Dear CQC,

NHS Clinical Commissioners response to the CQC’s new approach to regulating, inspecting and rating care services (May 2014)

NHS Clinical Commissioners (NHSCC), the membership body of Clinical Commissioning Groups (CCGs) welcomes the opportunity to provide a response to the CQC’s consultation on its new approach to regulating, inspecting and rating care services – this includes NHS acute hospitals, mental health services, community health services, GP practices, out-of-hours services, care homes.

CCGs commission high quality services for their populations. They have a duty and an interest in ensuring that the services they purchase for their populations meet basic standards of care. There is a lot of overlap between CCGs as supervisors of quality and the CQC as a national regulatory body – much of this overlap manifests at a local level. CCGs are responsible for or have an interest in all the services that the CQC inspects, it means they would be need to respond to seven separate handbooks in this consultation.

As a national body we would like to lift ourselves away from the detail, that is for commissioners and providers to shape, so our response to the consultation is focused on the new regulatory regime as a whole as opposed to being organisation/inspectorate specific, it is based on our overall observations, the input of our members and so through the lens of CCGs.

Our response

Overall we see the principles and ambition of the new inspection regime as a positive move towards a regulatory service that meets the needs patients. We are fully supportive of the five patient centred questions that are asked of each service for their simplicity and focus.

On 1st of May 2014, we launched our CCG manifesto for change in the NHS, within in it we have a specific policy ask on the operation of the new inspection regime, we say:

7. Better alignment of local commissioning to healthcare quality and the new inspection regime. Discussions on quality and safety need to move on from inspection to improvement. The Care Quality Commission (CQC) must see clinical commissioners as key partners in their work, supporting healthcare to go beyond national fundamental standards towards quality in the round, i.e. against the needs of a local health economy and using local clinical expertise. Inspection, like commissioning, should benefit from greater clinical input.

We would like to see the CQC move its regulatory lens beyond provision to understand the added value and complimentary role of clinical commissioning in the quality landscape. Our members are yet to see the post
Francis CQC make strident efforts to engage commissioners in a meaningful, consistent way and so realise the benefits of joint working relationships between the regulator of fundamental standards of care with those that drive up care quality through locally enhanced standards. Our feedback on the inspection regime is listed below:

- **Clarity of roles.**

  On reading the inspection handbooks it’s clear that there are a number of complex roles between providers, commissioners and the regulator that need to be aligned. From our understanding the CQC suggest CCGs are involved as ‘geographical entities’ or local boundaries in relation to the inspections. The default position is therefore that the CCG is a stakeholder in the process as a purchaser of health services from the provider but their role as an equal partner in the driving up quality within a healthy economy is not necessarily recognised. The reality is that CCGs are working with all their providers in real-time, aware of the day to day quality story as well as a critical partner in improving quality in the longer term.

  This brings us to ask for clarity on how the CQC will consistently embed local commissioners in the inspection regime such as the Intelligent Monitoring Report (IMR) and quality summit as more than the purchaser. Our members have told us that there is some variability in the involvement of CCGs in the new inspections, which must be addressed. A critical role will be to gather local quality evidence from the CCG on the provider being inspected and some assurance that the CQC data analysts and its inspection teams can work with the data. Has any CCG intelligence ever been tested/used in the development of the process?

- **Quality summits and quality at a broader level.**

  Our members have expressed reservations about the current outline of the post inspection quality summits, they require the involvement of CCGs as stakeholders but have the potential to vary in quality and impact. They are summits around specific providers as opposed to those providers in the context of the health economy – can these meetings create enough impetus and drive change to support the bigger objectives that commissioners have – such as that of integration and transformational change amongst a CCG’s providers?

  Quality discussions need a pathway approach. Huge CQC effort is expended on a single provider - is there a case for inspecting a local health system to pick up the integration and transformation issues - the only ways CCGs can ensure sustainable safety, effectiveness and experience is delivered? CCGs would really benefit from the 3 inspectorates working together in large and small providers for the benefit of the population.

- **Preparedness.**

  Our members have highlighted that the preparedness for hospitals, general practice and social care inspections vary in quality. CCGs are keen to have information to support their preparedness of inspections of the providers they commission, as well as an awareness of inspections in their patch. It helps to manage their expectations, risk management and their own intelligence monitoring, capacity to be involved etc. We would like to see more in the handbook around the way stakeholders are prepared for the inspection regime.

  Our second concern in this area is the ability for the CQC to coordinate the logistics of all the inspections that could occur in a locality at the same time – for example a CCG could have a series of inspections to prepare for at once – we need some assurance that the inspection regime will not
prove a burden to the health economy and CCGs and their capacity for involvement and do not end up servicing a set of processes as opposed to meeting their goals around improved care quality.

- **Inspection teams.**

The true test of the success of the inspection teams will be their ability to make a decision that is not open to challenge and assures the sector that basic standards are being met. The quality and sustainability of the inspection teams across the inspectorates is critical to the success of the new regime.

A lot of the judgements they make will be subjective, CCGs need to have confidence in these teams to deliver consistency in their judgements and ensure that they show the benefit of their lay and clinical expertise. It may be that the CQC judgment on quality could contradict the experience of the CCG locally, for example a Trust could tick green on all the boxes but experience at ground level could indicate quality is less than good. How will the CQC ensure its inspection teams see their inspections in the round?

We would suggest that where possible – commissioners from CCGs outside of the provider CCG/and outside the local area are invited to be part of the inspection teams to ensure clinical commissioners are involved and add value to the process.

- **Timeliness of the inspection report**

Our members have told us that there often appears to be delay in delivering the report following an inspection, sometimes giving very little time to absorb the contents before the post inspection quality summit. Is there anything the CQC can do to support timely reports so they can contribute effectively at quality summits and have CCGs fully on board? Can a set of timelines be added to the handbooks to support preparedness?

- **Ratings – the tipping point.**

The ratings are clear and simple to follow as an overall measure. Our feedback on these is to ask if the CQC is clear about the role of the ratings and the tipping point between them. At present the ‘tipping point’ is set at a subjective level, there does need to be some rigour in this area to ensure consistent decision making across the country.

We would also like to understand what the alignment is between the CQC ratings and how they could compliment the improvement activity that CCGs undertake locally through their enhanced standards for providers. Do the improvements move the CQC into the improvement space and so need to be jointly defined between CCGs and the CQC at a local level?

- **Sharing good practice.**

There is a significant gap in the handbooks around the sharing of good practice or positive learning from the inspection process. CCGs are keen to ensure their providers build self-regulation into the culture of provider organisations. How will the CQC share learning from the inspections nationally?

- **The KLOES and measures – still counting activity?**

One of the criticisms of regulation is that it focuses on what can be counted, measured, evidenced (the hard data). Our members have fed back on the KLOEs in the handbooks to say that many of them read as though they are ‘checks’ that you need to get right first time. We think their needs to be a much clearer flow in the KLOEs from outcome to activity. CCGs need providers to be measured
against what good looks like, as such the KLOEs need to explore how quality outcomes are being met, how is the outcome monitored, how it’s escalated, how does the organisation learn? Are providers meeting standards in order to create safe patient care? Or are they being measured against a set of indicators of activity.

How does the CQC avoid becoming simply a post-hoc inspector that can tell us what did happen and change into a quality promoter that works in tune with this aspect of CCG work? Passing the CQC inspection must measure of the true quality of a provider.

It’s clear that the regulatory system has built up a lot of evidence and data on the quality of hospital care over the years, does the CQC have that same confidence in the quality of the data available for general practice and social care?

We feel the KLOEs need to be patient led and to some extent the detail of the KLOEs must have commissioner buy in in order to really meet the needs of their populations and the experience of care across pathways and across organisational boundaries. Will the CQC work through the detail of the KLOEs with local commissioners?

If you would like any further detail on our response please do not hesitate to contact our Senior Policy Manager, Julie Das-Thompson j.das-thompson@nhscc.org

Yours Sincerely

_NHS Clinical Commissioners_