Written evidence from NHS Providers

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 have over 220 members – more than 90% of all NHS foundation trusts and aspirant trusts – who collectively account for £65 billion of annual expenditure and employ more than 928,000 staff.

INTRODUCTION

The progress the Care Quality Commission has made over the last two years is well documented in the National Audit Office (NAO) report *Capacity and capability to regulate the quality and safety of health and adult social care.* Our evidence highlights the progress CQC has made in implementing its new regulatory regime and outlines some areas of improvement which it may wish to consider as part of its forthcoming five year strategy:

- Regulating new care models
- Taking the local context into account
- Assessing a financial efficiency
- Demonstrating value for money

When considering the impact of the CQC it is important to focus on the role of quality regulation assigned to CQC which is one of setting minimum, national quality standards and identifying where services fall below those standards in order to protect the public. The primary responsibility for the quality of care delivered to patients and service users lies with NHS provider boards, and their staff, at the frontline.

NHS Providers benefit from a constructive working relationship with the senior leadership team at CQC. Our evidence is based on our regular dialogue with the regulator and with our members – NHS foundation trusts and trusts.

CQC'S CURRENT REGULATORY MODEL

CQC has made significant progress in developing and implementing a new quality regulatory regime and inspection model over the past three years within an ambitious timescale. Despite some slippage to its initial commitments, it has now inspected over 60 per cent of NHS foundation trusts and trusts.

Sector specific approaches

CQC's inspection model has largely been developed around the acute sector, with a tendency towards site-specific, episodic care. While the inspection model must apply consistent expectations and standards across all sectors, for it to be fit for purpose across all health providers it must take into account the specific characteristics of acute, mental health, community, ambulance and specialist services. For example, ambulance services are usually delivered by one organisation across a wide geographical area. Mental health services involve a different service user relationship

and experience, particularly for people held under the Mental Health Act. For both community services and mental health, provision of services may be sustained over time with multiple sites of care multiple. Feedback from our members suggests that there is more CQC could do to ensure its inspection model is aligned to different sectors, and that its inspection teams are trained and experienced in the different types of care they inspect. There also continues to be a need for CQC to ensure its staff are fully trained, supported and skilled to deliver their new operating model, and to target risk appropriately in different settings.

Assessing risk

NHS Providers supports a strong and effective risk-based quality regulation model. CQC's approach to regulation is underpinned by the 'intelligent monitoring system' which analyses 150 different sets of data to place providers into priority bands for inspection based on an assessment of relative levels of risk. We and our members share the NAO's concerns around the ability of this surveillance system to accurately assess risk. The NAO report clarifies that half the providers receiving an inspection rating of 'good' or 'outstanding' had a higher risk rating from intelligent monitoring. Our members concerns about the intelligent monitoring system are based on a number of issues, including: indicators which are not within the scope of the provider's control to influence, lack of clarity regarding the sources of some data and the rationale for its inclusion, and concerns about the quality, consistency and therefore comparability of data. There also remains a need to develop nationally comparable datasets for some sectors, such as mental health and community services, which CQC could then make use of in its monitoring.

A CHANGING CONTEXT

CQC's recent *State of Care* report helpfully recognised the complex and challenging environment in which the majority of providers are currently operating, both within the NHS and social care. It highlights the extreme financial constraint providers are facing and the significant level of improvement underway despite these challenges. These challenges, along with the focus of the *Five year forward view* on managing whole health systems and moving to new care models, will shift the context of quality regulation in the NHS. We are pleased to be working with CQC as it refreshes its strategy for the next five years, including considering the elements set out below:

Regulating new care models

CQC's inspection regime already operates within a complex NHS provider environment which varies within and between sectors. Alongside this, CQC must also consider how it adapts its regulatory model and processes as the sector begins to implement the vision set out in the *Five year forward view*. Although there are only two legal forms which secondary care organisations can take – foundation trust, or NHS trust – we expect to see developments in the functions which FTs and trusts seek to deliver in partnership with others. CQC's *State of Care* report acknowledged that it is already starting to see changes to registrations as a result of the *Five year forward view* vanguard programme, with some hospital trusts registering as providers of care homes. In this context ensuring clear lines of accountability will become essential as the rest of the sector, outside of the vanguard programme, begins to develop new care models. The CQC will need to ensure it can operate a regulatory regime and inspection model that is fit for purpose.

Taking the local context into account

CQC continues to face a challenge in balancing a proportionate and risk-based approach to quality regulation, in an environment where providers are facing challenges which may impact on quality, but often extend beyond their control and across their local health economy.

As part of its forthcoming five year strategy CQC is rightly considering its role in assessing quality of care across a local area as well as at organisational levels. It is piloting an approach in three localities and undertaking an informal consultation to develop its work in this area. We have welcomed this development as an acknowledgement that some issues within local health economies extend beyond the control of any individual provider. However we are conscious that accountabilities within the system remain institutionally based, and it will be essential to maintain clear lines of accountability nationally, and to local populations. Autonomous and locally accountable provider boards are still best placed to demonstrate the local leadership required to establish safety cultures and will wish to be held accountable for the quality of care they provide, and to agree robust governance arrangements with their partners when provision will be shared or integrated. For these reasons, we would envisage a rebalancing of CQC's activities to maintain organisational inspection alongside better insights into 'quality in a place' and the wider factors which may impact the performance of any one provider. There also remains potential to use the existing quality summits as a more effective forum for getting shared agreement and commitment to improvement plans at local health economy levels and we would like to see CQC explore this further within their forthcoming strategy.

Assessing financial efficiency

The Department of Health has recently given CQC new responsibilities to assess financial efficiency and use of resources by NHS providers. We share the NAO's concerns that CQC does not currently have the resource or capability to deliver this role effectively and we are particularly concerned about the risk of duplication with Monitor's statutory responsibility to regulate the financial sustainability of foundation trusts, and TDA's remit to performance manage NHS trusts.[1] If CQC is to deliver this new role effectively it must co-produce this element of inspection in partnership with the sector and with NHS Improvement to avoid duplication, ensure it adds value and does not dilute its statutory responsibilities as a quality regulator.

It is worth noting that under a previous regulatory regime (the Annual Health-check, carried out by the Healthcare Commission) the regulator relied on judgements made by other bodies for financial efficiency and use of resources elements: Monitor for foundation trusts and the then Audit Commission for NHS trusts.

DEMONSTRATING VALUE FOR MONEY

The NAO report concluded that CQC has made progress in demonstrating value for money and now has a clearer picture of the costs of its regulatory model. However it highlighted concerns around

[1] Monitor and TDA will soon be aligned under the new operating name of NHS Improvement but will retain the statutory duties of both organisations with regard to financial regulation and performance management respectively.

CQC's ability to demonstrate its effectiveness and overall impact on quality of care. It is important to emphasise that responsibility for quality improvement must lie with NHS provider boards and local organisations and not with the quality regulator. We therefore appreciate the difficulty CQC faces in quantifiably demonstrating its impact. However, we commend CQC for the investment it makes in independent evaluation of its impact. We are supporting an independent assessment of CQC's impact by with Ipsos Mori and The King's Fund which will build on the previous evaluation of their acute hospital inspection model undertaken by The King's Fund and Manchester Business School[2]; while we cannot comment on how far other bodies invest in evaluation, the CQC's approach is the most sophisticated model that we have been engaged in, across the arms length bodies.

In summary, we welcome CQC's commitment to working with the sector to understand and evaluate the added value of its new regulatory approach. CQC's leadership team have remained engaged with our membership since the new leadership team came in to place. We and our members value this engagement and look forward to continuing to work with CQC as it develops its forthcoming five year strategy for quality regulation.

26 October 2015

[2] Walshe K, Addicott R, Boyd A, Robertson R, Ross S (2014). Evaluating the Care Quality Commission's acute hospital regulatory model: final report. Available at http://www.cqc.org.uk/content/evaluation-helps-hospital-inspection-development (accessed 25 October 2015).