Royal College of Nursing's Response
Care Quality Commission Consultation
"Our Next Phase of Regulation"

General Comments

We appreciate that these proposals are being made against a background of a severe funding crisis across the health and social care sectors in England, and so while we welcome them in principle, it is under the firm understanding of our position that the CQC should not been seeking to secure fee increases from the sector to deliver them, but that it should be seeking sufficient funding from the Government to deliver them.

We welcome and support the overall direction of travel outlined in this consultation, on the basis that it will reduce regulatory burden while ensuring continued focus on the issues that staff and the public want to see addressed, the better use of resources, and improvements in the quality and safety of health and care services.

We also support the move to more responsive regulation, so that attention is rightly focussed most on those providers needing the most support, whilst also recognising the need to continue inspecting the outstanding and good providers in order to maintain or improve the quality and safety of their care. However, that must not be a mechanism to foster 'role creep'; the delivery of regulation and quality improvement must remain distinctly separate, to ensure each is properly and effectively done.

As the health and care system moves inexorably towards integrated services, where care is wrapped around the recipient, we would like to see further work undertaken on how the final separation envisaged in the proposal, that between 'healthcare' and 'social care', can be bridged to deliver regulation and inspection that follows this approach.

One way forward might be to have different components inspected by different experts, with the inspection being led by the most appropriate regulator and following the 'patient journey'. We understand that Ofsted have trialled an approach of this kind in Wiltshire, where in November 2016 the CQC, HMI Constabulary and HMI Probation looked at the authority's response to children living with domestic abuse[1]. We would like to see this approach examined for its applicability across the health and care system.

We have previously raised concerns regarding the use of 'whole-organisation' ratings, and so while recognising the political imperative of this approach would like to work with the CQC to design a regulatory system that is able to appropriately reflect the challenges of providing many services via a single organisational structure.

From that perspective the proposal to give greater prominence to the 'well-led' inspection and findings is an excellent step forward in addressing these concerns, and is a welcome

[1] See: http://www.wiltshire.gov.uk/news/articles/inspectors-praise-support-for-wiltshires-vulnerable-children#sthash.bp0FCHzT.dpuf (Last accessed 30.1.2017)

continuation of the regulators' attempts to address the challenges laid out by Sir Robert Francis following Mid-Staffs.

The employee dimension within the well-led domain can provide a critical source of information and intelligence about the experience of staff within healthcare environments. We therefore believe that it is important to allocate sufficient weight to the intelligence and evidence received from trade unions and other employee voice mechanisms about the experience of staff, and where appropriate give detailed consideration of the results of the 'Workforce Race Equality Standard' and the 'Equality Delivery System II'.

Our offices around England have reported that despite staff-side reporting clear concerns about staff experience this seems not to be reflected in the narrative contained within the overall performance ratings for NHS Trust. We would like some further consideration given to ensuring that the process is more reflective and responsive to these concerns.

The quality of assessment depends on the right people and we would wish to see maintenance of, if not an increase in, the numbers of clinical professionals' involved in leading assessments, and thereby making recommendations for improvements and change.

Lastly, we would expect to see any changes subject to a robust monitoring and evaluation process, so that any problems or failings can be quickly picked up and dealt with.

Response to consultation questions

1. **A. Do you think our set of principles will enable the development of new models of care and complex providers?**

   We neither agree nor disagree.

   B. Please tell us the reasons for your answer.

   This is a relatively new area for system regulation, and so it is very hard to say with any certainty how the approach will impact on the development of new models or complex multi-site or multi-speciality services. However, in that they are high-level, we do not believe that they will hinder such services.

   We would also like to see some reference to staff in the principles, for instance within the first principle, following on from the duty to protect and promote the health and well-being of people using services.

2. **A. Do you agree with our proposal that we should have only two assessment frameworks: one for health care and one for adult social care (with sector-specific material where necessary)?**

   We agree.

   B. Please tell us the reasons for your answer.

   We agree with the underlying principle behind the proposal, that the current situation is complex and confusing.

   We also agree with the rationale of creating two overarching frameworks, one for healthcare and one for adult social care, as this will create an easier and more understandable structure for all concerned, especially for providers and recipients of care.

   However, reducing health down to a single category is a broad brush approach, meaning that even very small services, such as cosmetic clinics employing nurses, will fall under it. This may result in it being seen as overzealous and onerous by the recipients, and so we would recommend some clarity about the way in which inspections will be undertaken across this broad spectrum of providers.

While recognising that these proposals are for cross-sector and NHS trust inspections, it would be helpful to have some guidance about how they will interact with primary care and general practice, which although technically separate are a key part of many people's journey through the health and care system.

Further to that, and in accepting the rationale for the two frameworks, we are mindful of the need to ensure focus is not lost on issues which arise at the interface between the two dimensions of care, such as during handovers and at discharge.

Lastly, and as noted in our general statement, we would like to see work being undertaken to explore how pathway regulation could be introduced, so that the regulatory system keeps pace with the now universally accepted drive for more person-centred and integrated services.

3. A. What do you think about our proposed changes to the key lines of enquiry, prompts and ratings characteristics?

We are happy with the proposals, and feel that they will enable a better understanding of how a service is meeting its obligations to those it is looking after. We do have some concern about the increase in KLOE's, and on that basis would welcome some commitment being made to review the new process, after a sufficient period had elapsed for them to have bedded into inspection practice.

We are very pleased to see the proposal for a new single framework for well-led healthcare providers, and will be offering specific comment on the assessments in our response to the CQC-NHSI consultation. We are also pleased to see this will be aligned with an updated version of the well-led framework for adult social care providers, as this will afford greater comparability across the totality of health and social care systems, something increasingly important as England moves to more placed-based provision through the development of devolution areas and Sustainability and Transformation Plans (STPs).

We support the introduction of the six new and strengthened themes, which we believe will ensure that inspections are better able to address the key challenges in delivering safe, effective and quality care.

However, we have some further comments on some of the specific themes and Key lines of Enquiry.

Themes

- *Technology* - under this theme we would like to see greater inquiry being made about the actual use of technology, including the availability of training and how versed staff are in using it. It would also be good to reference KLOEs under this theme against the uptake and use of national tariff monies for technology and innovation.

  Further to that we would also like to see inquiry made about training and education relating to technology, with equal emphasis being placed on education and training. Our report 'Every Nurse an eNurse' digital capabilities framework (being launched at RCN Congress 2017 and identified in NHS England's Building a Digital Ready Workforce Programme) provides a good template for this kind of inquiry.

- *Medicines* – under this theme we would like to see a focus given to prescribing by medical and independent nurse (and other AHP) prescribers (numbers), and specifically relating how they are developed and supported through CPD, and to take on leadership roles.

- *End of life care* – under this theme we would like to see focus given to the availability of EOL across care for all long-term conditions and cancer.
- *Personalisation, social action and the use of volunteers* – under this theme we would like to see one of the KLOEs (most likely C2.3) make explicit reference to the use of Directories of Services (DoS). We are aware that the lack of a DoS is a problem for NHS111, and NHS Digital are looking at a platform to enable this, a project which may offer benefits across the wider health and care system.

KLOEs

Healthcare Services

- *R3.1, R3.8: Do people have timely access to initial assessment, test results, diagnosis, or treatment* - the impreciseness of "timely" does not lend itself to contemporary and prevailing pressures facing the health (and care) systems. We would like to see this KLOE given an indicative measurement scale.

Adult Social Care

- *W4.1: Are resources and support available to develop staff and teams, and drive improvement* – we would like to see a specific reference made to time in this KLOE, as we are aware that it is often the crucial factor that prevents staff from accessing training and development (NB: it is explicitly identified in Healthcare E3.3)

B. What impact do you think these changes will have (for example the impact of moving the key line of enquiry on consent and the Mental Capacity Act from the effective to the responsive key question)?

In general we think they will improve the quality of the inspections, and through that improve the overall quality of care being delivered.

We especially welcome the greater focus given in both frameworks, under the well-led questions, to staff, service-users, and the public involvement and engagement.

On the specific issue of the Mental Capacity Act, we feel it vital the Act is given more prominence, given the increase particularly in the elderly population of dementia and better diagnosis of Alzheimer's. We have no comment to offer on moving the KLOEs to the 'responsive' category, but would recommend a review of how the change has impacted upon inspections after a sufficient period of time has elapsed for them to have bedded in.

4. **We have revised our guidance** *Registering the right support* **to help make sure that services for people with learning disabilities and/or autism are developed in line with national policy (including the national plan, Building the right support). Please tell us what you think about this.**

   We welcome the revision of this guidance.

   We hope that it will contribute to an improvement in services provided for people with learning disabilities, and connect with the recommendations contained in our 2016 report 'Connect for Change[2]', not least about the need to have a workforce that is sufficient in numbers and skills.

[2] See: https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2016/february/005525.pdf (Last Accessed 30.1.2017)

5. **What should we consider in strengthening our relationship management, and in our new CQC Insight approach?**

   We note that professional bodies and trade unions are not mentioned in the proposals for strengthening the CQCs relationship management. As an organisation that is both, and has an existing relationship with the CQC (at national and regional level) we would like to see this continued, and where possible improved, for instance to ensure reductions in unnecessary bureaucracy.

   We welcome the move to a new model for gathering intelligence, and as noted above would want to see organisations representing staff as professionals and as employees, included in its operation.

   We are happy to support CQC having more direct relationships with providers, but this must be on the basis of a clear and visible separation existing between improvement activity and inspections. On the same basis it would be good to see this approach extended to other Arm's Length Bodies, for instance NHS Digital and Health Education England.

6. **What do you think of our proposed new approach for the provider information request for NHS trusts?**

   We are very pleased to see this more streamlined and hopefully less burdensome approach being proposed, which should reduce costs and foster better information flows between the providers and the CQC.

7. **What do you think about our proposal that our regular trust inspections will include at least one core service and an assessment of the well-led key question at trust level approximately annually?**

   We agree with this proposal, on the basis that this will achieve the most cost-effective use of resources, and ensure that focus is retained on the most important element of any services, its core offer and how well it is being run.

8. **What do you think about our proposal that the majority of our inspections of care services will be unannounced?**

   We support this proposal. It can only be possible to fully understand how well a service is operating if inspectors experience it as ordinary everyday members of the public do. While it may be challenging for the services we believe that it will afford the inspectors better and more accurate views of a service.

9. **A. What do you think about the changes we have proposed to inspecting the maternity and gynaecology core service?**

   We support this proposal.

   B. What do you think about the changes we have proposed to inspecting the outpatients and diagnostic imaging core service?

   We support the proposal to separate diagnostic services on the proviso of using accreditation schemes where possible. However, the basis by which the decision to include or not is made must be based upon clearly and publicly available criterion, which can be challenged if other stakeholders feel a decision not to inspect is incorrect.

10. **A. Do you agree with our proposed approach to inspecting additional services (services that we do not inspect routinely) across a range of providers or sectors?**

    We agree with this proposal as described.

B. Please tell us the reasons for your answer.

We think this approach is more likely to take into account the nature of a health (and care) economy, and therefore be more salient to the needs of communities. It may also offer opportunities to share good practice across the providers of a service in a given area, or to highlight challenges that are systemic to a health economy.

11. A. Do you agree with our proposals for using accreditation schemes to both inform and reduce CQC inspections?

We agree.

B. Please tell us the reasons for your answer.

We support this proposal, as we believe it will both reduce the regulatory burden for these providers, and enable the CQC to make better use of its resources. Some form of quality assurance will need to be built into the system, for instance JAG for endoscopy.

12. What do you think about our current approach to trust-level ratings and how do you think it could be improved (taking into account the new use of resources rating)?

We remain cautious on the role and use of trust-level ratings, a position which we expounded in our response to the original consultation on the matter, overseen by the Nuffield Trust.

NHS Trusts, and the services that they oversee, are complex organisations, and often comprise of services sitting within very different situations. However, we appreciate the role that ratings can play in providing 'measuring-sticks' for improvement and innovation, and so are willing to accept their usage on the basis that they are used to support the improvement of services, in a positive and constructive manner.

Against these concerns we welcome the proposal to give greater focus to more tangible metrics, such as how well an organisation uses its resources, or how well its senior management team operate. We also support consideration being given to organisations that have taken over failing services, so that their existing ratings are either not impacted, or are amended in a manner that recognises the challenges they face.

Lastly, we would welcome some further detail on how the overlap between the old and new systems, especially the ratings (since they are publicly visible), will be managed.

Royal College of Nursing

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For further information please contact:

Mark Platt, Policy Manager

E: Mark.Platt@rcn.org.uk