The Royal College of Ophthalmologists (RCOphth) response to the Care Quality Commission's consultation Our Next Phase of Regulation

January 2017

1. Introduction

1.1 The Royal College of Ophthalmologists welcomes the opportunity to respond to this consultation.

1.2 The Royal College of Ophthalmologists is the professional body for ophthalmologists and we champion excellence in the practice of ophthalmology on behalf of our members to optimise care for patients. We set the curriculum and examinations for trainee ophthalmologists, provide training in eye surgery, maintain standards in the practice of ophthalmology, and promote research and advance science in the specialty.

1.3 We work with leaders across the eye health sector to help shape eye services for the benefit of patients.

1.4 We have set out below our responses to the relevant sections of the consultation.

2. Developing new care models

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

2.1 We neither agree nor disagree.

2.2 Principle 6 is the key point we consider likely to *enable* development of new models of care. Being penalised for taking over poor services because providers want to improve them, has been a significant concern, deterring providers from doing so, and preventing the development of new models of care.

2.3 The remaining principles should aid inspecting and regulating new care models, rather than have a significant impact on their development. New models tend to develop according to local innovation and need, available funding and the mindset of local providers and commissioners. However, the principles should ensure that development is safer.

2.4 Principle 2 "We will hold to account those responsible for quality and safety."

The accountability within new models of care can be very unclear, therefore this principle would be strengthened by adding that the CQC will ensure that it is

clear who carries responsibility (although this is defined to a certain extent in the explanatory text). We would welcome guidance on how the CQC will address shared responsibility.

2.5 For example, the CQC recently inspected a non-ophthalmic multisite specialty care service (neuro services from the Walton Centre) in which the report did not really take into account the extensive service delivered in other trusts' sites, which was classed as the other trusts "activity". However, the agreed responsibility for this activity lay with the Walton Centre and was potentially an area of increased risk. Therefore, safety issues within such provision would be missed using this approach.

2.6 Principle 3 "We will be proportionate, and will take into account how each organisation is structured and its track record to determine when and how to inspect."

We welcome the emphasis on being proportionate, since more complex care models require greater capacity to make comparable and appropriate assessments.

2.7 Principle 4 "We will align our inspection process, where possible, to minimise complexity for providers that deliver more than one type of service."

This principle should capture all complex care provision. It should clearly apply to both providers that deliver more than one type of service, and those who provide one service in multiple sites or ways. Minimising duplication is of particular importance for the latter class of providers.

2.8 Principle 8 "We will rate and report in a way that is meaningful to the public, people using services and providers."

We strongly suggest the CQC shares key learning points around what constitutes excellence in new care models, particularly after having inspected the whole country and gaining an overview, in order to help new services to develop and overcome barriers.

2.9 Principle 9 "We will bring together inspectors who have specialist knowledge of different sectors to inspect jointly, where this is most appropriate for the provider."

The need for specialist inspectors should also apply to single specialty provision, whether in a network or indeed in a multispecialty provider with a large specialty unit. For example, our colleagues at the Manchester Royal Eye Hospital did not feel their service was inspected as part of the Central Manchester Trust's inspection.

2.10 There is significant concern that the drive to achieve savings will stifle new developments and it would be useful to know how the CQC can help in this matter – as it should be in a powerful position to promote change.

3. Streamlining inspection frameworks

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)?

3.1 We strongly agree.

3.2 Reducing the number of CQC frameworks, as well as aligning with NHS Improvement frameworks, is crucial to clarify the methodology, improve transparency and reduce the burden on providers for complying and preparing for inspections. Probably the biggest single difficulty providers find with the preparation for inspections is the requirement to collect and submit enormous reams of data that are different from those submitted or prepared on a day to day basis and in formats which are not routinely used. There is huge duplication of data requested. As much as possible, data collection for inspection needs to be consistent with data generated or used day to day for commissioners and other national bodies. In order to collect relevant data easily, we would strongly support the CQC driving changes in the datasets that should be routinely collected.

3.3 The frameworks do however need to be flexible and versatile enough to be used easily within specific sectors and specific specialties which differ from the majority of care e.g. for ophthalmology in which, for instance, inpatient care is negligible.

3.4 We agree with the proposal to rate as well as inspect some sectors like independent doctors, community and dental, but this will need to be instituted with a clear plan of the overall benefits.

4. Relationship management

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

4.1 Regular engagement is welcome, as is concentrating most resource on new providers or those with known issues. Building up stronger relationships with providers can help smooth the inspection process. However, great care needs to be taken to ensure that more contact does also increase the burden on providers or divert scant resources away from care and leadership towards managing the CQC relationship.

4.2 Input from Royal Colleges can be important and strengthening the relationships between them and CQC should be encouraged. The Colleges are an important source of expertise and inspection resource, which is particularly valuable for “niche” areas such as ophthalmology. The RCOphth conducts invited service reviews, therefore the inspection burden on providers could be minimised by better working between the College and CQC. Input from professional bodies for non-medical professions should also be considered for ophthalmology, including the College of Optometrists and the BIOS for orthoptists.

4.3 It would be helpful if the CQC, working closely with NHS I, addressed the perception that their role is to penalise and promoted their role in supporting and nurturing developing services. Allowing providers to decide how to make improvements will support this, whilst of course reassessing to ensure that action taken has led to improvement.

4.4 There is a perception that ratings reflect the worst area found, even if that area is small, and can seem not to reflect that a large proportion of the work is good. This can be very demotivating for staff. There should be an element in which assessments involve weighing up how much of what is found is poor vs how much of what is found is good.

5. Streamlining information requests

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

5.1 Streamlining data provision is essential for improving the efficiency of inspecting complex care models. We ask that you consider how to be more flexible in terms of the format of data requested, which is often different from that used day to day or requested by other agencies. As much as possible please be flexible so that, where services differ from “standard”, they are able to supply the data in a way which best fits that service or specialty and does not have to conform uncomfortably to a standardised template or format.

5.2 It is important to ensure that nationally available data is appropriate and accurate for the service inspected. Length of bed stay is not helpful for ophthalmology as there are so few inpatients and one patient staying an extra night can skew data, is not significant. We strongly advise utilising specialty and sector expertise to ensure the data you collect for specific areas is pertinent and appropriately interpreted.

5.3 It is unclear, and we question why, the proposals do not indicate that independent providers will be assessed against leadership requirements in the same way trusts are.

6. Inspection frequency

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?

6.1 This seems reasonable. As with question 5, College expertise should be considered to support assessments of non-core services, particularly for single specialties like ophthalmology.

7. Announcing inspections

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

7.1 This will give a truer picture of how services are running vs planned inspections so that providers do not present a managed picture or indeed, as we understand some have, reduce activity on the days of the visit.

7.2 There will need to be a balance, however, as inspections will undoubtedly disrupt the day to day running of the unit and real care needs to be given as to how to assess services on the day without distorting the picture seen.

8. Separating outpatient and diagnostic services

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

8.1 Separating diagnostic services where this is clearly a significant and separate or standalone service is acceptable but some services have both of these so closely interlinked and specialty specific that it would be better inspecting them as a whole and this is usually the case with ophthalmology. With the increase in virtual medicine this may become more crucial not to separate out the two.

9. Inspecting additional services

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?

9.1 Strongly agree

9.2 There is a need to ensure all services are inspected periodically no matter where they are delivered to ensure patient safety and equivalence of quality. Specialty specific services within trusts can be completely missed and can feel their care is poorly reflected in a trust wide assessment, quite often some services run very well within a struggling trust but it still receives an inadequate rating overall and this can be discouraging to the staff involved.

9.3 Without assessing significant additional services separately, inspections may miss important pockets of excellent or of poor care. In addition, inspecting these additional services across traditional boundaries is crucial for new models of care. Although this might not in most cases affect an overall trust rating, if significant trust-specific issues are identified within a multi-trust pathway, this should be taken into account in their rating.

9.4 We would support, for ophthalmology, ensuring anywhere with significant provision has their ophthalmic services rated or assessed (whether by data or visit) separately.

9.5 In ophthalmology we are aware of more and more eye care services being delivered in community optometry and independent provider premises. Therefore, these must be inspected as part of the whole pathway. Standards and quality can vary greatly, and responsibility for quality and safety can be unclear. Community optometry in particular, where they are providing traditionally “medical” services, must be inspected and we consider that they should be fully registered in the same way.

10. Accreditation schemes

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

10.1 Where these accreditation schemes are robust and informative it makes sense to use them, but the standards used by the schemes must be made known to, and agreed by appropriate authorities, such as the Royal Colleges.

10.2 These schemes must be accessible to all and cost-effective. This may require considerable effort to establish and oversee and great care must be taken to ensure the accreditation is appropriate, sustainable and equivalent to CQC inspection. Otherwise this could result in a two tier system.

11. Trust-level rating

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)?

11.1 This will need significant work and judgement to get right in the new complexity of care models. Ideally a clear methodology will eventually merge. Not only do you need to consider where trusts merge or work together but also where providers supply good quality services to challenged organisations, how will you tease apart the issues from the provider and from the host? Will the provider be penalised for the limitations of the host? This is another area where examining and rating specialty care across multiple sites in a network as one pathway will be helpful and there will be a need to identify in detail which organisation is responsible for which elements where there are issues. Reviewing the whole system, as well as individual parts is going to become more relevant.

11.2 Resource use is of course extremely important and does reflect leadership quality but it is important to be sure that, in the final outcome, the greatest emphasis and importance is placed on to the quality, safety and patient focus of the care given rather than the business side of an organisation.