21 March 2018

Royal College of Anaesthetists

Royal College of Anaesthetists' response to the Care Quality Commission Consultation 3 *'Our next phase of regulation A more targeted, responsive and collaborative approach - Independent healthcare'*

About the Royal College of Anaesthetists

- Sixteen per cent of all hospital consultants are anaesthetists making anaesthesia the single largest hospital specialty in the UK[i,ii,iii]
- Anaesthetists play a critical role in the care of two-thirds of all hospital patients[iv] and 99% of patients would recommend their hospital's anaesthesia service to family and friends[v]
- With a combined membership of 22,000 fellows and members, representing the three specialties of anaesthesia, intensive care and pain medicine, we are the third largest Medical Royal College by UK membership.

Introduction

The RCoA welcomes the opportunity to provide a response to this third phase of the wider consultation of Care Quality Commission (CQC) activity. As independent healthcare providers increasingly play a role in providing NHS services, it is paramount that they operate to parity with the high standards of care expected of all NHS providers. This is particularly true for independent acute hospitals, and, as the single largest hospital specialty in the UK, our response mainly focuses on acute care providers.

A summary of the key points of our response is provided below. Our response to the consultation questions, in full, is provided underneath the summary.

- We support the proposals in this phase 3 consultation for the alignment of standards between independent and NHS acute hospitals across all levels, including collection of data, adherence to reporting and learning systems and prevention of serious incidents
- CQC should ensure that its inspection methodology is able to accommodate pathways that intersect through both NHS and independent providers. This is particularly important in the development of perioperative care pathways[vi]
- We strongly support the proposal for the CQC to utilise information from accreditation schemes to save time and resources, especially when a service has gained a CQC recognised accreditation award, such as the RCoA's Anaesthesia Clinical Services Accreditation (ACSA).

Should you have any questions on this consultation response, please contact Elena Fabbrani at efabbrani@rcoa.ac.uk or by phone on 020 7092 1694.

CONSUTATION QUESTIONS

MONITORING THE QUALITY OF SERVICES
We propose to strengthen how we manage our relationships with providers of independent health care and with local and national organisations.

Q1a. Do you agree that this is the right approach?

We strongly agree with this approach.

Q1b. What impact do you think this proposal will have?

As well as leading to a more collaborative and efficient way of working on both sides, this approach should encourage independent providers to maintain high standards of care and embark on quality improvement initiatives regardless of inspection schedules.

Q1c. Which organisations do you think we should exchange information with?

The list of organisations in the proposals is comprehensive, but may not be 'future proofed' as the NHS in England continues the evolution to New Care Models.

Independent healthcare providers are increasingly playing a bigger role in delivering NHS services, with a greater emphasis on integrated care along primary, secondary, community and tertiary organisations as per the *Next Steps on the Five Year Forward View* document by the NHS[vii].

The CQC will need to establish links with accountable officers in Sustainability and Transformation Partnerships (STPs) and the more developed Integrated Care Systems to ensure that, where a contribution from the independent sector is in place, high standards of care and patient safety are prioritised.

In our response to the CQC consultation 2 *(Our next phase of regulation: A more targeted, responsive and collaborative approach to regulating in a changing landscape of health and social care)* we have expressed concern over the lack of clarity on how the CQC regulatory framework would develop in parallel to the New Care Models programme.[viii]

In its latest report on the work of the CQC the Public Accounts Committee of the House of Commons has raised concern over the request to the Commission by the Secretary of State for Health and Social Care to undertake reviews of twenty local health and care systems, stating that such activities would fall outside of the remit of the CQC and are not compatible with current legislation[ix].

We believe that the CQC needs to work closely with NHS England and NHS Improvement to clarify how this relationship will work in practice and how independent providers will fit in the new systems.

We propose to develop our CQC Insight tool to monitor data about the quality of independent healthcare services, starting with CQC Insight for acute hospitals and mental health services.

Q2a. Do you agree that this is the right approach?

We strongly support this approach in terms of how good quality data can be used in spotting general trends in a service across the sector, as well as monitoring the performance of individual providers.

Q2b. What impact do you think this proposal will have?

If successfully rolled out '*CQC Insight'* should lead to standardisation of inspections and monitoring across both NHS and independent providers, compelling the latter to work towards the same standards of care as the former.

While being mindful that information governance arrangements in private hospitals can differ considerably from those in NHS organisations, the CQC will need to work closely with independent acute hospitals to agree the data sets it requires from them, but also a deadline for private hospitals to adapt their own reporting systems to the requirements of *'CQC Insight'* and to bring these in line with those of NHS acute hospitals.

It is likely that there will be administrative duplication with NHS Improvement's (NHSI's) Model Hospital Programme and Getting It Right First Time (GIRFT) work stream, with respect to data input. CQC should work closely with NHSI to mitigate placing avoidable burden on organisations.

We propose to collect information regularly from independent healthcare providers to help us to monitor the quality of services in between inspections.

Q3a. Do you agree that this is the right approach?
We strongly agree with this approach. Additionally, this offers an alternative to those providers which will not be able to provide data for '*CQC Insight'*. We are also encouraged that the CQC will obtain data already available through other sources, such as Hospital Episode Statistics data, and keep requests to a minimum.

Q3b. What impact do you think this proposal will have?

The proposals should have a positive impact on quality improvement monitoring within providers, who will be encouraged to incorporate the collection of data and updating of information into routine daily practice.

It will also provide evidence and reassurance early after an inspection, that actions are being taken to improve areas of practice that have been found to be inadequate or to require improvement, and equally give early warning of deterioration in the quality of a service.

However, the resource and time required to gather information cannot be underestimated and the CQC will need to work closely with independent providers to agree exactly what evidence is required and in what (uniform) format.

PLANNING INSPECTIONS

We propose to move towards more unannounced and short notice inspections.

Q4a. Do you agree that this is the right approach?

We strongly agree with these proposals.

Q4b. What impact do you think this proposal will have?

Such an inspection regime will encourage providers to continuously assess services and maintain high standards of care at all times.

Unannounced inspections are becoming common practice in other sectors, such as in the food and the construction industries, and studies have shown a reduction in untoward incidents following their introduction. [x]

Unannounced or short notice inspections are also likely to lead to fast and consistent improvements in areas of practice that have been found to be a cause for concern in previous inspections.

CORE SERVICES

In independent acute hospitals, we currently assess the existing core service of 'outpatients and diagnostic imaging'. We propose to separate this core service to create two distinct core services of 'outpatients' and 'diagnostic imaging'.

Q5a. Do you agree that this is the right approach?

We strongly agree with this proposal – Radiology is a rapidly evolving specialty, which has seen considerable technological developments in recent years and deserves individual assessment against specialty related standards.

Q5b. What impact do you think this proposal will have?

Separating the assessment of outpatients and diagnostic imaging services would allow for these services to be rated separately, giving patients a clearer picture of the quality of each service.

In independent acute hospitals, we currently assess 'medical care' and 'surgery' as two separate core services. Some hospitals manage these services together, with no separate governance or organisational arrangement, and they treat patients on the same wards with the same staff. For these hospitals, we propose to combine these two services into a single core service of 'inpatients'.

Q6a. Do you agree that this is the right approach?

We disagree with this approach for the reasons provided below.

Q6b. What impact do you think these proposals will have on a provider overall and in relation to its ratings?

Although some independent acute hospitals are small in size, we believe that the differences in patient pathways between these two services are too great for a single assessment and rating to work in practice.

The RCoA has worked with specialties involved in the extended surgical team to develop perioperative medicine pathways. Perioperative medicine describes the practice of patient-centered, multidisciplinary, and integrated medical care of patients from the moment of contemplation of surgery until full recovery. [xi]

Anaesthesia and perioperative medicine is one of the work streams of the GIRFT programme aimed at improving medical care within the NHS by reducing unwarranted variations in hospitals.[xii]

Increasingly anaesthetists, as the 'perioperative physicians', are working towards perioperative pathways that improve patients' outcomes, and which are significantly different from those of general 'medical care' patients. Therefore, we do not believe that the two services can be assessed as one within independent acute hospitals.

Moreover, perioperative medicine and perioperative pathways have been incorporated in the standards for the RCoA ACSA scheme, which the CQC has formally recognised as an official information source for its inspections.

Finally, we are also concerned that, in instances where a hospital manages these services together and are jointly rated by the CQC, if one service is rated 'good' and the other 'inadequate', this would lead to a distorted and confusing picture for patients.

In hospitals where medical and surgical services are managed separately, we propose to continue to inspect the two separate core services of 'medical care' and 'surgery'.

Q7a. Do you agree that this is the right approach?

We strongly agree with this proposal.

Q7b. What impact do you think these proposals will have on a provider overall and in relation to its ratings?

As above, we support the separation of 'medical care' and 'surgery' as two different services, requiring separate assessments and ratings, given the different nature of these two areas of medicine (see answer to question 6b)

Some independent community healthcare providers may only deliver a single service, or may deliver only a small part of a community service. For these providers, we propose to introduce the 'community single specialty' service.

Q8a. Do you agree that this is the right approach?

Q8b. What impact do you think this proposal will have on a provider overall and in relation to ratings?

We have no comments to provide in response to questions in this section.

INSPECTION

If a service has gained accreditation by an appropriate recognised scheme, we propose to use this to both inform CQC inspections and, over time, reduce our inspection activity and duplication for providers.

Q9a. Do you agree that this is the right approach?

We strongly agree with this approach.

Q9b. Please explain why you agree or disagree with this proposal.

As stated in our response to the CQC phase 1 consultation *(Our next phase of regulation - A more targeted, responsive and collaborative approach)*, we believe that 'a comprehensive and evidence based accreditation scheme will deliver a root and branch review of the quality of a particular service and demonstrate areas in need of quality improvement. Engagement with these schemes is evidence of a positive culture within a particular service and at Board level, a commitment to quality and improvement'. [xiii]

A well-constructed accreditation scheme will look at policies and processes in highly specialised areas of medicines and will be constructed by experts who understand the service best and know what constitutes 'good' for that service.

This proposal would allow the CQC to save a considerable amount of time by avoiding duplication of assessments already carried out by rigorous accreditation schemes, such as the RCoA's ACSA scheme. The RCoA is undergoing pilots of ACSA reviews across two independent acute hospitals (March 2018) to determine how ACSA standards can be applied to the anaesthetic services of independent providers. The CQC could use the standards agreed by ACSA to inform its inspections standards for private hospitals.

For example, an area that the pilots will look at is the capability of independent acute hospitals to deal with emergencies and the need for robust transfer arrangements to larger NHS facilities in the absence of in situ critical care units.

The projected increase in number of inspections in the independent sector and concerns over CQC's staffing levels[xiv] inform a need for the Commission to make use of tried and tested accreditation schemes' information on services and reduce inspection activity, where evidence that high standards of care is provided by well-established accrediting organisations.

We propose to publish a more accessible and user-friendly inspection report with a separate appendix of evidence for some independent healthcare providers.

Q10a. Do you agree that this is the right approach?

We agree with this approach.

Q10b. What impact do you think this proposal will have?

We welcome any changes to the report which makes the information more accessible to the public. It would also be helpful to providers to be able to see clearly the recommendations and areas where improvement is required so that these can be quickly acted on.

RATINGS

We propose to rate the independent healthcare services that we now have the powers to rate in the same way that we rate all other services. Do you agree with the following specific proposals:

Q11a. Award a rating for CQC's five key questions (are services safe, effective, caring, responsive and well-led?) and aggregate these up to an overall rating at service and/or location level.

Q11b. What impact do you think this proposal will have?

Q12a. Rate at the service and/or location level on our four-point scale of: outstanding, good, requires improvement and inadequate.

Q12b. What impact do you think this proposal will have?

Q13a. Aggregate ratings using our published ratings principles.

Q13b. What impact do you think this proposal will have?

Since Independent Acute Hospitals are already rated, we have no comments to provide in response to questions in this section.

OVERALL APPROACH

Q14. Do you have any other comments on our proposed approach to regulating independent healthcare services?

We are encouraged by the proposals in the phase 3 consultation document and we believe these to be comprehensive and aspirational.

While we acknowledge that private hospitals operate under different financial and leadership models, we would also like to recommend that assessments by the Commission also look closely at specific areas of patient safety, namely: participation into national reporting and learning systems; evidence of learning from serious incidents; and compatibility of independent providers' existing safeguards and QI activities with the NHS integrated systems they might provide services for.

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[i] NHS Digital. *NHS Hospital & Community Health Service (HCHS) monthly workforce statistics - Provisional Statistics*. July 2017.
[ii] Stats Wales. *Medical and dental staff by specialty and year.* March 2017.
[iii] Information Services Division Scotland. *HSHS Medical and Dental Staff by Specialty*. December 2016.
[iv] Audit Commission. *Anaesthesia under examination: The efficiency and effectiveness of anaesthesia and pain relief services in England and Wales*, National report, 1998.
[v] EMK Walker, M Bell, TM Cook, MPW Grocott, and SR Moonesinghe for the SNAP-1 investigators. Patient reported outcome of adult perioperative anaesthesia in the United Kingdom: a cross-sectional observational study. British Journal of Anaesthesia 2016
[vi] Getting it Right First Time. Medical Specialities: Anaesthesia and Perioperative Medicine.
[vii] NHS. Next Steps on the Five Year Forward View. March 2017
[viii] Royal College of Anaesthetists. *Response to CQC phase 2 Consultation -Our next phase of regulation: A more targeted, responsive and collaborative approach to regulating in a changing landscape of health and social care.* July 2017
[ix] House of Commons Committee of Public Accounts. *Care Quality Commission: regulating health and social care Twenty-Fourth Report of Session 2017–19*
[x] David I Levine et al. Randomized Government Safety Inspections Reduce Worker Injuries with No Detectable Job Loss. *Science* 18 May 2012: Vol. 336, Issue 6083, pp. 907-911
[xi] Royal College of Anaesthetists. *Perioperative Medicine – the pathway to better surgical care.* 2015
[xii] Getting it Right First Time. Medical Specialities: Anaesthesia and Perioperative Medicine.
[xiii] Royal College of Anaesthetists. *Response to CQC phase 1 consultation Our next phase of regulation A more targeted, responsive and collaborative approach*. July 2017
[xiv] House of Commons Committee of Public Accounts. *Care Quality Commission: regulating health and social care Twenty-Fourth Report of Session 2017–19*