4 March 2021

NHS Providers response to CQC's strategy consultation

About NHS Providers

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 £92bn of annual expenditure and employing more than one million staff.

Introduction

We welcome CQC's commitment to redevelop its regulatory approach as part of its new strategy, which takes into account the context and learning from COVID-19, the importance of addressing health inequalities, and changes to the wider health and care landscape such as the shift towards system working and increased use of digital technologies. We are pleased to respond to this consultation on behalf of our membership and welcome the ongoing opportunity to feed into the development and implementation of the strategy.

In our response, we set out our views on the four strategy themes as well as CQC's approach to reviewing systems and its ambition to tackle health inequalities as part of the draft equality impact assessment, published alongside the strategy. We have engaged with CQC previously on its draft strategy and have consistently welcomed the ambition of the strategic themes. Trust leaders have however raised questions about what the proposals will look like in practice. While many of these questions remain we note that additional detail has been provided on some of the proposals we queried since earlier drafts.

Our response has been informed by engagement with trusts and foundation trusts in England, including targeted discussions with trust leaders, engagement with our members on the draft

strategy, and responses to our annual member survey on regulation. This consultation has been published during a hugely challenging time for trusts, so we look forward to working with CQC over the coming months as it continues to develop its new approach and implement changes to its regulatory model. Working with providers, other agencies, system partners and other regulators to develop new regulatory models that underpin high quality and equitable care will be key to its success.

Key points

- Trusts support a move to a smarter and more responsive regulation and will welcome a reduction in burden, less reliance on inspections, and CQC's intention to base their judgements on a more rounded picture of quality. Any new thresholds for choosing to visit or inspect trusts will need to be communicated clearly and applied consistently.
- Trusts welcome the mechanisms being put in place to review performance and outcomes at a system level, including how Integrated Care Systems (ICSs) are working to address health inequalities. Trusts also support CQC's intention to look at quality across pathways. Trust leaders are keen that this is done in partnership with NHSE/I, complementing the new system oversight framework.
- With the increased emphasis on system working, CQC needs to assure providers that its approach to supporting whole system improvement will not add burden or detract from existing improvement activity. While CQC may play a valuable role in promoting improvement, it should ensure this does not overstep its core regulatory role or duplicate improvement work driven locally or by other national organisations.
- Trusts remain committed to involving people and communities in decisions made about services. However it will be crucial for CQC to take into account the complex context in which providers are operating, and the need to balance person-centred care with wider national policy imperatives including constraints on the financial envelope, workforce challenges (particularly in the wake of the pandemic where many frontline workers are exhausted) and system priorities.
- It is worth highlighting that the timing of the new strategy has restricted member engagement on the detail of the proposals, and continues to form a backdrop of significant operational pressure, and strategic change as the service stabilises after COVID-19 and prepares for legislative change to place system working on a statutory footing. We would encourage CQC to future proof its own strategy as far as possible and keep its plan under review as the strategic environment continues to evolve.

- We recognise CQC's role in identifying the risks to safe care during the COVID-19 pandemic. However the regulator's approach must be supported by a regular, constructive dialogue with trusts to ensure it remains proportionate. While not directly relevant to the proposals set out in the draft strategy document, our regulation survey results and anecdotal feedback from our membership reflect a clear concern that CQC's recent regulatory activity has not consistently taken into account pressures at the frontline during the pandemic. We also know that trusts are concerned about the increase in the CQC's use of prosecutions. We suggest that CQC continues to work with its local teams to ensure the strategic direction it advocates nationally is felt on the ground, uniformly, by all trusts.
- Safety is the top priority for trust boards, and their staff. However the complexity inherent in healthcare settings needs to be reflected in how safety is regulated. Not all risks can be eliminated, but we welcome a focus on learning cultures as a way of supporting trusts to improve their approach to safety and manage risk appropriately without setting unrealistic expectations of eliminating all harm. We also welcome the move by CQC to adopt language around safety issues which is consistent with that used by colleagues in NHSE/I and other national bodies, and safety experts, and would support a continued focus on complementing, rather than duplicating, work being undertaken by these other bodies.

Response to proposals outlined in the strategy

People and communities

We remain supportive of the shift to regulate health and care services based on how people experience them, and the ambition to encourage providers to proactively engage with their communities. In our recent members survey on regulation, three quarters of the 51 respondents expressed support for this proposal to ensure regulation is driven by what people expect and need from services. While there is support for the direction of travel for this proposal, trusts also highlight the need for CQC to outline what good practice looks like, and the need for consistent assessments against a benchmark.

This "focus on what matters to the public, and to local communities, when they access, use and move between services" will ensure people and communities are at the forefront of conversations around quality and safety. Trusts support this and remain committed to involving people in decisions made about services and how they are delivered.

We also recognise that there are important quality and safety considerations that go beyond what people using services may prioritise, so the voices of NHS staff are valuable to providing new insights

and day-to-day context about the quality of care delivered within their services, and enriches the picture CQC may gain of how decisions are made about services. Staff engagement is also a proven indicator of quality and how well led an organisation is and we therefore encourage CQC to consider how best to include the voices of trusts and frontline NHS staff as part of this exercise.

We would ask that CQC recognises the fact that trusts must strike a balance between meeting the needs which patients, service users and staff highlight in a way that is sustainable within a constrained funding envelope, within nationally agreed pay and policy requirements for the workforce and in line with wider organisational and systemic needs. As one respondent in our recent regulation survey commented, "*I am strongly in favour of user-driven changes but there does need to be some consideration for providers to be able to deliver services as they feel appropriate for their organisation as a whole…And of course, you can't be everything to everyone, and providers need to be able to have some autonomy in this decision making/planning*".

We would also encourage the involvement of all trust types in defining what it means to promote the ambition of "having an agreed and shared view of quality", as operating contexts differ widely, and may change how quality is conceptualised and made real at the frontline. For example, care staff may see it through the prism of personal and professional standards, while hospital managers may emphasise meeting requirements and standards, while clinical staff tend to focus more on person-centred care and clinical effectiveness.[1] This should be acknowledged as it will help system partners understand how they can come together to work through quality issues supportively.

Finally, there is a need to avoid duplicating the work of other organisations in seeking to achieve this aim. We know that CQC work closely with the National Quality Board to develop a shared view of quality, and we therefore encourage alignment with the board on this as well as other bodies working in the field of quality and safety, to avoid duplication and conflicting definitions. We would also encourage setting out a clear definition of what good and outstanding care looks like as this will promote this consistent and shared view and will enable trust boards to effectively carry out their own assurance.

Smarter regulation

[1] https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-021-06104-0

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.

Nine in ten (89%) trusts in our regulation survey said they are supportive of the proposal for a smarter approach to regulation, with an ambition to provide an up-to-date, consistent, and accurate picture of the quality of care in a service and in a local area (68% highly supportive, 20% somewhat supportive). However many highlight the need for this intention to be matched by practical changes to the way they experience regulation from CQC, with a reduction in burden.

Trusts particularly 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 welcome the intention to create a mechanism to update ratings without the need for a visit, particularly for those trusts keen to improve their ratings or to exit special measures. We look forward to working with CQC on the detail behind these proposals and understanding the impact on all trusts.

The circumstances described in which CQC would continue to visit trusts appear to be proportionate and realistic – site visits are an important way to get a rounded picture of culture and behaviours which influence quality, and to speak to front line staff about their experiences of providing care. We have always advocated a proportionate and risk-based approach, minimising regulatory burden on providers and reducing duplication. Trusts are eager to see a move away from a time-intensive and transactional relationship with regulators to one which takes account of all the drivers of care, the context within which trusts operate, and which is founded on a mutual understanding of what it means to provide good care and how regulatory activity can support improvement.

However, it will be important that the rationale for choosing to undertake a physical visit is applied consistently across trusts in all sectors and communicated clearly. Our members' feedback suggests that while the intentions set out by CQC appear proportionate and are welcomed in principle, their experiences vary widely and can diverge from the intended or communicated approach.

Around two thirds (63%) of trusts responding to our regulation survey said that they felt CQC had a fairly good or very good understanding of the pressures they were facing due to the coronavirus. However some trusts felt that the threshold for triggering a site visit had been low and created disproportionate pressure at a time of significant challenge. Other concerns trusts raised include the volume and format of data requests during the pandemic, and the deadlines given for completing

them. Some trusts said that the step-change in CQC's approach during the first wave of the pandemic was replaced with a return to a more risk averse and, in some cases punitive, approach to inspections and information requests.

In light of this recent feedback, we are somewhat cautious about CQC's proposals for a more proportionate regulatory approach, as while welcome in principle, it will only be possible to assess the impact once implementation is underway. We would strongly encourage CQC to maintain a dialogue with the providers they regulate, to support a mutual understanding of proportionality and burden, and we would welcome the opportunity to facilitate this. We also recommend that CQC works with their local teams to ensure that strategic changes to the way they operate are felt on the ground, and that the impact of its approach aligns consistently with its stated intentions.

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. A piloted approach or a staged roll out should be considered in to test this model before wider implementation, and understand how this impacts trusts' ratings. It will also be important for to CQC to ensure this this new approach does not inadvertently create additional burden, cause ratings to become overly volatile, create gaps in insight or a loss of clarity on what trusts are being measured against. As one respondent to our recent regulation survey commented:

"The critical functions for quality improvement are data collection and statistical analysis, audit of processes, standard operating procedures based on best practice, and a culture dedicated to continuous improvement. Inspection as practiced by CQC tells you only what the inspector saw and anecdotal evidence picked up during the inspection. It is of no value in improving quality because it is a statistically insignificant sample of the work of the Trust. We do 2,000,000 patient interactions a year. They look at less than 100 of them." – Chair, community trust

Additionally, there are new capabilities CQC may need to develop to make sure they deliver this new model of 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.

Finally, we would emphasise the need for better alignment between CQC's activity and that of the other national bodies with oversight of the trust sector. Trusts have highlighted the challenges associated with a regulatory landscape that is 'out of step' and 'confused', with multiple conflicting or duplicated requirements and frameworks. Some examples include requests for similar data in different formats, which requires trusts to set up more than one collection method for the same data. This is all the more pertinent given the further development of integrated care systems (ICSs) with the potential for oversight functions to take place at a system level.

Safety through learning

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". Despite the demands and pressures on providers, they make safety their top priority, but they also need the wider system issues and the impact those 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 intention 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.

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 and care 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 key line of enquiry would have an impact on providers' ratings. 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 KLOEs might be adapted to support this ambition.

While we welcome the recognition of a need to secure a consistent definition and language to talk about safety across all sectors, it is important to note the complexity of this task, given the number of organisations involved in defining and measuring safety, and for CQC to consider its role alongside these bodies including the Healthcare Safety Investigation Bureau (HSIB). Trusts are keen to have this discussed and agreed in partnership with providers, aligned with other policy work such as the NHS Patient Safety Strategy, and set out clearly as part of the Key Lines of Inquiry. This will ensure there is a consensus around the models being used to make decisions and judgements about safety across all sectors, and alignment across the system will be key to achieving clarity.

"I do not think a stronger approach to safety is applicable to CQC as this cuts across HSIB - only 1 of these should do this. Focusing more on improvement does not sit well with the current ethos and culture of CQC - to change to this would require a change of direction for the leadership team and new ubmit" – Chair, community trust

However, while there are clear factors which we know influence safety, we would caution against trying to measure and improve safety on the basis of a fixed definition and framework which seeks to put parameters around something that cannot be measured or predicted with complete certainty. It is important that there are expectations around the actions organisations will take to make steps towards enhancing safety, but at the same time CQC should seek to engage constructively with trusts where these steps are perceived not to have been taken in a timely or sufficient way – including open discussions about the barriers trusts and staff might be facing, wider systemic issues, and other dilemmas which will need to be taken into context. These conversations provide learning opportunities, which in the view of trusts who perceive CQC action to be at times punitive rather than constructive and promoting learning, are missed at times. We welcome CQC's commitment to a shift in culture away from blame and towards supporting trusts to understand and improve safety in their own services, without perverse incentives created by punitive regulatory action.

As a national regulator CQC has an important role and voice in drawing attention to these systemic barriers – for example during COVID-19, CQC's insight reports and provider collaborative reviews have highlighted the issues faced by care providers and shared good practice as well as calls for policy changes to support good care. Conversely, trusts have recently expressed concern at the risk that they may be 'made an example of' as part of CQC's ambition to promote a national conversation on safety – we would welcome clarity about CQC's plans to avoid inhibiting learning in this regard.

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.

"[CQC] needs to ensure inspectors and assessment tools have the maturity to measure the important elements like culture and emotional intelligence not just weighting inspections to what's easiest to measure" – Chief executive, acute specialist trust

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. The experiences and priorities of service users and what matters to them are an important element of what makes high quality care, but cannot form the full picture of alone. We would caution against using this measure as a singular priority, given staff working in healthcare undertake complex processes of managing risk, while balancing clinical leadership with patient engagement.

We would emphasise the value of the insights of frontline staff as well as the observations of operational activities and interactions between staff, and service users, as an important lens into safety in the health and care system, providing 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.

We would also welcome a recognition of the latest developments in understanding of how care failures can emerge over time, in response to shifting norms, workarounds and acceptance of behaviours which do not promote safe care. If CQC is seeking to anticipate the drivers of poor care before critical safety incidents arise, this will take a nuanced conversation with trusts, as well as a strong understanding of the softer signals which can lead to further problems. As described above, prioritising the voice of frontline staff alongside those of patients will be critical in gathering this understanding.

Improvement

With the increasing emphasis on system working, CQC needs to assure providers that its approach to supporting whole system improvement and to convening coalitions of partners will not add burden or detract from the existing safety and improvement activity providers are undertaking individually – or duplicate other programmes underway nationally. CQC's intention to develop collaborative

relationships with providers to help them find their own route to improvement, including pointing them to sources of guidance, best practice, and other organisations, rather than 'telling them what to do', is welcome and may help it to support trusts without compromising its core regulatory role.

The Health and Social Care committee's recent inquiry into the safety of maternity services in England has heard evidence that demonstrates how having multiple improvement initiatives can lead to confusion.[2] We therefore encourage CQC to test their proposed approach in practice and ensure its shift into the improvement space is robust and does not become overly complex or duplicate work taking place elsewhere.

Respondents to our regulation survey raised concerns around improvement coalitions and commented on whether this ambition oversteps CQC's core regulatory role. For this reason, take up of this initiative may be mixed, and should be voluntary and informative rather than forming part of the regulatory offer for trusts.

"It is important that work to develop improvement coalitions does not duplicate arrangements that already exist and therefore not see as the CQC looking to expand their remit" – Company Secretary, acute trust

"I am not sure establishing/facilitating nationwide improvement coalitions is consistent with the CQC regulator role and this is already a crowded area. Better for a focus on improving the current approach rather than adding another body…" – Chair, acute trust

CQC should ensure that these coalitions consist of providers from every sector, 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 trusts work within. It may also be valuable for CQC to support providers within a sector to collaborate, as well as encourage system-wide peer support and learning that brings together expertise from different parts of the system. We feel trusts are well-placed to play a leadership role in supporting these alliances and the work of the CQC.

Regulation in the context of system working

[2] https://committees.parliament.uk/oralevidence/1418/pdf/

The COVID-19 pandemic has accelerated the shift towards health and care services working more collaboratively as a system to deliver care. As such, CQC has identified that its 'single provider service model' is no longer fit for purpose in the current and evolving landscape around system working. It has therefore outlined its intention to review how well health and care systems are working together.

Mechanisms for reviewing performance and outcomes at a system level are seen by trusts as an important component of removing barriers to collaborative working. Similarly, organisationally focused regulation is seen as a barrier to collaboration as it introduces competing priorities and incentives, and systemic issues are often not adequately taken into account when addressing specific issues trusts face. Our regulation survey of members shows that the vast majority (90%) of trusts support a move towards models of oversight which take into account system working, and this has increased since 2019 (80%).

However, the process of identifying the right mechanisms for doing this is complex. ICSs are coalitions of many partners working across health and social care, including non-NHS organisations such as local authorities and the voluntary sector which are not subject to the same lines of accountability and oversight as trusts and other NHS organisations. Trusts have highlighted a need for better alignment of policy priorities with regulatory requirements, and the removal of barriers to integration related to organisationally-focused performance measures. It is right for CQC to consider its role in supporting system working and examine its regulatory model for barriers to collaboration.

In our survey, we also asked trusts what changes they felt could be made to CQC's existing regulatory framework to support the further development of system working and integrated care. Our findings highlight a need to ensure new capabilities and infrastructure are developed to support this shift including a robust understanding of the complexity of systems among inspectors and other staff, so as to avoid the risk of this new approach measuring the wrong things. It also remains unclear how CQC will assess quality at the ICS level before they have put in place quality assurance, procedures and systems that can be assessed. CQC will therefore need to be clear about what measures are being used at the system level, and whether there is yet the discrete infrastructure in place at the ICSs level that can be assessed.

Trusts are broadly supportive of CQC's intention to take the system-wide context into consideration when reviewing services. More than four in five (84%) respondents expressed their support for CQC's ambition to review how well Sustainable Transformation Partnerships (STPs) and Integrated Care Systems (ICSs) are working together to improve outcomes for people in their communities. Additionally, three quarters (75%) said they would be supportive of its proposal to hold STPs/ICSs to

account for the quality of care in their area. Some trusts highlighted that this should be accompanied by a review of organisationally focused work to reduce duplication or conflicting judgements.

"...Re STP/ICS holding to account, once legislation is approved then the CQC should focus on system but also review work with individual providers so as to avoids duplication." – Chair, acute trust

The main concerns trust leaders noted were around the legislation to support this shift towards system working which is currently being developed. Many questions remain around the complexity of implementing this in practice in a way that won't add burden and increased bureaucracy for trusts. The comments also highlight a need to ensure changes to regulating systems aren't made hastily before the legislation is implemented.

"The law will need to change first of course, but for trusts there are well known barriers to efficient and effective care delivery such as social care arrangements which would need to be incorporated in order for this to reflect reality and to be fair to trusts." – Other, acute trust

There are also considerations around how system-focused models of regulation and oversight may impact trusts whose work spans multiple systems and places. These trusts may face multiple conflicting judgements depending which system's context is being looked at as part of any given assessment, and they may be subject to performance management from multiple ICS boards. This could prove to be burdensome, duplicative and confusing for trusts whose work spans larger geographies and populations.

Success in CQC being able to effectively review health and care systems 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 as changes begin to take place nationally. Alongside developing these stronger relationships locally, it is also important that CQC provides trusts with clarity over how it intends to review issues within the system outside of its control.

Tackling health inequalities through regulation

The draft strategy also signals an intention to place a greater emphasis on reviewing how health and care systems are working together to address health inequalities. The COVID-19 pandemic has renewed the focus on health inequalities, so we are pleased to see this ambition run throughout CQC's four themes presented within its strategy. Trusts will also welcome this focus, which will be

important as they consider their approach to recovering from COVID-19 and restoring services in a way that addresses inequity in existing health outcomes and minimises the disproportionate consequences on marginalised groups.

There are a number of frameworks available, such as the "Reducing Health Inequalities Associated with COVID-19: A framework for healthcare providers" developed by the Provider Public Health Network, to guide trusts on how to address health inequalities, and we would encourage CQC to align its assessment of trusts' progress in this area to existing models in order to create the necessary clarity and avoid duplication. Alignment of work in this area with other national bodies and regulators will be crucial to avoid duplication and confusion when communicating and providing clarity on proposed changes to trusts. CQC must ensure it does not overstep its core regulatory role when it considers gaps in oversight on health and care inequalities.

In order to have the greatest impact, the wider determinants of health will also need to be considered as part of a system-wide approach to health and care. We therefore welcome CQC's approach to reviewing systems and "developing its focus on how providers are working together to ensure fair access to health and social care services for everyone". However, implementing this in practice should not be underestimated, as CQC will need to develop new capabilities and effectively map out and understand the full picture and the variation of health inequalities across whole system footprints as well as the impact of the wider determinants of health, socioeconomic factors, and the influence of non-NHS partners as well as determine individual providers' contribution to efforts to reduce health inequalities and influence on outcomes driven by complex processes and interdependencies. This is unlikely to be straightforward to measure.

As health and care systems evolve and collaborative working increasingly becomes the norm, this process will need to be carefully thought through to mitigate the risk of providers being judged on factors outside of their control. Using the existing Provider Collaborative Review (PCR) process as a tool to review how well health and social care services work together to reduce inequalities is a useful starting point, and we therefore support the inclusion of this within the new draft equality impact assessment.

The draft equality impact assessment provides some clarity and detail on how CQC intends to assess how its proposed changes to regulation could impact equity and human rights for people and ways to mitigate this. We encourage CQC's intention to continuously review, assess and develop how it regulates in this area, and we welcome the involvement of "service providers, Experts by experience and a diverse group of people who use health and care services when it reviews and redesigns its

regulatory model". The involvement of providers in co-designing this approach will be important to ensuring the new model effectively supports them to deliver quality care to everyone with equality in mind.

We also encourage CQC to ensure its future approach in this area aligns with its ambition to be a proportionate regulator that promotes a culture of learning and improvement, as this will enable trusts to innovate and develop new ways of working to address inequity in a rapidly evolving health and care landscape. CQC's intention to "work closely with service providers and stakeholders to gather more comprehensive and robust information that helps it understand how well the health and social care system is working and how it might need to respond", has the potential to add additional burden on trusts even if it intends to collect this information once.

We urge CQC to be mindful of the pressure providers are under as they continue to cope with the COVID-19 pandemic and when they begin to recover and restore services, particularly as gathering this information will require extra resource and capacity. We would also encourage CQC to provide stronger clarity on how information it requests from trusts will be used to drive improvement in this area and ensure trusts are given reasonable timeframes to respond. This will also be important to consider in its approach to "understanding where the gaps in oversight of safety in the health and care system are and whether CQC or another body should – and could – fill that gap to offer greater support to sectors outside of NHSE/I remit".

CQC acknowledges that "encouraging providers to involve people in decisions about their safety more, including managing risks, could be perceived as a burden for providers". We appreciate CQC's intention to set out more "clearer expectations of providers of health and social care in meaningfully involving people in decisions about their own care, in particular on decisions about safety and risk". CQC should provide clarity on what "good practice" in this area looks like so trusts can effectively measure themselves against this.

It is worth noting that trusts and NHS staff make safety a priority whilst managing risk and huge complexity in delivering quality care and they need the support and resource to do this well. "Sharing good practice about involving people in decisions about their own safety risks, with a focus on where it has had a positive impact on equality or human rights" will be useful to trusts, but we would also recommend CQC continues to take into consideration trusts' views, particularly when its approach to regulation may add burden and especially within the context of the current pressures they are under and will continue to face as they recover from COVID-19. Trusts want to deliver high quality and equitable care to everyone so working with them and enabling dialogue in this area will be important.

As CQC develops its new approach with the added focus of addressing inequalities in the wider health and care system, we are pleased to see the intention to incorporate a review process to determine how it can improve assessment over time. We reiterate the importance of considering providers' views alongside the views of people who use services in this review process when CQC considers the impact of its regulatory model. CQC needs to ensure its approach is proportionate, adds value, and enables and supports trusts to improve health and care outcomes for everyone, particularly those from marginalised groups.

Conclusions and considerations for the implementation of the strategy

We recognise that CQC must find the correct balance between timing its consultation exercise during a period when stakeholders are able to engage, and being ready to support trusts and launch its new methodology when the pandemic ends. We have welcomed the opportunity to engage with this process over the past year.

However, throughout this period of engagement trusts have been in the midst of the greatest challenge to face the health system in its history, and some trust leaders have expressed concern at their ability to engage fully to support the development of the strategy and more widely with other national policy changes this year. For this reason we welcome CQC's commitment to co-produce the implementation phase of the strategy so that there are further opportunities for trusts to feed back.

Trusts are broadly supportive of the direction of travel set out in the strategy. The intention to take a more flexible approach to gathering information to inform CQC's assessments is positive and has potential to reduce burden and improve trusts' experience of regulation. Likewise, the move for CQC to place greater emphasis on systems is welcome. However, there are many elements to the strategy which we feel will only be possible to assess once they have been implemented, and we look forward to an ongoing dialogue with CQC during the next phase of the strategy.

There is a risk that while the system remains flexible and responsive to the changing risks of the pandemic and the recovery period, that the context may change again and warrant further developments to the strategy. We would encourage CQC to consider whether certain elements of the strategy can be future-proofed further, particularly around the proposals for systems given the status of legislative proposals.

We appreciate the constructive and transparent relationship we have with the senior leadership team at CQC and colleagues throughout the organisation. We look forward to continue working with them throughout the implementation and delivery of this new strategy and would welcome the opportunity to facilitate more engagement with our members.