CONSULTATION RESPONSE

Changes to the way the CQC will regulate, inspect and rate health and care services

4 June 2014

About the Health Foundation

The Health Foundation is an independent charity working to improve the quality of health care in the UK. We are here to support people working in health care practice and policy to make lasting improvements to health services.

We carry out research and in-depth policy analysis, run improvement programmes to put ideas into practice in the NHS, support and develop leaders and share evidence to encourage wider change. We want the UK to have a health care system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable.

Developing a more complete assessment of risk

The Health Foundation welcomes the constructive dialogue it has had so far with the CQC on how it regulates and inspects health and care services in England. We responded to the previous consultations setting out the CQC's new approach – *Introducing Fundamental Standards*[1] and *A New Start*[2] – and provided input on how it inspects for patient safety and person-centred care in particular.

As part of the current consultation process, the CQC has published a range of handbooks for providers of health and care services – acute, community, mental health, primary and social care. We note that these handbooks are aimed at provider organisations and therefore we only offer a brief comment on the content of the acute provider handbook, and in particular the development of the Key Lines of Enquiry (KLOEs) for the use of inspection teams.

We are pleased to see that the KLOE document for assessing safety is structured around the research that the Health Foundation funded Charles Vincent, Jane Carthey and Susan Burnett to undertake.[3] The research encourages organisations to understand the future risks associated with their services, rather than just identify the frequency of past harms. This includes hard, and critically, soft measures to help local providers develop a more complete assessment of risk.

[1] Health Foundation, 2014. *Response to Introducing Fundamental Standards.*
[2] Health Foundation, 2013. *Response to A New Start.*
[3] Health Foundation, 2013. *The measurement and monitoring of safety.*

The role of regulation and a model of quality improvement

The main focus of our response is to offer our view on how the CQC might fulfil its role to 'encourage improvement'[4] – a role which is reiterated in the acute provider handbook. We recognise that the primary role of regulation is to act as a backstop when the other layers within the health and care system may be failing to deliver a safe, effective and person-centred service. It is there to identify where there is poor quality care, and high risk of harm to patients.

CQC's exact responsibility to encourage improvements in the quality of care in providers is not very distinct at present. Its improvement role is also unclear with respect to other arm's length bodies (ALBs) such as Monitor, the Trust Development Authority and NHS England, and this needs to be clarified. It would also be desirable to see the development of an overall medium term strategy and consistent approach to improvement across the NHS. Given the Health Foundation's experience in health care improvement over the last decade, we would be happy to advise the CQC and other relevant bodies in this area.

Suggested steps to enable the CQC to encourage improvement and become a continuously learning organisation

Based on the Health Foundation's experience of researching, developing and testing methods of quality improvement, we suggest that there are four steps that the CQC could take in order to more clearly define the role, and approach, it should take in encouraging improvement in provider organisations:

Step 1: The CQC should create the supportive environment that would encourage and enable organisations to identify and report risks in their services. To create such an environment the CQC would need to be constructive in how it reacts to the disclosure of these risks. We have heard feedback from providers, as part of our work to test the concept of 'safety cases',[5] that organisations remained concerned that the regulator would sanction the trust before giving it the opportunity to address the risks and issues themselves.

Step 2: In our response to *A New Start*, we welcomed the CQC's commitment to 'acknowledge and highlight the many hospitals, care homes and other services in England where people are receiving good or outstanding care'. We would encourage the CQC to consider how it might share the learning from these examples directly with organisations that would benefit from their experience.

Step 3: The CQC should avoid the trap of directing providers to prioritise only those performance measures that the CQC will use to target its inspections. As we stated in our response to *A New Start*:

> *We know from past experience the unintended consequences of organisations giving total priority to certain performance targets. We feel the risk here is that organisations focus solely on those areas that are being monitored by the national regulator, and ignore many of the areas that are important to their local*

[4] Care Quality Commission, 2014. *Provider handbook consultation: NHS acute hospitals.*
[5] http://www.health.org.uk/areas-of-work/programmes/safer-clinical-systems/

population or service areas, and are particularly important to service improvement rather than accountability.

Therefore, we recommend that the CQC actively encourages NHS organisations to continue to develop and give priority to their own locally developed metrics ...The highest performing trusts have developed a range of internal measures that the regulator can play a role in encouraging, and particularly when making assessments of what constitutes 'high quality care'.

Step 4: We would encourage the CQC to show leadership by how it measures its success as a regulator, for example through its inspection activities and through its actions to rate providers, and itself to demonstrate continuous improvement based on measurement and experience. We note that the number of enforcement actions taken by the CQC on NHS trusts increased from 21 in 2012-13 to 73 in 2013-14.[6] While this may be due to a combination of a toughening of action, a decline in standards and/or staff feeling more able to raise concerns, the CQC must define what it constitutes success in its work and undertake further work to understand the reasons and significance of this rise.

We look forward to continuing to work with the CQC as it refines its approach to the regulation, inspection and rating of health and care providers, as well as its own evaluation.

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[6] HSJ, 27 May 2014. *CQC NHS enforcement action triples*.