Consultation response
A New Start - Consultation on changes to the way the CQC regulates, inspects and monitors care

August 2013

Introduction

We welcome the opportunity to contribute to the Care Quality Commission (CQC) consultation on changes to the way it regulates, inspects and monitors care. This short paper sets out the views of The King's Fund.

The CQC has been under extremely intense national scrutiny in recent months and years, and overall we support its proposed new strategic direction. We are concerned that there is a broad public expectation that the CQC could and should be able to provide absolute assurance to the public that all health, mental health and social care services in England are safe and effective. While it is undoubtedly essential that the CQC continues to develop, test and refine the most effective possible mix of regulatory activities to fulfil its role, it is important to accept that quality regulation can only be the third line of defence against serious quality failures.

The first line of defence is frontline professionals, both clinical and managerial, who deal directly with patients and carers and are responsible for their own professional conduct and competence and for the quality of the care they provide. They are first-hand witnesses when things go wrong and often have ideas about how the quality of care could be improved. It is vital that they are able to speak up and are empowered to act to prevent failings in care. The second line of defence is the boards and senior leaders of providers responsible for ensuring the quality of care delivered by their organisations. They are ultimately accountable when things go wrong and should be able to address problems that arise because of a lack of systems and processes. It is vital that they are able to monitor the quality of care, take action to resolve issues, and create a culture of openness that supports staff to identify and solve problems. The third line of defence is the external structures and systems, usually at national level, responsible for assuring the public about the quality of care, which includes the Care Quality Commission..

For the Care Quality Commission to be most effective it is essential that its work is proportionate, and so supports both frontline staff to deliver high-quality care and to act to prevent failings, and supports boards and leaders or organisations to focus on quality. There is a risk that the regulatory requirements of external bodies crowd out a focus on the effectiveness of internal quality governance arrangements and that the activities related to fulfilment of these requirements run counter to an organisational culture that promotes learning and improvement. Our comments on the consultation are made with this overarching principle in mind. Our comments cover:

- inspections
- ratings
- the involvement of and provision of information for patients and the public
- whistleblowing
- thematic work and investigations
- working with Monitor and other national bodies
- the CQC's role in quality improvement
- the proposals for intelligent monitoring and the tier one indicator set.

Inspections

We note with interest that the Keogh mortality team's review methodology offers a blueprint for the Care Quality Commission's new approach to inspections. We welcome the change that ensures that inspectors have expertise in the area they are inspecting.

In designing the new approach to inspections, it is very important that the experience of previous regulators is not lost. For example, the Chief Inspector of Hospitals' plan for an 'army' of clinicians joining the inspection teams is reminiscent of the inspector mix used for the Commission for Health Improvement's clinical governance reviews. The main challenge with such an approach is mitigating the impact of taking clinical staff away from frontline duties of care to do regular rounds of inspections (as different to intensive, one-off, reviews like the Mid-Staffordshire or the Keogh mortality review). It will be important for the CQC to be clear how providers will be supported to release staff to support the inspection system.

Finally, we are concerned that it may be difficult for the CQC to resource the intensity of inspections proposed. For example, under the present system, between a quarter and a third of services were judged to be non-compliant. If the failure rate were to increase by any margin, does the CQC have the resources to cope with the number of services requiring expedited inspection and further action to ensure they met the required standards?

Ratings

Measures of quality and performance can be used for different purposes, for example, to improve choice, drive quality improvement directly, facilitate naming and shaming, or increase public accountability. If these are not well-aligned, they could, at best, be confusing for users and, at worst, contradictory. The proposed ratings system will need to align with the friends and family test, quality accounts and NHS England's consultant-level clinical indicators.

In principle, we think that providing ratings at service, hospital and trust level is the right direction of travel, given the problems with achieving a meaningful measure with a single rating. However, while we welcome the general principle, we would note that much depends on getting the detail right in terms of indicator selection and methodology.

There are a number of important methodological considerations when developing a composite measure of quality or performance, most obviously the selection of indicators and the choice of weighting given to each indicator. Composite ratings can mask important variation in the quality of care within organisations. Inevitably there is a trade-off between comprehensiveness and the ensuing complexity on the one hand, and the simplicity but inadequate coverage of salient issues on the other.

Involvement of and provision of information for patients and the public

Patients and service users must be at the heart of any new quality regulation system and they need to be able to understand and have confidence in the system. Regulators must focus on patients and users and we welcome CQC's intention to engage with Healthwatch England and its local offices. However, we are keen to learn more about how this relationship will work in practice.

It is vital that ratings and information from inspections are made available to the public. We would be interested to hear how the CQC envisages the published outputs from the inspections. These will need to be well written, accessible and in plain English, and the

numerical data presented clearly and with necessary explanation. We would urge the CQC not to underestimate the expertise and resources needed for this to be done well, and would note that there is much learning from previous efforts and from related work through quality accounts and NHS Choices which should be drawn on.

Whistleblowing

Whistleblowers must be given adequate support and protection, and staff working in health care must be made aware of how to raise concerns about the quality and safety of care. As such, we welcome the retention of the central confidential whistleblowing helpline.

Thematic work and investigations

We welcome the clear recognition in the consultation document that health and care organisations do not work in silos. For the many people who use multiple health and care services their experience of how joined-up and properly co-ordinated their care is an important dimension of quality. We therefore welcome the CQC's intention to conduct thematic work and investigations that will look at the quality of whole local health and care systems for particular groups of people. These investigations will require as much knowledge, skill, methods development and testing as the CQC's routine inspections. We therefore look forward to hearing more about the CQC's specific approach to this work.

Working with Monitor and other national bodies

Financial and quality failures are closely linked and so we welcome the intention to introduce a single failure regime, and more broadly the commitment to ensure that the activities of the CQC, Monitor and other national bodies are effectively co-ordinated. We welcome the Memorandum of Understanding signed by the two organisations which will strengthen the way the regulators work together and share information. Building effective relationships and sharing information is a key step to ensure a more collaborative approach between the two regulators.

CQC's role in quality improvement

We would urge caution in the CQC's ambitions to assure minimum standards and to contribute to quality improvement. For example, the proposals for inspections seem to be targeted at detecting poor performers, which we would support, but this then means that they will produce only limited learning on how good services can become excellent ones. We would argue that CQC's role in quality improvement should be limited to:

- developing expert insight and evidence through its inspections and reviews on the levers and drivers for improvement
- using that learning to refine the scope of inspections and review so that they focus on the factors that make the most difference to quality improvement
- communicating clearly what good practice looks like.

We would reiterate the importance of proportionality in CQC's approach here. In all it does, the CQC must support front line staff and leaders to focus on quality and not be unhelpfully distracted by unnecessary additional regulatory requirements. If the CQC is perceived to be disproportionate in its activities it risks yet again being seen to fail.

Comments on the Annex - Proposed model for intelligent monitoring

The choice of indicators for the tier one set

It is unclear why the CQC has focused solely on outcome indicators in tier one. Most accreditation and quality assurance models internationally include process and structure measures in addition to outcomes. For many areas where outcome measures are not robust, eg, palliative care, maternity, mental health, learning disability, process measures are important. If the outcome indicators relate specifically to tier one, then this should be stated explicitly in the principles listed in Table one. However, we do not believe this reduction in the scope of quality assurance is either necessary or warranted.

We strongly support the CQCs intention to use clinical audit data as part of its overall intelligent monitoring, as it is a rich and relevant data source. We would also recommend integration of the National Confidential Enquiry into Patient Outcome and Death data into the CQC's indicator development model, since these contain valuable material about poor care leading to serious/adverse events and deaths.

The Annex to the consultation document states explicitly that the focus is on indicators that measure harm. However, failure to provide high-quality care is also a neglect of duty and can impact negatively on outcomes; this reiterates the importance of clinical process indicators.

We understand that tier two indicators are only invoked if there are concerns about tier one indicators. The tier one indicators focus predominantly on mortality, and specifically on the main causes of death. Mortality rates may be easily measurable but they have innumerable problems when used as quality indicators, including case-mix, being either too high level (eg, Hospital Standardised Mortality Ratios (HSMRs), Summary Hospital-Level Mortality Indicator) or too specific (eg, by procedure, diagnosis) in measuring rare events, resulting in small numbers and random variation. Furthermore, it is also important to measure mortality where the risk of death is low, ie, where death is a sentinel event, such as maternal death. Finally, poor-quality care frequently does not end in death. We would therefore argue that more indicators of adverse outcomes are needed in tier one.

In the effectiveness domain, indicators are needed for maternity and newborns; although the risk is low, adverse outcomes are unexpected and the number of births and population at risk (mothers and babies) are large. This illustrates the problem with using the 'main' causes of death as a selection criterion for indicators.

In the caring domain, we strongly support the use of patient surveys for measuring caring systematically. However, the CQC needs to take full account of confounding factors in patient survey data such as the 'London effect', and we would argue it could draw more on the richness of the patient survey data within tier one.

In the well-led domain, The King's Fund is currently working with Professor Michael West on a project for the CQC to help it develop its approach to inspecting the culture and leadership in acute organisations. We would not wish to prejudge the outcomes of that work in this consultation response. It is clear that there is a great deal more routine data available from sources such as the staff survey, vacancy rates and use of locum doctors and agency workers, all of which are just examples of some of the other key indicators which could be incorporated into the CQC's model.

Testing of the risk model

It is imperative that the CQC test its risk model for identifying organisations for inspection. Data-based risk assessment models are not foolproof and there is a strong risk of false positives and false negatives. We would recommend a case-control study, where inspectors are sent blind into organisations assessed as high, average and low risk and a random sample, to test the sensitivity and specificity of the CQC's surveillance model.

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