Written evidence submitted by the care Quality Commission (HSC0906)

About CQC

1. The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. Our purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage these services to improve.

Introduction

2. We welcome the opportunity to contribute to the Health and Social Care Committee's inquiry into the White Paper. The White Paper rightly addresses the need for greater integration, accountability and reduced bureaucracy across services, underpinned by a transparent and responsive system. We are working with the Government to ensure the successful implementation of these objectives by sharing our own evidence on where legislative change is required.

3. The forthcoming Health and Social Care Bill is a once in a decade opportunity to improve the health and social care system for the better.

4. Several proposals impact on our work and have implications for our future strategy[1], which we will be implementing over the coming years. Our draft strategy focuses on improving people's experience of care by looking at every stage of their journey through the health and care system. As part of this, we want to support a common understanding of quality, and look at how services work together to improve people's experiences and outcomes. Further to this, we want to develop a regulatory approach that is agile and dynamic in responding to risk. Our vision is to be data-driven and intelligence led, meaning we are better able to intervene in cases of unsafe care.

5. We have identified key White Paper proposals below and offered our independent reflections as the health and social care regulator in England on how this impacts our work and the wider health and care sector.

Integration and collaboration

6. We welcome efforts to improve integration across the health and care system, as we know from our work how critical this is to delivering safe, high-quality services that meet people's needs.

7. We welcome the move to place Integrated Care Systems (ICS) on a statutory footing, but would make a number of points with regard to how they are established and governed:

    a) We note that the new legal entity is the ICS NHS Body, which does not cover social care – ensuring through the Health and Care Partnership that the social care sector is an equal partner in the design and delivery of integrated care will be important. We are engaging with the Government on this to better understand the role and powers allocated to these Partnerships.
    b) Within the ICS NHS Body, there must be a strong role and coordinated voice for primary care (including GPs, pharmacy, optometry, dental providers etc) alongside NHS Trusts.

[1] https://www.cqc.org.uk/news/stories/cqc-launches-strategy-consultation-%E2%80%93-we-want-hear-what-you-think

Clarity on the role of the independent hospital sector is also needed as there is no direct reference to what role it would play in an ICS.

c) While accountability for safety and quality of care ultimately rests with providers, we recommend clear governance arrangements outlining what role the ICS will play in this – we would expect to see ICSs taking a leading role in seeking to improve safety and quality across the system

8. The White Paper states, 'ICSs will be accountable for outcomes of the health of the population and we [the Government] are exploring ways to enhance CQC's role in reviewing system working'. We welcome this statement and have detailed our ambition to work across systems in our recent strategy consultation[2]. Our assessment of people's care must look at every stage of their journey through the health and care system, looking at both individual services and across different providers and organisations. To support this ambition, we would recommend a free-standing provision that enables us to assess systems on our own initiative. This would allow us to assess the quality of care in an area and the levers that affect it, such as the commissioning of services in all sectors (health and care), and to assess how people move through pathways that may span multiple ICSs.

9. We would work closely with people who use services, their families and carers, those who represent them, the public and our partners to set out expectations of what good system working looks like. We also want to ensure this approach is complementary to existing standards, and that there is no duplication with the role of other bodies, including NHS England (NHSE).

10. We are working with the Department of Health and Social Care (DHSC) and NHSE colleagues to establish the best legislative framework and practical approach for our role in ICS accountability. It is important that there is independent assurance to the public, parliament and government of how well health and social care partners within an ICS area are working together and the quality of care people are receiving, which we believe we can provide.

Proposals on NHS Trusts

11. The focus on joined-up care will require some changes for NHS trusts in how they work more closely with other providers in their local systems. We are building more collaboration into all of our provider assessments across health and social care. This is a long-standing ambition that appears in our recent strategy consultation. As we develop our new assessment and rating approach at the NHS trust level, we will build in an assessment of how trusts are working collaboratively and meeting the triple aim (to simultaneously pursue better care for patients, better health and wellbeing for everyone, and sustainable use of NHS resources).

12. We recently published a consultation[3] on flexible regulation, looking at how we can assess and rate providers in a more dynamic, agile way. We proposed developing a new approach to assessing and rating NHS trusts at the organisational level. This new approach would simplify the existing ratings structure and increase our focus on overall organisational leadership, management and culture. We are looking to develop this assessment approach and plan to engage with stakeholders on the detail of that approach this year.

13. As we seek to implement changes to our assessment frameworks, we will need to factor in alignment with NHSE/I's System Oversight Framework – there is a direct connection between our trust ratings, Special Measures and NHSE/I decisions on improvement support needs.

[2] https://www.cqc.org.uk/get-involved/consultations/world-health-social-care-changing-so-are-we

[3] https://www.cqc.org.uk/get-involved/consultations/consultation-changes-flexible-regulation

Proposals on arm-length bodies (ALB) Transfer of Functions

14. Regarding a new power for the Secretary of State (SoS) for Health and Social care to transfer functions between ALBs, it is unclear whether we would fall within the scope of the power or not.

15. If we were to fall within the scope of this power, this could potentially weaken our core purpose, which is to provide independent assurance on health and social care and drive improvement across sectors. It may also impact on our accountability to parliament and on public perceptions of our independence as the health and social care regulator.

16. In light of the above, it would be helpful to have a commitment from the Government that excludes CQC from the scope of this proposal.

Proposals on Adult Social Care (ASC)

17. A role for us in oversight of local authority adult social care duties is welcomed. Commissioning is a major influencer of quality and ASC commissioners have a significant impact on care quality, exhibiting variance in how effectively they deliver this and their wider Care Act duties.

18. We will develop our oversight approach in parallel with our model for provider regulation and with consideration for how our role across health and social care systems might develop. In particular, this will mean aiming to develop clear standards and expectations that work for all these purposes and which speak to people's experiences.

19. The formal establishment of ICSs, and their duty to collaborate with local authorities, provides an opportunity to address the duplication and inefficiency that exists across systems partners when it comes to describing and measuring quality.

20. We note the limited discussion of ASC in the White Paper, and the absence of detail on the long-term funding solution for the sector. This will unfortunately reinforce perceptions from the sector that social care is of secondary importance to the Government.

Health Service Safety Investigations Body (HSSIB)

21. We welcome the new legislation to establish the HSSIB as an independent statutory body. In order to succeed, HSSIB will need to work closely with other bodies such as ourselves to ensure there is a common understanding and clarity of each organisation's role, purpose and powers.

22. Specifically, there will need to be an agreed approach on how and when we exchange information on common points of interest, whilst also recognising the importance of ensuring that one organisation's duties should not fetter the actions of another.

23. The 'safe space' proposals will require some further discussions with DHSC to ensure due regard for safety. Information confined to discussions in safe spaces could limit our ability to take necessary action to protect people in health and care settings. Additionally, we could be obliged to provide information (e.g. whistleblowing information) or evidence if HSSIB were to use its relevant powers. This has implications on confidentiality and how we protect whistleblowers.

24. We would also support further discussions about how 'safe space' measures could impact on duty of candour obligations.

Proposals on Fit and Proper Person Test

25. We will continue to liaise with NHSE/I and NHS Leadership Academy as (non-statutory) programmes are developed and implemented. Where appropriate, we will update relevant guidance and supporting materials and reflect this in our assessment approach.

26. Leadership and culture are key components in our approach to assessing well-led organisations, and the safety pillar of our draft strategy[4] reinforces this, placing an emphasis on 'open, honest cultures'.

Proposals on data sharing

27. We welcome greater information sharing. It has the potential to reduce the duplication of data requests and therefore reduce burden on the health and care system. In developing the proposals, we suggest the Government acknowledges existing national data collections from providers, for example our existing approach and how these will be built on, not duplicated.

28. If we are to assess the quality of care provided under an ICS, there is a need for the sharing of data between social care and health. Moreover, there needs to be actionable consensus on what 'quality of care' means across the different parts of the system. Data sharing is more than clinical outcomes - it is about quality of life, as supported by quality of care.

29. A first practical step would be to require a common framework based upon and linked to CQC's existing Fundamental Standards[5] (the standards below which care must never fall) for adoption by ICS quality frameworks even if they are not legally accountable to us (due to not being registered). This will provide a common frame of reference and a set of minimum expectations from which will flow greater collaboration and information sharing.

30. There is a reference in the White Paper, outlining a proposed requirement for "health and adult social care organisations to share anonymised information that they hold between themselves where such sharing would benefit the health and social care system". We would like to better understand how the criteria for determining benefits to the health and social care system would be established.

31. In addition, it would be helpful to explore further how data from independent health can be better shared across the system.

Proposals on Hospital Food Standards

32. We support the proposals to amend legislation to more clearly establish hospital food standards on a statutory footing to ensure that staff, patients and visitors are able to eat well when in the hospital environment. To meet the October 2020 Independent Review of NHS Hospital Food[6] recommendation on enforcing the NHS food and drink standards, we will need to ensure our regulatory approach develops in an appropriate way to deliver regulation in line with our emerging strategy.

33. CQC's role in this area is focused on ensuring the food and drink supplied by hospitals meets the nutritional hydration and wellbeing needs of service users, taking account of individual requirements and preferences as appropriate. We will be exploring how we can develop and update our assessments in that area in line with the recommendations of the NHS Food Strategy. We also have a role in assessing how NHS trusts' overall organisational approaches to food provision are complying with national guidance, and how they are ensuring the wellbeing of their staff.

[4] The world of health and social care is changing. So are we. | Care Quality Commission (cqc.org.uk)
[5] https://www.cqc.org.uk/what-we-do/how-we-do-our-job/fundamental-standards
[6] https://www.gov.uk/government/publications/independent-review-of-nhs-hospital-food

36. As we develop our methodology, it will include, for instance, assessing the overall food strategy and management approach for the organisation, service user and staff feedback of food quality in hospital, etc. We do not expect that this would involve CQC staff carrying out detailed inspections of commercial food retailers or vending machines, and will avoid overlap with the responsibilities of other bodies such as the Food Standards Agency. We will be working closely with other bodies such as NHSEI to ensure expectations on NHS trusts are clear.

37. Depending on the final approach, there could be an associated ongoing increase in our resource required to implement the NHS hospital food review recommendations, as well as a development cost. Any additional costs may need to be met by additional Grant-In-Aid from DHSC or a potential increase in provider fees. We will, however, consider first how our assessment of compliance with food standards can fit within our existing assessment approach and resources.

Proposals on new national medicines registries

38. We support the proposal for the Medicines and Healthcare products Regulatory Agency (MHRA) to develop and maintain publicly funded and operated medicine registries. This may lead to a better understanding of the prescribing of prescription only medicines in the independent sector.

39. Our concern however, is that this proposal would not necessarily give us or other agencies any further insight around the use of medicines where monitoring is particularly important (for example Schedule 4 & 5 controlled drugs)[7].

Patient safety issues around online services

40. The ever-changing online healthcare market and the accelerated take-up of digital health services during the pandemic, has presented a combination of benefits and risks to people. Due to current regulatory gaps, we are in discussions with DHSC about how we can update our regulation and put in place policy initiatives to ensure that independent online prescribers who prescribe to patients adhere to safe practice.

41. There is a need to address safety gaps in the following areas:
    - over prescribing of opioids and other medicines online.
    - prescribing online without knowledge of a patient's history or access to patient records.
    - the type and quantities of medicines that can be prescribed by independent providers online.
    - the lack of measures and checks in place when medicines are dispensed in England, following a prescription from outside England.
    - Limited jurisdictional ability for UK regulators to take action in response to harmful prescribing by providers or registered persons based outside the UK.

42. We have recommended proposals for primary legislation in order to tackle international trends of dangerous healthcare provision to people in England. This includes the over-prescribing of controlled drugs by providers outside England which has already caused significant harm. Moreover, changes to primary legislation, would allow us to future proof our legislation so that we can keep pace with digital trends in healthcare, enabling us to respond to emerging risks via an effective range of powers.

43. We believe that where services are delivered virtually without any direct contact between patient and provider from outside England, and therefore not carrying out a regulated

[7] https://bnf.nice.org.uk/guidance/controlled-drugs-and-drug-dependence.html

activity, we should have a power to stop them from causing harm as we do with all domestic services. We have current examples of death and severe harm caused by digital services delivered from outside England. Our view is that as digital services grow in popularity, and breadth, over the coming decade there is a gap in government's power to intervene where harm is being caused.

44. We recommend cross-government agreement on the best way to progress the above issues, including setting out the legislative pathway for the necessary changes to be made, so that we can better protect people using these services. We are having constructive conversations with DHSC about this and we encourage further joint conversations with healthcare regulatory bodies and government departments. This may include, but is not limited to, the General Pharmaceutical Council, the Medicines and Healthcare products Regulatory Agency, the Home Office and the Department for Digital, Culture, Media & Sport.

Further opportunities presented by the forthcoming legislation

45. During our conversations with DHSC, we have also suggested several other areas that this legislation could address and highlight these below for your awareness.

46. We support the **National Guardian Office's request to be placed onto a statutory footing.** This would promote its independence, transparency and accountability as the organisation continues to expand.

47. **We have recommended an amendment to enable early publication of our enforcement activity,** so that secondary legislation can be made, allowing us to publish details of our civil enforcement action at the time action is taken. Making this information available to the public could enable them to make important choices for themselves and their loved ones.

48. **We have put forward an amendment to enable us to require information from third parties (Section 64 of the Health and Social Care Act).** The police and professional regulators do not currently by law have to share information requested by us, and at times there have been delays in third parties sharing information with us. This slows down our regulatory action and may result in delays in registration or enforcement action by us to protect patient safety, thereby exposing people who use services to risk.

49. Finally, we have requested an amendment to enable us to charge and retain a profit when providing advice and assistance to other public authorities (Schedule 4). The proposed amendment will not only bring us in line with other non-departmental public bodies (e.g. NICE) but will also provide us with the opportunity to invest in and offer expertise and assistance to help providers improve services.

If you have any queries regarding this submission please contact Senior Parliamentary and Engagement Adviser, Ayesha Carmouche

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