It should move us to place based accountability and support.

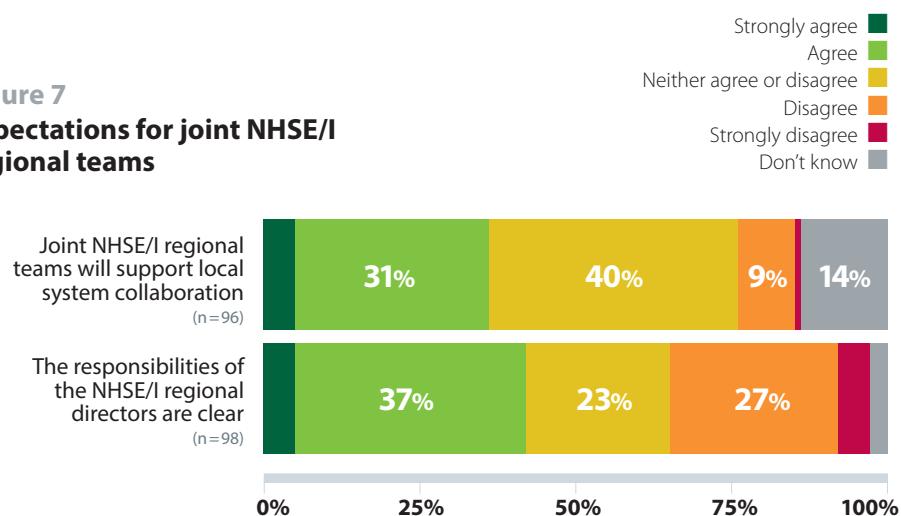


This is an opportunity for NHS England and NHS Improvement to focus on how they can add value. That means taking or supporting real action in key areas such as capital and service/organisational change where the national bodies and/or regional offices have the authority to make change happen.

Expectations for joint NHS England and NHS Improvement regional teams

It is inevitable that organisational changes at the scale currently taking place within NHS England and NHS Improvement will involve periods of uncertainty, and this is reflected in our survey results: less than half (42%) of trusts agreed with the statement “*the responsibilities of the NHS England and NHS Improvement regional directors are clear*”, while 32% disagreed. We also asked trusts whether they agreed with the statement “*joint NHS England and NHS Improvement regional teams will support local system collaboration*”. Given the current period of change, it is perhaps not surprising that the majority of respondents (40%) selected ‘neither agree or disagree’ and 14% selected ‘don’t know’. Just over a third (36%) said they agreed.

Figure 7
Expectations for joint NHSE/I regional teams



Trust leaders told us they believe the new NHS England and NHS Improvement regional teams will be better able to support whole system solutions to long-term challenges and support more effective collaboration between providers and commissioners. Trust leaders are optimistic that the joint working arrangements will result in more joined up and consistent messages from the two bodies to commissioners and providers, as well as clearer processes and easier access to support. Respondents commented that they would like to see the regional teams taking timely action to support local organisations, and use their authority to drive improvements, rather than focus on assurance and oversight.

Some respondents pointed out that there remains a lack of clarity over the distinction between the roles and responsibilities of RDs and those of STP/ICS leaders. There is also variation in the approaches being taken by RDs: some felt that there is a danger the RDs may take some power away from local system leaders and may impose directions from above rather than allowing or facilitating local systems to make decisions collectively.



We need clarity on the relationship between NHS England and NHS Improvement and ICS roles and responsibilities. We need to ensure that we do not replace two regulatory organisations with a different two.



[Regional directors] must be given real authority. They will only be able to add value if they are allowed and encouraged to act independently to secure improvements in their regions.

Others were optimistic that the RDs will be able to offer neutrality and objectivity which may help with working through thorny, long-standing issues in local systems. They pointed out that the new regional structure offers an opportunity for the RDs and their teams to develop closer relationships with local leaders and develop a greater understanding of local challenges and priorities. The RDs can also act as advocates for their regions at a national level.

The most common response among trust leaders was that it is not yet clear how the new regional teams and directors will benefit their trust. In the time since we surveyed trusts, NHS England and NHS Improvement regional teams have carried out significant programmes of work to develop relationships and ways of working with local providers, commissioners and other partners. We look forward to repeating this survey next year to explore how the new regional structures have bedded in, and the benefits that have been delivered in practice.



I have a good relationship with my regional director – I am afforded autonomy but feel supported.



[Regional directors] need to ‘walk in our shoes’ to truly understand the pressures we are dealing with.

CARE QUALITY COMMISSION

Embedding a more intelligence-driven and risk-based approach to the way NHS trusts and foundation trusts are regulated and monitored has been a welcome, key focus for CQC over the last 12 months.

CQC's new approach to inspections was introduced in 2017. In line with its five-year strategy, it involves moving towards a more responsive inspection model, in which resources are targeted to areas where concerns about quality of care are greatest. As part of this new approach, CQC made changes to the provider information request (PIR) to attempt to streamline the information that trusts are required to provide in advance of inspections.

Over the last 12 months, CQC has been carrying out the first round of well-led inspections, which were introduced as part of CQC's new approach to regulation and are based on the well-led assessment framework used by both CQC and NHS Improvement. Currently, trusts undergo a well-led inspection annually, approximately, following a targeted inspection of at least one core service. However, CQC has signalled that it intends to adopt a more risk-based approach to carrying out well-led inspection for trusts that are rated 'good' and 'outstanding' in future.

CQC and NHS Improvement also now report and rate use of resources (UoR) for non-specialist acute trusts. These assessments are carried out by a team from NHS Improvement who provide their findings to CQC in order for CQC to write the assessment report and decide a trust's UoR rating. This rating is then combined with CQC's existing five quality ratings for the trust.

This year has been one of continuity in terms of CQC's approach to calculating fees for NHS trusts. CQC introduced changes to its fee structure in 2018/19 as part of its move to a full chargeable cost recovery model. As a result, CQC confirmed earlier this year that it will not make any changes to this methodology for 2019/20 – each trust will continue to be charged in proportion to its turnover levels and there is no minimum or maximum fee. This continuity is welcome, however there is a risk that CQC will be dependent on a small number of providers for a significant proportion of its income and the CQC will need to recognise the impact of this on its relationships with those providers.

Care Quality Commission's new approach

As in previous surveys we asked respondents to reflect on their most recent CQC inspection and share their views on the process and their interaction with CQC. Last year we asked trusts for their early views on CQC's new approach which revealed that trusts were generally optimistic about the potential benefits it would bring. However, this year's results suggest that trust leaders feel the benefits have not yet been felt at the frontline. This is explored in more detail throughout this chapter.

Four in five (80%) respondents to our survey said they had received a PIR within the last 12 months and 87% had received either a comprehensive inspection, core service with well-led inspection or focused inspection. Our findings therefore provide a valuable insight into how CQC's new approaches to regulating and monitoring providers are bedding in and the impact on trusts in practice.

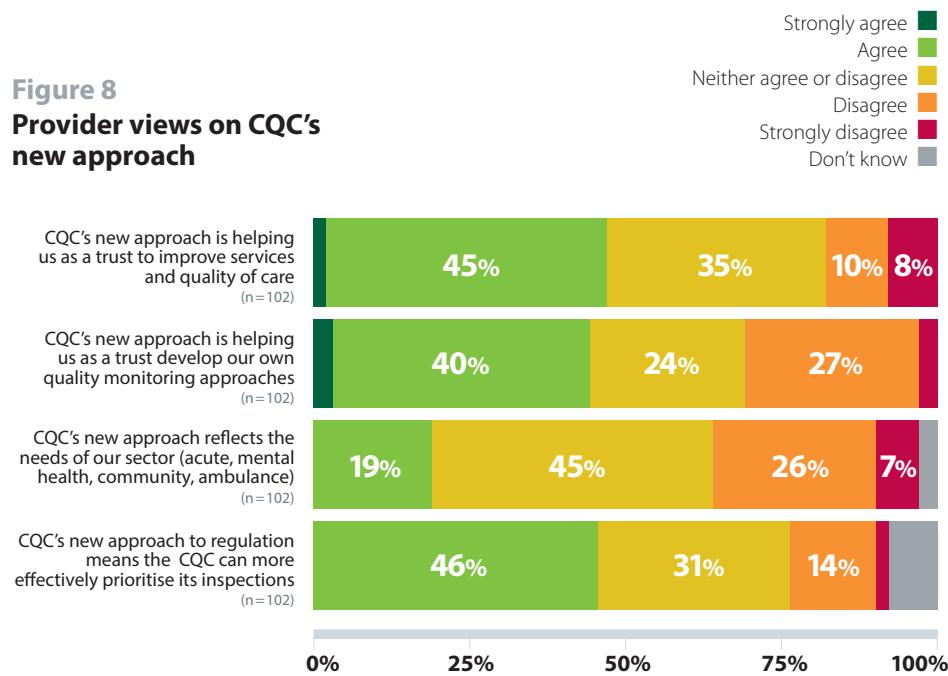
Just under half (47%) of trusts agreed that the new approach is helping them to improve services and quality of care. Last year, 63% of trusts said the new approach would help them to improve services and quality. Also just under half (47%) of trusts said they felt CQC's new approach is helping them to develop their own quality monitoring approaches. This is significantly below the proportion of trusts in last year's survey (80%) who expressed optimism that CQC's new approach was likely to help them to do so. Last year, 57% of trusts agreed that the new approach would provide a fuller understanding of quality of care, whereas this year, only 39% of trusts agreed that this was the case in practice.

Our findings around the extent to which the new approach reflects the needs of particular sectors also seems to suggest the experience of CQC's new approach over the last 12 months has fallen short of some expectations. This year, only 19% of respondents agreed that CQC's new approach reflects the needs of their sector, whereas 62% of respondents to our survey last year felt that the new approach was likely to have this effect.

The majority of respondents (81%) to last year's survey either 'fully' or 'partially agreed' that the new inspection approach was likely to enable CQC to prioritise inspections more effectively – this year only 46% of respondents said this was case in practice.

Taken together, the results suggest challenges remain as CQC moves to a more focused inspection model which includes annual well-led assessments. In our response to CQC's consultation on the move to a new inspection approach, we highlighted the importance of training CQC inspection teams, ensuring the reliability of insights gained through the new intelligence model and importance of improving relationships with providers at the local level (NHS Providers, 2017). The feedback gathered in this year's survey suggests trust leaders believe CQC could do more to equip, train and support inspection teams, as well as further refine its intelligence-driven approach.

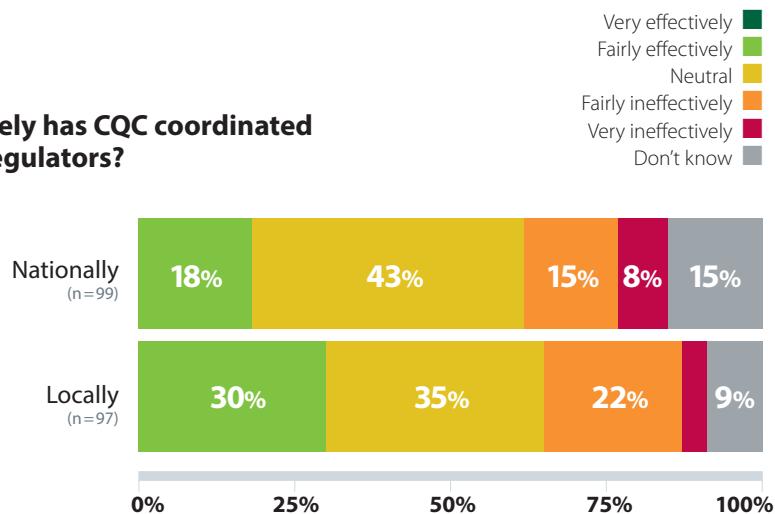
Figure 8
Provider views on CQC's new approach



Coordination with other national bodies

Trusts' opinion was divided as to whether CQC had coordinated its activity effectively with other regulators and national bodies locally (30% agree, 26% disagree, 35% neutral). On a national level, more trusts felt CQC had not coordinated effectively than those who did (18% agree, 23% disagree, 43% neutral). Trusts pointed out that there is more CQC could do to align its processes and requests with local bodies, as well as other national regulators. For example, one respondent highlighted that some ad hoc incident reporting required by CQC duplicates reporting to local commissioners.

Figure 9
How effectively has CQC coordinated with other regulators?



There seems little or no co-ordination with other agencies to ensure that investigations can be done once and then not replicated.

[CQC PIR] is very burdensome. Much of the data is already provided to NHS Improvement so not clear why we are asked to provide it to CQC.

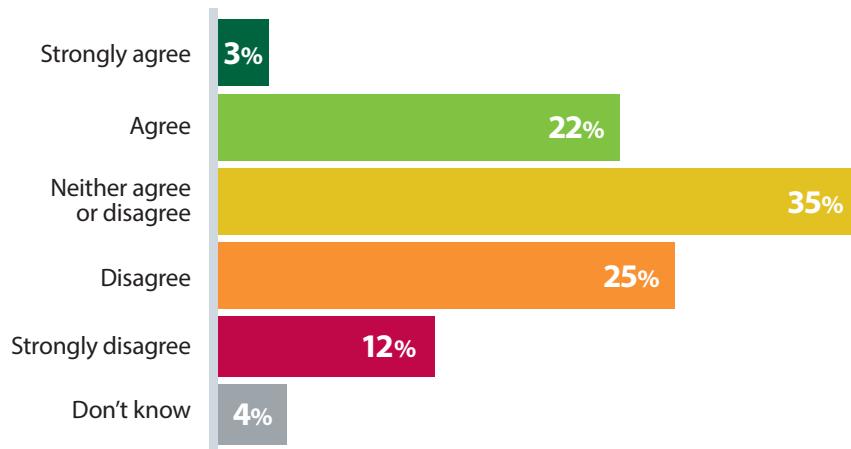
Benefits and challenges of inspection

As in previous years, we asked trusts to describe some of the benefits and challenges of inspection.

Only one in four (25%) trusts agreed the benefits of their most recent inspection justified the cost, which is a significant drop from last year (37%) and exactly half the proportion of trusts

Figure 10
The benefits of our most recent CQC inspection justified the cost in terms of resources to the trust

(n=101)



who felt the cost was justified when we first began surveying trusts on their views of the regulatory regime and its future in 2014.

As was the case last year, respondents to this year's survey highlighted that preparing for, and undergoing, CQC inspections divert significant attention and resources away from trusts' main duties, and inspections offer less value for money as a consequence. While CQC fees were not explicitly referred to as often this year, these findings seem to suggest that the concerns raised last year about whether the benefits of CQC regulation and inspection justified the increase in fees in 2018/19 persist.

Also in line with last year's findings was the consistent message coming from trust leaders about the extent of administrative burden CQC's new approach places on their organisations. This year, 64% of respondents this year disagreed that CQC's new approach to regulation had reduced administrative burden, whilst only 11% of trusts agreed.



The amount of information requested - usually at short notice - is so large that it is disruptive to day to day functioning of the organisation during this period.

The PIR process was highlighted as particularly time consuming and burdensome, suggesting there are further opportunities to reduce the burden of data collection prior to, during and post-inspection. Trusts highlighted in particular challenges with the volume of data requested and the format the data needs to be submitted in, which does not match how some trusts collect data internally. Other trusts commented that the generic template means that not everything that would be relevant can be shared, or requests for information are made which are not relevant to particular sectors. Trusts also reported receiving duplicative requests - a number of trusts commented that they received requests for information that they had already provided through the PIR, or by other means, for example, to NHS Improvement. Finally, they also highlighted that requests are often accompanied by a short timeframe for submission.



I worry about the distraction from serving our patients quality care whilst trying to get data in a format that CQC wants - not necessarily what can be produced by our systems.



It is a lot of work and paralyses an organisation for three months. A more data driven approach would be welcome.

A number of trusts questioned the extent to which the PIR adds to CQC's overall assessment process, which is particularly concerning considering the amount of time and resource trusts are using to complete returns. A number of respondents said inspection teams had not appeared to have read their trust's PIR prior to the inspection, or the PIR data did not appear to have been taken into account in their trust's final CQC report.



It is... very frustrating when the data is provided to CQC and when the inspection team arrive they haven't even read it and then ask for information that has already been provided.

The make-up of inspection teams continues to be a key area trusts identify for improvement. Respondents highlighted the importance of having experienced inspectors with the appropriate skills and knowledge, who are well-briefed on the trust and its context. As was the case last year, respondents also highlighted the importance of consistency, with several reporting that variation persists in the objectiveness of the judgements reached by inspection teams.



There is still too much variation in the quality of inspectors.

Some respondents did give positive feedback about the PIR process, commenting that it had been less burdensome than CQC's previous approach. Preparation trusts took in advance and having completed a PIR before were highlighted as factors that made the process more manageable. This suggests that it may be possible for some of the issues trusts are experiencing to be overcome the more trusts get to grips with the new information collection process.

There were also a number of positive comments from trust leaders about the value of developing local CQC relationships and having more regular interaction with their local CQC teams.



Having a linked person at CQC has made a big difference to the trust especially when it comes to asking and getting answers to questions. A single point of contact has been very helpful.



The new CQC insight process has included regular interaction with core services in the trust, which has helped in building relationships, and potentially means a better opportunity to present a balanced look at the core service.



I hope the new way of working with engagement throughout the year will reduce the burden.

Well-led

As with last year's survey, we asked trusts how useful the CQC well-led inspection had been for their organisation and to provide feedback on the assessment process.

Trusts have told us, separately to the survey, that the well-led framework and key lines of enquiry are useful and provide good structure for review, self-assessment and action planning. While trusts do think the local system they are working in or their contribution to the local system could be better reflected in CQC assessments and reports, their concerns tend to be with the CQC's approach to inspecting against the framework, rather than the framework itself.

This was borne out in comments from respondents to our survey. A number of trust leaders raised concerns about the experience and quality of well-led inspection teams, and suggested that this limited the value of the process and the feedback they received as a result. The importance of inspection team members having board experience as well as experience in the sector they are inspecting cannot be overstated.



Not a satisfactory experience due I suspect to the inexperience of CQC inspection team.

However, a number of respondents commented that their well-led inspection was a useful and constructive experience. In these cases, trusts felt they were given fair feedback and that the inspection provided a helpful, external perspective that focused their thinking or added to improvement work already underway in their organisations.



*Well-led inspection is genuinely helpful process... that brought the board and executive team together and gave some insight into where we are as a trust.
Fresh pair of eyes is always helpful.*



Fair feedback with some good recommendations that the trust is taking forward.

In line with last year's findings, several respondents said there continues to be a lack of consistency between initial feedback they received immediately after the inspection and their final report. Several trusts also commented that the process continues to be resource and time intensive.

Overall, this year's survey results suggest there remains a general consensus that potential positive impacts of CQC's new approach are yet to be delivered in practice. Trusts recognise that CQC is in the initial stages of implementing its new approach and several respondents expressed hope that CQC will learn and refine it as time goes on. Our findings suggest more time for the new approaches to bed-in may help with some issues. However, more time alone will not remedy all of the issues trusts have raised, particularly the quality of inspection teams and the challenges system working presents to CQC's current sector-based model.



The approach to CQC inspection is still not risk based and has not reduced the burden of bureaucracy. We are hopeful that this may be addressed in 19/20.



I do believe that CQC are interested and listening and I am hopeful that the process will improve in the future.

CQC local system reviews

The environment within which trusts are operating is changing fundamentally. It is important that the regulatory framework is flexible enough to take account of these changes and does not prevent the provider sector from innovating and working in new ways to deliver new integrated models of care and system collaboration.

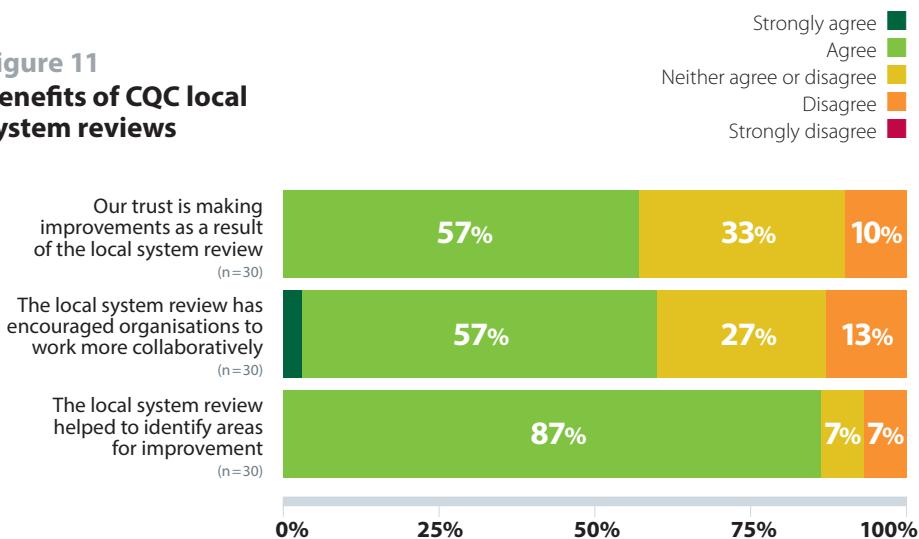
CQC has set out broad principles underpinning how it is seeking to adapt its regulatory approach to take account of the evolving ways in which care is being delivered, both in terms of the move to system working, and in relation to 'complex' providers – trusts delivering a range of services that cross traditional sector boundaries, such as acute care and mental health care, and increasingly, primary care and social care. CQC has put forward welcome proposals for monitoring and inspecting complex providers, including putting in place a single CQC relationship-holder for each provider.

CQC's existing sector-based model was raised by respondents as a concern, with some trust leaders commenting that CQC inspections struggle to assess integrated care pathways or services that span sectors. 28% of trusts said CQC's approach to regulation is a barrier to delivering integrated care, while 34% disagreed.

CQC has also reflected the move to system working in its approach to regulation. CQC completed its programme of local system reviews of health and social care in 23 local authority areas and published the report *Beyond barriers* in July 2018 (Care Quality Commission, 2018). The local system reviews, carried out under special powers at the request of the secretaries of state for health and social care and housing, communities and local government, focused on care for older people across a whole system. CQC found that, while there are often good intentions to work together and good planning between services, organisations mostly focus on their own goals and are not funded in a way that supports them to work together.

Just under a third (30%) of trusts that responded to our survey had been involved in a CQC local system review. As shown in figure 11, the overwhelming majority of these trusts (87%) agreed the local system review had helped identify areas for improvement. A majority of them (60%) also agreed the local system review had encouraged organisations in their system to work more collaboratively, and over half (57%) said they are making improvements as a result of their local system review.

Figure 11
Benefits of CQC local system reviews



Given these findings, it is welcome that the Department for Health and Social Care has confirmed it will commission CQC to carry out further local system reviews. CQC is currently considering the focus of these reviews.

There is much that the national bodies can learn from this programme as they progress the development of new models of oversight at system level. Some trusts had already commented, separately to this year's survey, that the reviews had been well received given their welcome focus on improvement, as opposed to performance management or pleasing the regulator, because CQC cannot take regulatory action against systems (NHS Providers, 2019).



I believe that the greatest challenge to regulation will be the way in which CQC is able to assess, but more importantly reflect and describe what organisations are achieving and delivering at a system level.

As CQC makes further progress on adapting its approach in response to the changing operational context for providers in particular, CQC must work with other national bodies to ensure their approaches are aligned. A crucial element CQC needs to consider is how, when designing system-level assessments, it will work with NHS England and NHS Improvement to ensure that its approach is aligned with ratings for STPs/ICSs, in order to ensure providers and their system partners will not be subject to multiple judgments. The chapter of this report on oversight and regulation of systems and new organisational forms considers these issues in further detail.



[CQC] needs to shift... to systems not organisations.



Acute inspections are designed around single site acute hospitals and are not well adapted to assess integrated care pathways or 'group' organisations.

Use of Resources

Close to half of all trusts (47%) told us they have had a Use of Resources (UoR) assessment in the last 12 months. There was a fairly even number of positive and negative comments about how helpful the assessment had been and the assessment process itself.

Some respondents felt that the assessment process offers a valuable opportunity for self-reflection. However, a number said the external assessment did not add value beyond what the trust already knew. Others felt it was still valuable to have an external perspective validate the trusts' own assessment.

A number of respondents highlighted the resource-intensive nature of the assessment, with a few describing it as unstructured. There were concerns about members of the review teams lacking senior experience and some reports that feedback provided on the day was subsequently contradicted in the final report and rating.

Other comments concerned the data used to guide assessments, with trust leaders suggesting that data is not always up to date, or that it fails to adequately reflect their trust, for example where they are delivering integrated services that span traditional sector boundaries. As in previous years, leaders of non-acute trusts told us that they would like the UoR framework and assessments to be widened to include their sectors.

A number of trust leaders also reflected the view that UoR is a blunt tool and not nuanced enough to properly reflect an organisation's position, in particular, the reasons why a trust may be in deficit. There was a sense among some respondents that their UoR ratings were automatically limited by their organisation's underlying cash position and/or performance against control totals - therefore it was unclear what value the UoR assessment itself added.

CONCLUSION

This year's survey was carried out during a period of transition for NHS regulation and oversight. It is likely that trust leaders' experiences of the regulatory framework will continue to shift over the next few months as the changes to the national architecture settle in. Nonetheless, our survey paints a picture of the aspirations and concerns among trust leaders for the regulatory framework as it adapts.

Trust leaders tell us they are optimistic about the potential for new oversight frameworks to hold systems to account for collective performance, and for the alignment of system oversight with regulatory requirements at an organisational level. However, in the absence of legislative change, it will be complex for the national bodies and regulators to reconcile regulation and oversight at organisational level with the policy ambitions for collective accountability at system level.

Where trusts have been involved in CQC local system reviews, they overwhelmingly report positive benefits of the reviews. There is much that the national bodies can learn from this programme as they progress the development of new models of oversight at system level, particularly the clear value in focusing on supporting improvement across whole systems.

However, it is disappointing to see that the expectations trust leaders reported last year for the new CQC inspection regime have not yet been met. Trust leaders continue to emphasise concerns that CQC inspections divert significant attention and resources away from trusts' main duties, and that inspections could offer better value for money with experienced inspection teams. While trusts are optimistic about the potential benefits of CQC's new approach, more work is needed to implement the changes effectively.

It is particularly promising that for the first year since we started running this survey, trusts do not feel the regulatory burden has increased over the last 12 months. There is an indication that the move to greater joined up working between the national bodies, reflecting what is going on at the frontline, is having a positive impact in terms of consistency and coordination between the regulators. It will be important for the national bodies to maintain the focus on ensuring proportionate, risk-based and streamlined regulatory requests during a period of considerable organisational change.

Trust leaders continue to feel that regulation is focused on performance management rather than improvement. However, there are signs that the new NHS England and NHS Improvement regional teams are starting to build productive and supportive relationships and ways of working with trust leaders. The joint working between the two bodies offers an opportunity for the two bodies to reset the culture and shape the values and behaviours for their own organisations and across the NHS.

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