

CQC CONSULTATION 'OUR NEXT PHASE OF REGULATION: A MORE TARGETED, RESPONSIVE AND COLLABORATIVE APPROACH' - NHS Providers' response

ABOUT NHS PROVIDERS

NHS Providers is the membership organisation and trade association for the NHS acute, ambulance, community and mental health services that treat patients and service users in the NHS. We help those NHS providers 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 96 per cent of all trusts in membership, collectively accounting for £65 billion of annual expenditure and employing more than 928,000 staff.

INTRODUCTION

NHS Providers welcomes the opportunity respond to CQC's consultation on the next phase of developing its regulatory approach for NHS trusts and foundation trusts. Our submission is based on our regular dialogue with our members, as well as a dedicated engagement event with our members held in partnership with the CQC on 1 February 2017 to discuss these proposals in detail.

We support the CQC's role in setting minimum, national quality standards and identifying where services fall below those standards through a risk-based and proportionate approach. At the same time, we are concerned that quality of care should be understood as being the primary responsibility of provider boards and their staff, with responsibility for driving improvement also resting with them. Our response is therefore based on these principles.

KEY MESSAGES

- We welcomed the launch of CQC's new strategy for 2016-2021 last year, which followed on from an extensive engagement and consultation process. The strategy committed the CQC to reforming its regulatory approach, including becoming intelligence-driven and taking a risk-based approach to inspections.
- We are supportive of the general approach outlined in the consultation document which we believe that, if implemented appropriately, should enable the CQC to achieve the ambitions set out in its strategy document.
- Implicit throughout the proposals in the consultation is the presumption that the new approach to regulation will result in a reduction of the burden imposed on providers, but we would urge the CQC to closely and robustly monitor this throughout its implementation and continued use. Maintaining close engagement with those inspected as the new approach is rolled out will be essential to ensure its success.
- Key to the successful implementation of the new approach will be training for CQC inspection teams to ensure they are fully equipped to deliver it, demonstrating the reliability of insights gained through the new intelligence model and improving relationships with providers at the local level.
- Working more closely with arm's length bodies and other parts of the system will be essential to achieve better alignment, reduce burden and facilitate 'one version of the truth' when assessing provider performance.

- We have long argued for a 'period of grace' for trusts which take over struggling services or other providers with the aim of improving patient care and making efficient use of available resources. We therefore strongly welcome the recognition of the need to ensure the new regulatory approach supports rather than penalises these trusts whilst recognising safety.
- Finally, trusts have been charged with the challenge of radically transforming how care is delivered at pace and scale in the face of rising demand and continued resource constraints. With this in mind, we would like to see the CQC demonstrate a clear focus on streamlining the burden and complexity of regulation on providers to ensure resources are not diverted away from patient care.
- The emergence of new models of care and the changing landscape will make it imperative for the CQC to ensure that its regulatory and inspection regime keeps pace with these developments.
- It is imperative that the CQC avoids further increases to provider fees as it seeks to implement the new approach and redoubles its efforts to demonstrate that it is delivering value for money.

REGULATING NEW CARE MODELS AND TAKING LOCAL CONTEXT INTO ACCOUNT

We strongly welcome that the CQC is looking at how it can adapt its regulatory approach in response to the new models of care and complex provider organisations emerging across the country that are being driven through STPs. Our response to the CQC's strategy consultation argued that the regulatory framework must be flexible enough not to prevent the provider sector from innovating or moving towards new and reconfigured patterns of service delivery.

We welcome that the CQC has set out in the form of broad principles what will underpin its approach to regulating the changing landscape of care provision. The proposed principles are reasonable – for example, we agree with the need to consider the impact of ratings on trusts taking over struggling services with the aim of improving patient care and avoid disincentives such as having their rating consequently pulled down, something NHS Providers has called for in the past. In addition, the aim of minimising complexity of the inspection process for providers delivering more than one type of service (i.e. acute services as well as community, mental health or primary care services) is welcome, given the increasingly diverse range of organisational structures and models that are developing in the NHS. Likewise, the proposed bringing together of inspectors who have specialist knowledge of different sectors to inspect jointly where a trust is providing care across more than one service type is also a positive move.

Furthermore, we note positively that the CQC will be looking at how it can schedule its inspection activity 'in a way that recognises where providers are working together in less formal partnerships or as an entire local health and care economy'. Developing a coordinated approach to inspections in a local area is something we welcome. However, we would urge the CQC to explore further ways to develop its regulatory approach in a way that takes local context into account, while at the same time ensuring that quality is not compromised and ensuring proper lines of accountability are maintained. Through STPs, there is now an imperative for providers to work with others in the interests of the wider system and there are ways in which CQC's regulatory approach could helpfully support this focus. For example, we would suggest that there is a need for inspection reports to be explicit about recommendations which require the input of other partners in the local health economy. Also, we would welcome the continuation of quality summits which could be used as fora for getting shared agreement and commitment to improvement plans at local health economy level.

While the principles in the consultation are a positive first step, we will be keen to see further detail on how the CQC will look to translate these into practice. We and our members remain committed to working with the CQC to ensure its regulatory approach is flexible enough to cope with care being delivered in new ways. As new models of

care are already operating across parts of the country, with more expected to get off the ground, there is a pressing need for this work to progress quickly in light of this rapidly evolving picture.

RELATIONSHIP MANAGEMENT

We are encouraged by the strong emphasis in the consultation on the need for the CQC to strengthen its relationships with providers and develop more regular contact throughout the year. While our members report varying degrees of satisfaction with their current relationship with CQC locally, they universally express a desire and motivation to achieve a good relationship with the CQC, which they feel would enable the regulator to develop an in-depth understanding of their trust and enable it to more effectively fulfill its regulatory functions. Information from ongoing relationship management at a local level will arguably play an even greater role in guiding when, where and what to inspect as the CQC seeks to implement a more targeted approach.

Trusts frequently emphasise to us that a positive relationship with the CQC would be one which offers two-way communication. Members have highlighted instances in the past where they are asked to provide information as a result of a potential concern being raised, but do not then receive feedback on whether or how the CQC acts on the information shared, which was felt had the potential to undermine the overall relationship.

We and our member trusts would also be keen to see CQC developing good local relationships with other bodies – in particular, the benefits of better linking with NHS Improvement and NHS England would be considerable. Several of our members have suggested a model of joint regulatory meetings at the local level which would help bring together all the parts of the system, achieve better alignment and facilitate ‘one version of the truth’ when assessing provider performance. This would also be essential in order to minimise the collective burden that regulation and oversight frameworks place on providers. We understand that this model is already being used in some areas across the country and would be happy to facilitate some shared learning of this.

Carrying out evidence gathering activities (such as focus groups with staff) throughout the year rather than at a single time during inspection is also a positive move but must be carefully balanced against not imposing additional burdens on trusts. We would welcome clarity about the likely demands this would create at a provider level, for example will such evidence gathering activities be arranged by the CQC. Concerns about the significant demands of preparing for an inspection are consistently borne out by feedback from our members, so we would encourage the CQC to carefully consider how the regulatory burden on providers could be eased under the new approach.

NEW INSIGHT MODEL

As stated in our response to the CQC’s strategy consultation, the introduction of the new ‘Insight Model’ will be fundamental to the success of CQC’s ambition for an intelligence-driven approach to regulation.

We appreciate its intention to draw upon qualitative data more fully as part of the new model as well as the prospect of using an expanded range of information sources, including providers’ own accounts of the quality they provide. A consistent approach will be imperative when interpreting qualitative data. We also strongly support the development of the new model so that it can support benchmarking against a suitable peer group, provide a view on whether quality of care is improving or deteriorating and be updated more frequently so that the data is as real-time as possible.

Given the range of concerns about the precursor Intelligence Monitoring system, it will be important for the CQC to build confidence in its new Insight Model and road test it in order to ensure it is fit for purpose and works across all

types of providers. We would strongly encourage CQC to consider how it can use data that is already made publicly available by trusts or held by other national bodies when developing its Insight Model. This approach is in line with the [reducing regulatory burdens challenge panel](#) work CQC and NHS Providers are involved in with the Department of Health. We would be happy to facilitate further dialogue with our members to support the detailed development of the new model. Also, we believe that a key priority should also be for the CQC to develop its analytical capability to ensure it can extract the best possible insight from the data it will amass. It would be useful for the CQC to provide further clarity regarding what outputs from the new Insight model will be made publically available.

NEW STYLE PROVIDER INFORMATION REQUEST (PIR)

We agree that converting the PIR from being a pre-inspection questionnaire (i.e. completed within the lead up to an inspection) into an annual return is logical in the context of the proposed changes to the approach to regulating trusts. A frequently voiced concern by our members in relation to the current inspection regime has been about the significant amount of time and resources involved in responding to the PIR in its present form. Therefore, we welcome CQC's commitment to reducing the reporting requirements on trusts by introducing a more streamlined PIR.

Furthermore, the aim of making more use of information that is already collected and available from other sources is also welcome. Managing duplicative requests for information from different national bodies continues to pose a considerable challenge for trusts, so it will be important to ensure that the PIR avoids duplication with what is asked of providers by other bodies. We note that the consultation also refers to CQC's plans to move to a single online data collection mechanism to support reporting both to the CQC and to NHS Improvement. To reduce the burden of reporting, trusts would strongly welcome having one integrated repository of data which national bodies draw from so that they do not have to submit separate returns for different regulatory bodies, or have to do so in slightly different formats. We would welcome more detail on how that portal will work and we would encourage the CQC to engage closely with providers in developing this. We would encourage further thought be given to allowing providers through the portal to update the PIR on a rolling basis, rather than having to input all the data in one go, which would make it less of an onerous task.

We would however like to emphasise that notwithstanding the new style PIR, providers would need a degree of certainty about when, within a year, this will be required to be submitted to the CQC (unless the CQC intends to ask for PIRs in the same period each year) to be able to effectively plan for it. We would caveat this with the need for the process to be scheduled to avoid periods where trusts already face more intensive information collection and also be coordinated with other arms-length bodies to reduce the likelihood of providers having to respond to multiple data requests at the same time. An approach of seeking to align the PIR process with providers' own quality assurance cycles would be helpful.

Careful consideration would also be needed of the timing of the PIR relative to that of the regulatory planning meeting that is now being proposed for each trust. Our members have previously raised concerns both in relation to the PIR and also the intelligence monitoring system about the information losing its value due to becoming outdated. We believe the same risk could also arise if there was a substantial time delay between the submission of the PIR and the regulatory planning meeting taking place.

We are aware that the proposed timescales for moving to the new approach will mean that the first new style PIRs to be sent out from April 2017 – we would therefore encourage the CQC to communicate the content of the new PIR to providers as soon as possible and allow a sufficient lead in time for this to be completed. We would also urge

the CQC to adopt an approach that allows the new style PIR to be rolled out and amended as necessary on an iterative basis, based on feedback from providers. We would be happy to assist with this wherever possible.

CHANGES TO INSPECTION AND REPORTING APPROACH

We have long endorsed a more proportionate and targeted regulatory approach and the proposed approach of moving towards an annual cycle of a trust-level well-led assessment and inspection of at least one core service is consistent with that. A central concern for many of our members has been about the substantial resources involved in preparing and participating in an inspection. This has also been echoed in our [surveys](#) of members' experiences of regulation which have repeatedly raised the 'big bang' burden of hosting disproportionately large inspection teams. We welcome the proposals in the consultation to scale back the size of inspection teams given the focus on core service inspections and we would encourage the CQC to work with trusts collaboratively to make the inspection process as manageable as possible in the context of the considerable service demands that trusts are facing.

That said, it must be acknowledged that the new approach would involve an increased frequency of inspections and while the anticipation is that the proposals will result in a reduction of the burden on providers, we would strongly encourage the CQC to closely monitor this as it develops and rolls out its approach to avoid a situation where the total burden of regulation on providers is in reality increasing.

We agree that the approach of unannounced inspections would help provide a realistic picture and encourage an ongoing focus on quality care, but also we would encourage the CQC to consider this as part of a sustained effort to reduce the administrative and resource demands that inspections place on trusts. We agree with the proposals in the consultation for well-led inspections to continue to be announced to enable the appropriate logistics to be arranged.

In terms of the proposed frequency of inspections, our members support a sliding scale approach which allows the CQC to target its resources where concerns about quality of care are greatest and also enables a sooner re-inspection when a provider has made improvements. The intervals put forward in the consultation for how often services will be re-inspected seem sensible, although some members have voiced some concern that services rated 'outstanding' could be without an inspection for up to five years, given the potential for the rapidly changing external environment to affect even outstanding providers.

Within the proposed intervals, we would urge the CQC to retain and apply a degree of flexibility in terms of how it plans its inspection activity. For example, where the CQC through its monitoring and relationship management is confident that a trust is already addressing any areas of concern, this should be factored in the scheduling of inspections. Trusts, particularly those currently rated 'requires improvement' overall, would benefit from a clearer understanding of how the proposed approach of a small number of core services inspections annually will support their aspiration to having their overall trust rating reviewed and moving to a 'good' rating in the short term. For newly registered providers who will be subject to a baseline comprehensive inspection, further clarity regarding the timescales for that to take place would be welcome.

Furthermore, while CQC is aiming to hold an internal regulatory planning meeting and acknowledging that ultimately any decisions about where to focus inspection activity must remain with the regulator (particularly in the context of moving towards more unannounced inspections), we would nonetheless encourage the CQC to develop a collaborative approach with providers and take into consideration representations from them when making

decisions about what to inspect or about the scheduling of inspections (other than through relationship management).

The consultation notes that the CQC expects to have this new approach fully embedded by April 2019. A key issue for trusts will be what the baseline year for applying those intervals will be i.e. the year of their last inspection or starting from when the new approach will be rolled out. Again, this would have major implications for how soon trusts which have received rated 'requires improvement' or 'inadequate' in the first round of comprehensive inspections would have the opportunity to demonstrate improvements made to enhance their ratings.

While the proposed intervals will determine inspection activity for a single provider, the CQC will need to consider the constraints on its own capacity and reflect on the implications of the new approach on its own workload and overall programme of inspections across all providers. We believe the fundamental guiding principle should be that the CQC undertakes this new inspection regime within existing resources, rather than this resulting in an increase of CQC fees for providers.

The shift to a more targeted inspection approach is largely supported with an expectation that turn-around times for the publication of reports following an inspection will also improve, given the lengthy delays that some providers have experienced between their CQC inspection and receipt of the final inspection report in the past. This new approach should be viewed as an opportunity to ensure trusts receive more timely feedback after an inspection, which will become even more important in the context of pre-set intervals for re-inspection. Reducing the time between inspection and publication of reports will be essential for services due to be re-inspected sooner, but that should not be at the expense of ensuring that all providers, regardless of their previous or likely ratings, receive the outcomes of their inspection in a timely manner.

Furthermore, as touched on above, we believe that clarification is needed on how the 'quality summit' element will be taken forward under the new approach. While this should be a key opportunity CQC to assist in bringing local health economy partners and local authorities together to better understand how services affect and impact upon each other, and to facilitate joint local ownership and accountability for quality improvement, member feedback on the effectiveness of this process has been mixed and it will be important for CQC to continue to consider how it could be improved going forward.

While the inspection process has improved, our members remain concerned about the continued variation in CQC inspections and inconsistencies in inspection outcomes that have arisen. We would wish to see acknowledged the need to introduce a formal appeals process where providers are not satisfied that their reports and/or rating accurately reflect care in their organisation, which has been lacking in the current regime. Although there is a process for providers to comment on the factual accuracy of the report prior to publication and request a review of their overall rating (once their inspection report has been published), we would believe that a fair, consistent and objective appeals process including before publication of the report should be part of a more transparent, open and mature regulatory relationship with providers.

APPROACH TO RATINGS

We note that the consultation states that overall trust ratings will only be reviewed and updated following a trust-level well-led assessment and planned core service inspections.

Considering the intention for core service inspections to be mostly unannounced while still aiming to give providers notice of when their trust-level well-led assessments will be carried out, it can be inferred that for the majority of trusts, these will take place at different times within a year. A question not addressed in the consultation is whether the CQC intends for trust-level ratings to be amended if core service inspections precede the well-led assessment within a year. We would strongly favour trust-level ratings being refreshed throughout the year, rather than be contingent on when the well-led assessment was undertaken. This will reflect the most up to date information on the quality of care being provided.

We would encourage the CQC to give further consideration to how the presentation of ratings could be improved in the future. The consultation document suggests that ratings emerging from annual core service inspections will be amalgamated with previous ratings and an updated rating grid consisting of new and existing ratings would be published. It remains our view that ratings must remain accessible and clear for a public audience and that information about the quality of services must be presented in a way which is easy to understand. With this in mind, it will be essential that publication of ratings to be accompanied, as a minimum, by an indication of what sample of core services have been re-rated for the trust in question within the respective year in order to provide clarity and transparency.

There has been a persistent concern among our members that the current approach to ratings does not demonstrate the direction of travel of a trust, i.e. whether quality of care is improving, staying the same or deteriorating as at the last inspection, which would help produce a more nuanced overall understanding of that provider. We believe that the move towards annual inspections is likely to bring the need for the CQC to show a direction of travel within its ratings (both at trust and core service level) more sharply into focus. We see the move to the new system as an opportunity for the CQC to engage with the sector to identify the best way for achieving this.

We note that the consultation document considers how the ratings system might need to evolve to account for situations in which trusts provide more than one service type (particularly where the scale of those services may be unequal) and also in situations where providers take over struggling services to improve their quality of patient care.

We have long called for and strongly agree that the new approach should be enabling, rather than penalise, providers that take over struggling services because they want to improve patient care. At present, regulation too often can feel punitive which encourages risk aversion. For those engaged in mergers or takeovers, we agree that it makes sense to continue to assess and rate the constituent parts separately for a set period of time. This would lend recognition to the fact that these processes can take a number of years to become well established.

We recognise the complexities that the CQC has identified in the consultation that in larger and more complex organisations, it can prove challenging to show how the CQC has balanced the scale and quality of different services in aggregated ratings at provider level. We have expressed concerns that that trust level ratings can mask good (or poor) care in individual services. While we would in principle support a ratings methodology that is sufficiently flexible so that it can fairly assess a diverse range of provider models and take local context into account, we would be concerned that reliance on professional judgment of individual inspectors or moving to a differentiated approach in terms of the best level at which to provide an aggregate rating may leave a significant amount of scope for inconsistency and variation. Careful consideration would be needed that this does not erode credibility in the ratings system, while at the same time it will be important to recognise that communicating a differentiated approach to the public could be challenging. We recognise that there are important trade-offs that must be carefully balanced and would welcome working with the CQC as its thinking develops. We would encourage the

CQC to maintain an ongoing dialogue and consultation with the sector about the design of the ratings system in the future.

We will also be responding to the CQC and NHS Improvement's separate consultation on use of resources, and particularly the issue of whether or how the new ratings could be combined within the CQC's quality ratings. We understand the rationale for the CQC planning to keep the new rating separate from existing quality ratings in the short term.

ASSESSMENT FRAMEWORKS AND CHANGES TO KEY LINES OF ENQUIRY

We agree that the move to one overarching framework for healthcare and one for adult social care has the potential to make assessments more comparable between organisations, enable organisations to better understand what is expected from them and also enable members of the public to make comparisons with more ease. We welcome that the CQC has acted on feedback that it has received and learning from inspections carried out to date in reviewing the prompts and key lines of enquiry (KLOE). We would agree that the key question for consent would sit best under the 'responsiveness' domain for the reasons outlined in the consultation document. We would encourage the CQC to closely monitor the impact of the proposed changes. Furthermore, we note that trusts' quality systems are often structured around the CQC's current frameworks, so will require time for those to be modified to account for any changes on the back of the proposals in the consultation.

We would however query the introduction of a new prompt on the availability of seven day services for acute hospital services (E4.5 - *'How are high-quality services made available that support care to be delivered seven days a week and how is their effect on improving patient outcomes monitored?'*). Overall, there remains a need for greater clarity for providers as to how far they should prioritise the development of 7 day services within a host of competing priorities and a tight financial envelope, so we believe its inclusion under the 'effective' domain has the potential to complicate and introduce uncertainty into assessments under this domain.

Also, we would stress that the CQC must ensure that the new approach to regulation is fit for purpose across all sectors including the specialist, community, mental health and ambulance sectors. This should be a key priority for the CQC to avoid the inappropriate application of an acute-focused model which has been a key concern for our members in those sectors in the past.

CONCLUSION

Overall we feel that the proposals in the consultation document are a step in the right direction in terms of enabling the CQC to deliver on its ambitions set out in the strategy. There is more detail still to work through on some of the aspects of the proposals so we would encourage the CQC to maintain a collaborative approach with providers as it moves into the implementation phase.

NHS Providers benefits from a constructive working relationship with the senior leadership team at the CQC and with colleagues throughout the organisation. We look forward to continue engaging with them throughout the implementation of the new approach to regulation and would welcome the opportunity to facilitate further engagement with our members.