NHS Providers response to CQC draft strategy proposals

Introduction

NHS Providers is the membership organisation for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. We help those NHS trusts and foundation trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has all trusts in voluntary membership, collectively accounting for £87bn of annual expenditure and employing more than one million staff.

We welcome CQC's ambition to reconsider how it regulates from April 2021 onwards, taking into account the context and learning from COVID-19, and changes to the wider health and care landscape such as the shift towards system working and increased use of digital technologies. This document sets out our views on the key proposals in the draft strategy, which we hope are useful in further development ahead of the consultation period in early 2021.

Working with providers, other agencies, the voluntary sector, system partners and other regulators to develop a shared understanding of this and developing new regulatory models that enable trusts to deliver high quality care effectively will be key to its success.

Key points:

- We welcome CQC's intention to consider how it adapts its regulatory approach to system working, as health and social care provision becomes more integrated. CQC will need to provide trusts and wider system partners with clarity on how they will be assessed, particularly as we await the outcome of legislative change, and the potential for CQC to move to regulating systems, within the forthcoming NHS Bill.
- We would like greater clarity on how CQC's proposals will align with NHS England and Improvement's intention to develop a system oversight framework. This would support a

shared and coherent definition of quality, performance and what constitutes 'well led', reduce burden, and ensure new models of regulation are introduced in a streamlined way.

- We welcome the shift to regulate according to how people experience services, and the commitment to encourage providers to proactively engage with their communities. It will also be essential for CQC to set out what good practice in this area looks like, so that trusts have a standard to measure themselves against.
- We would encourage CQC to take account of the voices of frontline NHS staff alongside the experiences of people receiving care in their regulatory model, as staff experience is an important indicator of care quality and how well an organisation is working. We would also encourage the involvement of all trust types in defining what good and outstanding care looks like, to promote a consistent and shared view
- We are pleased to see CQC developing a more insightful monitoring and benchmarking system as part of its shift towards a more proportionate and risk-based model. Delivering this in practice should not be underestimated, and we would encourage CQC to consider piloted or staged roll out approaches to test models before wider implementation.
- We would also welcome further detail on how CQC plans to adapt its infrastructure and workforce to match the skills and capacity needed to implement its ambitions around smarter regulation.
- We welcome CQC's intention to secure a consistent definition and language to talk about safety across all sectors and suggest this be agreed in partnership with providers and set out clearly in the new strategy. This will ensure there is a consensus around the models being used to make decisions and judgements about safety across all sectors.
- In terms of CQC's ambitions to promote stronger safety cultures, it will be crucial for CQC to set out how this will be measured in practice, given the complexity of assessing culture effectively. We would also encourage CQC to consider a broad range of data when it comes to safety, using both quantitative and qualitative metrics to provide context for numerical data.
- CQC should ensure that its improvement alliances comprise diverse providers from all sectors, including community, mental health, acute and ambulance trusts, social care, primary care and others working in the system, in recognition of the unique operating environment the different types of trust work within. We feel confident that trusts will be able to play a leadership role in supporting these alliances and the work of the CQC.
- The stronger emphasis on system working within the new regulatory model will mean CQC needs to set out clearly how they will align their approaches to support whole system improvement, and assure providers that this approach will not add burden or detract from existing safety and improvement activity providers are undertaking individually.

Reviewing systems

We welcome CQC's commitment to considering how it can adapt its approach as systems evolve and collaborative working increasingly becomes the norm. As part of this CQC will need to consider what good quality care looks like in the world of system working and how it will assess the role of private and voluntary sector partners, as well as the role of commissioners such as local authorities and CCGs. As CQC does not have the statutory remit to regulate commissioners or local authorities this raises questions about how CQC can best interact with systems in their entirety, particularly if legislative change is not forthcoming next year. We look forward to understanding further how CQC intends to look at systems – either in a formal regulatory capacity, or in line with its current model of reviewing systems as an adjunct to their current regulatory activity.

The draft strategy describes many actions under each of its four interdependent themes which apply to both individual services and to local systems, signalling an intention to explore numerous metrics and indicators at both provider and at the system level. As health and social care provision becomes more integrated, this shift in approach is pertinent, and is a welcome step towards reducing the tensions between the impetus towards system working and organisationally focused regulation, but CQC will need to set out in more detail how this will be achieved. This may include piloting and testing its regulatory models to measure its impact in practice first, prior to wider and large-scale implementation.

We support the intention to consider the wider system factors contributing to care along a pathway or in a place. CQC may also wish to explore how metrics will be measured and collected at the system level, and how this will interact with the provider-level assessments. CQC may wish to consider whether aggregated data from organisational level assessments may provide a more useful insight into system performance than seeking to define places and pathways in a way that allows them to be measured, given the complex and varied nature of integration and system working.

This process will need careful consideration, so as to avoid introducing multiple conflicting judgements, and mitigate the risk of providers being judged on factors outside of their control. We would also recommend engaging with trusts and other system partners locally to understand existing methods of measuring how well care pathways and integrated models of care are working for patients.

CQC's plans to assess people's experience of care across a pathway and ensure its regulatory model considers the system-wide context providers are operating within are welcome. However, details of

how CQC will gain a full picture of system-wide issues have not yet been specified. While the regulator cannot currently inspect local authorities or commissioners, it has undertaken 'system reviews' and more recently undertaken reviews of provider collaboration using its existing powers. CQC should ensure they use these reviews to identify where the gaps are to support the longer-term approach to looking at systems. The draft strategy does not yet provide clarity on how this method of regulating will operate on the ground, with a need for further detail about the metrics, footprints and different organisations' contributions being considered.

More broadly, we would like to see greater clarity on how these proposals will align with NHS England and Improvement's intention to develop a system oversight framework which will take a similar approach to reviewing system performance on a more formal basis as well as giving systems a greater role in managing performance and quality across their patch. This would support the creation of a shared and agreed definition of quality, performance and 'well led', reducing burden, and ensuring new models of regulation are introduced in a streamlined way.

1. Driven by people's experiences

The draft strategy describes an ambition to regulate according to how people experience services, with a closer focus on people's experience and outcomes of care. The draft strategy sets out how it will not be possible to achieve a rating of good or outstanding without evidence of engaging with people and communities. We welcome the commitment to encourage providers to engage with their communities. However, it will also be essential for CQC to clearly set out what good practice in this area looks like, so that trusts have a standard to measure themselves against.

Safety happens at the point of care, at the interface between patients and staff. Understanding trends and patterns, and listening to a diverse range of views, can help providers judge the status of safety in their organisation. We would therefore encourage CQC to include the voices of frontline NHS staff alongside the experiences of people receiving care in the regulatory model, as they provide an important insight into the running of day to day services, and the experience of staff is an important indicator of how well an organisation is working. CQC may wish to consider the role it could play in encouraging this dialogue between leaders, staff, and patients in trusts.

Involving trusts in the process of setting out a clearer definition of what good and outstanding care looks like, based on what matters to people, and using this to underpin their assessments of services and the information they collect is also welcome. This will be key to promoting a consistent and shared view on what quality care looks like in practice for all trusts.

2. Smarter regulation

The draft strategy describes an intention to take a more dynamic approach to regulation, moving away from relying on a set schedule of inspections to a more flexible approach using all regulatory methods, tools, and techniques to assess quality continuously. Trusts welcome the proposed move towards a more flexible, 'real-time' approach, based on developing constructive relationships with their local CQC teams, and less reliance on resource intensive, 'set piece' inspections. We would welcome further detail on how this will affect providers, for example there will be a need to understand what fewer inspections means for those trusts keen to improve their ratings or to exit special measures.

There are evidently benefits to this proportionate and risk-based approach, particularly regarding intentions to minimise regulatory burden on providers through its targeted approach and reducing duplication. However, the draft strategy does not set out the evidence base behind these proposals and questions remain on how this will impact trusts in practice. CQC will need to ensure this approach does not add burden elsewhere, cause ratings to become overly volatile, create gaps in insight or a loss of clarity on what trusts are being measured against.

We are pleased to see CQC developing a more insightful monitoring and benchmarking system as part of its shift towards a more proportionate and risk-based model, drawing from a wider range of sources on a more continuous basis. However, implementing this in practice should not be underestimated, and a piloted approach or a staged roll out could be considered in the first place to test this model before wider implementation.

Additionally, there are new capabilities CQC may need to develop to make sure they deliver this new model for regulation appropriately, including enhanced digital and analytical capabilities. CQC has highlighted that data and technology will underpin its regulatory activity to help it to better understand risk and how people experience care across sectors. Success will depend on establishing these new capabilities and ensuring its method accurately predicts the health of the system. We would also welcome further detail on how CQC plans to adapt its infrastructure and workforce to match the skills and capacity needed to implement this change.

3. Promoting safety

The draft strategy outlines ambitions to promote safe care for people by driving providers to see safety as a top priority and enforcing standards of safety more proactively. We welcome its intention to secure a consistent definition and language to talk about safety across all sectors and suggest

these be discussed and agreed in partnership with providers and set out clearly in the new strategy. This will ensure there is a consensus around the models being used to make decisions and judgements about safety across all sectors.

For example, all providers certainly aspire to all care being delivered as safely as possible, but there is a risk that setting an ambition of 'zero' harm may discourage recognition of and reporting of harm where it does occur, acting as a barrier to improvement. We welcome CQC's interest to move away from this language around "zero avoidable harm" and a shift towards using "minimising avoidable harm", as this captures the landscape providers operate within more accurately and recognises the complexity of healthcare and the risks inherent in this environment, without detracting from the critical importance of focusing on safety as a priority in services. Trusts will welcome clarity on how they will be expected to build on what they are already doing to ensure safe care, and we would be keen to understand further how the key lines of enquiry (KLOEs) might be adapted to support this ambition.

There is complexity within provider organisations, and this needs to be reflected in how they are regulated – while safety is a key priority across the health system, the same approach to assuring safety may not be appropriate for every setting. CQC's model will need to be tailored specifically to each sector. It will be helpful to see further detail on what prioritising safety might look like in practice, and whether an approach of increasing the weighting of the Safety KLOE would have an impact on providers' ratings.

Despite the demands and pressures on providers, they make safety their top priority, but they also need the wider system issues and the impact they have on managing safety to be recognised and acknowledged, and for national organisations to play an active part in helping to create the conditions for safety. CQC's intentions to include these wider system issues within their regulatory approach is therefore welcome and should consider the significant impact of increased demand, financial challenges and workforce pressures as part of this if it wants to enable cultural improvements over the long-term.

In terms of CQC's ambitions to promote safety cultures more strongly in the new strategy, further questions around how this will be measured in practice remain. Culture is multi-layered, complex, and takes a long time and concerted effort to influence. Rather than looking broadly at the overall culture of an organisation, it may be more useful to examine which components of culture might influence aspects of performance in providers. Culture can also be affected by the expectations placed on providers which means the approach taken by the CQC must be underpinned by a realistic,

transparent conversation around risk, and a mature understanding of safety within a complex adaptive system like healthcare. What constitutes a safety culture, and the behaviours that underpin it, should be role-modelled by all parts of the wider system. There may be a tension between the impetus to set benchmarks and define complex and subjective domains such as culture set against a drive for a more value based and supportive relationship with providers, which should be considered and addressed to help providers visualise how the new strategy will affect them in practice.

We would also encourage CQC to consider a broad range of data when it comes to safety, beyond quantitative metrics. Safety strongly relates to those aspects of care and influences on care that can be harder to measure like relationships and people's experiences. Qualitative data, such as the experiences of service users and frontline staff or observations of operational activities and interactions between staff, and service users, is a valuable and important insight into safety in the health and care system and provides context for numerical data. This is particularly important in the context of moving away from set-piece inspections where qualitative information about culture could be drawn from, and we would be keen to understand how CQC plans to replace insights that can only be gathered through on-site visits in a more remote and continuous approach.

4. Driving improvement

We fully support CQC's interest in supporting trusts to drive their own improvement through its new improvement alliance made up of key partners from all sectors.

CQC's ambitions to provide benchmarking information using data and technology, and enable access to shared learning, information, advice, and support so that services can help themselves is welcome. In enhancing its role in improvement, CQC will need to be mindful of its reputation as a regulator and seek to support locally led improvement. Moving to a more provider-led model for improvement may help address some of these challenges while maximising CQC's assets as an objective authority on care quality with a national voice and the capacity to share its findings effectively across England to support improvement. CQC should ensure that these alliances are made up of diverse providers from all sectors, including community, mental health, acute and ambulance trusts, social care, primary care and others working in the system, in recognition of the unique operating environment the different types of trust work within.

With a strong emphasis on system working, CQC will need to set out clearly how it will support whole system improvement, and assure providers that this approach will not add burden and take away from existing safety and improvement activity providers are undertaking in their own ways.

The strategy also signals an intention to place a greater emphasis on health inequalities, and we support this ambition given the increased focus on tackling health inequalities and prevention in the wake of COVID-19. There are numerous frameworks available to guide trusts on how to achieve this, and we would encourage CQC to align its assessment of trusts' progress in this area to existing models in order to create the necessarily clarity.

Conclusion

We welcome CQC's vision outlined in its draft strategy to transform its approach to regulation to reflect wider health and social care changes, such as the shift towards integrated care and system working, and bringing together learning from its regulatory approach throughout COVID-19. However, CQC still needs to set out what this will look like in practice, and we recommend that new regulatory models and definitions be co-produced with providers, other agencies, the voluntary sector, system partners and other regulators to develop a shared understanding and consistent view of high quality care.

Regarding better alignment with other regulators, trusts have previously expressed concerns that provider regulation and system oversight does not always align closely with the context in which they work, and at times subject to contradictory judgements which can disincentivise collaboration. Our 2019 regulation survey found that over half (58%) of trusts who responded agreed that it is possible to align system oversight with regulatory requirements at an organisational level. As NHS England and Improvement (NHSE/I) is in the process of developing its system oversight model, there is a real opportunity for greater alignment. We would recommend that CQC sets out how it plans to align with other parts of the system, including other streams of work like the NHS patient safety strategy, within its new strategy.

With significant changes to the provision of health and social care currently on the horizon, including potential legislative change within the upcoming NHS Bill, the regulatory activities that underpin CQC's new approach will need to be based on robust evidence in real-world settings. We would therefore recommend piloted and/or staged approaches to new regulatory models to test impact first prior to large-scale implementation. We look forward to working with CQC on behalf of our members as it moves into the next phase of developing its new strategy from April 2021.