CARE QUALITY COMMISSION CONSULTATION ON THEIR NEW APPROACH TO REGULATING, INSPECTING AND RATING CARE SERVICES

RESPONSE FROM THE ROYAL COLLEGE OF SURGEONS

The Royal College of Surgeons is grateful for the continuing opportunity to comment on the CQC's new approach to regulating, inspecting and rating care services with this latest consultation. The RCS fully supports the significant changes that the CQC is making and will offer its support and input wherever possible and desirable.

In responding to this consultation, the RCS has focused primarily on the documents relating to acute hospitals.

Consultation questions – NHS acute hospital services

1. In addition to inspecting the core services, we are also considering focusing on specific patient groups during an inspection, for example people with a learning disability mental health condition, diabetes or dementia. We would assess whether the provider understands and meet the needs of these specific groups. Do you agree that this is the right approach?

The RCS strongly supports a patient-centred approach to assessing the quality of services, and also supports the recognition of co-morbidities. The focus on patient groups should allow a review of the whole patient pathway and thereby aid the assessment of interfaces between service providers and locations and how well the care received by individual patients is coordinated. This approach helps encourage providers to look at integration and coordination of care.

The three patient areas suggested span a wide section of the population and could be described as 'Cinderella' areas of care at present – as such assessing the quality of care for these patients ought to provide a good litmus test for all patients.

The RCS is concerned at the ability to recruit sufficient expert inspectors to sustain the CQC inspection regime and believes the CQC should emphasise to Trust CEOs the benefits of releasing senior personnel.

2. Do you feel confident that the key lines of enquiry and the list of prompts will help our inspectors judge how safe, effective, caring, responsive and well-led NHS acute hospitals are? Is there anything we are missing? We have provided examples of evidence we may collect during our inspections. Do you agree that this is the right kind of evidence for us to look at? Is there other evidence we could use?

The RCS would wish to see use of individual Consultant Outcome data and audit information (including results from all national audits the Trust has contributed to and any audits underway or planned) forming a strong part of the intelligence used to identify key lines of enquiry. Generally, the key lines of enquiry and list of prompts seem to provide a good starting point for inspectors. However, the ability of the inspection team to then respond to findings from the on-site part of the inspection process to expand or add new lines of enquiry is critical to the credibility and effectiveness of the inspection visit. This emphasises the value of specialist assessors during an inspection. There is also a need to ensure the information provided in advance and the reporting and recording mechanisms during the inspection visit are clear and simple to avoid key messages being lost and to ensure all areas are covered adequately.

There is minimal detail in the guidance on how the CQC will implement its responsibilities in terms of the requirements on institutions around the duty of candour and the College feels this continues to be an omission.

3. Do you agree that the characteristics of 'outstanding' are what you would expect to see in an outstanding acute hospital service? Do you agree that the characteristics of 'good' are what you would expect to see in a good acute hospital service? Do you agree that the characteristics of 'requires improvement' are what you would expect to see in an acute hospital service that required improvement? Do you agree that the characteristics of 'inadequate' are what you would expect to see in an acute hospital service that was inadequate?

The characteristics are a mix of objective and subjective measures. A level of subjectivity is probably inevitable, but the RCS believes there is a strong role for Colleges and Specialty Associations to play in providing clear standards to support as much objective measurement as possible.

4. Our key lines of enquiry, prompts and ratings characteristics are generic. Do you agree that they can be applied to all of the core services? Do you feel confident that a generic approach covers the issues most important for each core service? Is there anything missing?

As with question 2, the generic approach provides a good starting point for all services – but the ability to respond to findings from the on-site visit is critical.

5. We want to know whether you agree with our approach to human rights. Please see our separate human rights approach document, in which we are asking a number of questions. We would also like your comments on our equality and human rights duties impact analysis.

The approach to human rights seems very thorough - including focusing on treatment outcomes for people from different ethnic minorities, which the RCS believes has not been part of the routine information pack or the site inspection process for Wave 1 or 2 inspections.

6. How best do you think we can ensure that providers improve the way they conform with both the wider Mental Capacity Act and the Deprivation of Liberty Safeguards?

a) **Make sure we give sufficient weighting to this in our characteristics of good?**
b) **If providers do not meet the requirements of the MCA and the Deprivation of Liberty Safeguards, apply limiters (meaning a service could not be better than requires improvement) in a proportionate way to ratings at key question level?**
c) **In other ways?**

Either option a or b would seem appropriate.

A simple indicator of whether a NHS trust has the basics of this in place is whether it has ready onsite access to mental health trained staff.

7. During our inspections of NHS acute hospitals, we will use a number of methods to gather information from the public about their views of the services provided. Do you agree that the proposed methods of doing this are the right ones to use? Will they enable us to gather views from all of the people we need to hear from?

The RCS supports the spread of information sources to support obtaining views from the public, as this should help views to be triangulated and provides maximum opportunity to hear from a range of patient, carer and public perspectives and use their views to drive improvements to care. The RCS also suggests that there should be similar emphasis on getting an equivalently representative staff perspective.

8. Are there ways in which we could promote learning between providers and services, particularly where we have identified outstanding care?

The RCS supports the CQC in stimulating improvement in services as well as providing an inspection 'snapshot'. The CQC may consider providing periodic generic reports on the amalgamated findings of CQC visits (an approach the RCS has taken with its learning from invited reviews). For example, providing a similar report to the report from the theme Wave 1 inspections but with a greater focus on the good practice found. The RCS also recognises that there is already significant information available on good practice and the key challenge is in

ensuring improvement action actually takes place. The RCS is keen to support the Action Planning part of the CQC inspection process and believes Colleges can play a significant role in working with providers to help improve services. For example, where it is clear from a CQC visit that a further detailed analysis of a surgical service is required the RCS is happy to provide this to the Trust on request through an invited review.

9. Do you agree that the grounds on which trusts can challenge their inspection reports and ask for a review of their ratings? [In responding to this consultation question it might be useful to consider whether:

- **The process described is workable for providers?**
- **The process is fair and transparent?]**

The RCS recognises the need for there to be a process by which a provider can give their views on a rating decision - but whatever process is agreed the focus must be on addressing patient risks (whether real or potential) rather than arguing over ratings.

10. Do you agree that providers should be able to apply for a single focused inspection to recognise where improvements have been made?

The RCS does support this as it sees the CQC inspection process as a driver for improvement action. Providers should be encouraged to make improvements as soon as possible and allowing them to apply for a single focused inspection is an opportunity to encourage improvement action to be taken sooner rather than later. As stated earlier – the RCS believes Colleges have a strong role to play in assisting with any improvement action and preparation for a single focused CQC inspection.

11. Do you agree that the five key questions are equally important and should be weighted equally in our aggregation method?

The RCS believe the key questions are not only equally important but also highly interdependent – and this interdependency needs to be recognised in the aggregation of ratings.

12. Do you agree that in general the core services should be weighted equally, the only exception being where a core service at a trust is particularly small?

The RCS agrees the core services should be weighted equally, and recognises the value of the inter-service discussions and comparisons during the inspection on-site visits.

13. Do you agree with the guidelines for aggregating ratings? Are there any that you disagree with? Is there anything else that we should include?

The guidelines seem appropriate – the key factor is a consistent application of the guidelines. The aggregation process also needs to be pragmatic with those responsible avoiding a fixation on the "methodology" and ensuring all parties focus on any immediate patient safety risks and ensuring they are addressed.

14. Do you agree that CQC should use key pieces of information as described? What pieces of information would you recommend that we should use?

The RCS supports provision of seven day services in the 'limiting' information. The RCS believes this is a view also held by NHS England's Medical Director, who has stated that for acute services to be judged safe, they should be safe 24/7.

Additional comments re Cosmetic Surgery

The RCS presumes that cosmetic surgery services undertaken within an NHS Acute Hospital are covered in the scope of the CQC NHS Acute Hospital inspection, under the core area 'Surgery'. What is not clear is how independent providers of cosmetic surgery would be inspected. With the level of risk to patient safety in this area, the RCS would wish to see cosmetic surgery services clearly reflected in the scope for inspections of independent providers – whether in a hospital or high street clinic setting. The RCS would also want to see the process for publishing aggregated ratings being sufficiently 'user-friendly' to allow potential or actual cosmetic surgery patients to readily find and access the rating awarded to the provider(s) and location(s) they are interested in.

Comments on the Interim Regulatory Impact Assessment

The RCS notes that there are no mentions of costs or benefits from the existing inspection regime. Estimates of the CQC's own costs and those of its inspection teams, plus estimates of the opportunity cost to NHS trusts (staff preparation, changes to work routines on the inspection days, etc) would have been helpful. The RCS recognises that quantifying the benefits (actual or potential) is not easy, but is nonetheless important.