MEETING	**PUBLIC BOARD MEETING** **16 September**
Agenda Item **Paper Number**	**9** **CM/09/20/09**
Agenda Title	**Our Transitional Regulatory Approach Update**
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PURPOSE OF PAPER:

Actions required by the Board

- **Discuss and endorse** the transitional regulatory approach

1. Summary: Our transitional regulatory approach

As the risks relating to the delivery of health and care during the COVID-19 pandemic change, we are evolving our approach to regulation in a way that is sensitive to the changing circumstances of providers, while continuing to put people who use services at the centre of what we do.

Our transitional regulatory approach brings together elements of our existing methodologies with learning from our COVID-19 response. Our overarching aim is to continually monitor risk in a service and respond to changes with the right regulatory action. This includes, where necessary, physical inspections. Training will start soon with our inspection teams, and rollout will start from October with adult social care and dentistry. We will continue to iterate our transitional regulatory approach in response to feedback

and as we explore longer term changes to how we regulate and look to explore through engagement with all our stakeholders on our future strategy.

Developing our monitoring approach

Our focus over the last few months has naturally been on the immediate risks presented by the pandemic. We stopped routine inspections and developed the Emergency Support Framework. We know that this needs to evolve.

We are taking forward the technology and some elements of how the ESF worked, building on the benefits of a structured approach to monitoring and stronger relationship management. We are taking a wider and more robust view of risk, our monitoring will have clear areas of focus, based on our existing Key Lines of Enquiry (KLOE), with a particular emphasis on safety, access and leadership, but also including some elements of all five key questions. This monitoring will enable us to be more targeted and responsive to risk in our regulatory activity. We will have flexibility to build in other areas of focus as we develop this approach.

We will also draw from a growing pool of intelligence sources to support our monitoring. This includes the work we're doing as part of the Provider Collaboration Reviews (PCRs), as well as information gathered through ongoing monitoring. We will use information we hold about not only individual providers, but about local systems, building on the work as part of the PCRs to understand where there are barriers to good care and to target our activity to help break these down.

The experiences of people who use services, their families and carers are central to this approach, and to our future direction. We cannot operate effectively without them. For this reason we are trialling improvements to how our inspectors and Experts by Experience gather people's experiences at all stages of our assessment process. We have launched a year-long campaign with Healthwatch England, voluntary sector partners and others to encourage people who use services to share their experience through our Give Feedback on Care service.

Our transitional regulatory approach requires our inspectors to review information from all available sources. This will be used to decide on the level of risk within a particular service and to support decisions about what further action we need to take in response – for example, collecting further information from people who use services to help confirm our judgment or undertaking on-site activity. Our risk model and monitoring activity helps prioritise services where there may be a greater level of risk and helps identify

what a proportionate response might be. Inspection teams will always have the option to act quickly and use their own judgement where other sources of information indicate greater levels of risk elsewhere.

Responding to risk

With the risks relating to COVID-19 still present, we won't just be returning to business as usual. Our activity – including site visits will be more targeted and focused on the aspects of care we most need to look at. We will draw from the best of our existing methodologies, adapting them to work within the environment we're in. We are clear that we will continue to inspect where we have concerns about care and will take action to protect people if necessary.

Due to the pandemic we cannot return to our fixed timetable or frequency rules and given the pressures on providers and the risk of spreading infection it is unlikely we will return to frequency-based inspections, albeit a consultation will be required to formalise a new, long term, approach. We have a balance to strike between making sure we hear people's experiences of care first hand and making an accurate assessment of quality while minimising infection control risks and not adding unnecessary pressure on the health and care system. Where we do carry out physical inspections, our action will be targeted and driven by the information we hold on a service and will focus on areas where we can't collect information by other means or on services where we need to visit more, for example in closed settings.

On-site inspections are a crucial tool and one we will continue to use. Alongside this we will continue to use and develop our monitoring tools, using the learning from our response to COVID-19 to develop the way that we regulate so can we support providers to provide the best possible care.

We are also planning to run pilots in adult social care and general practice – with our transitional approach as an umbrella for testing new ways of working that will inform our future strategy and approach. Both will be used to explore new ways of gathering evidence without physically crossing the threshold, done with the explicit consent of the provider.

Our general practice focused inspection pilot is designed to enable us to respond to risk. We will carry it out initially with approximately 30 services. The pilot will evaluate how developments in digital technologies and working away from offices and locations can be used as part of regulatory approach for the benefit of CQC, providers and the public. It will test how we can gather information, including how we can directly access evidence such as clinical records.

In adult social care we are carrying out a pilot with approximately 60 home care services, testing different ways of engaging with providers, people who use services and staff through the use of phone or video calls, as a replacement for visits to location offices. The immediate focus through this work will be to consider if the service is safe and well-led. Through the pilot we will explore the instances in which we will be able to rate a service following this regulatory activity.

Upon completion of the pilot inspection activity in both sectors we will publish a short inspection report setting out that the work was carried out as part of a pilot.

How we'll rate providers and report on our findings

We know that our ratings and information about our assessments are key in giving a view of quality at a service. Following monitoring activity, using the streamlined set of KLOEs, if we are confident that our review indicates that the level of risk is low, and there aren't risks to people who use the service then we will take no further action and will let providers know this outcome. Over time our plan is to publish a short statement on the service's page on our website to let people know we have reviewed the service and are taking no further action. Before we do this, we first want to work with people who use services to ensure what we publish works for them. We will also share a short summary directly with the provider.

Where our monitoring activity does lead to us to need to formally inspect a service, we will use our existing methodologies for inspections, adapting to work with the environment we are in. This means across the sectors we regulate, we are still able to look at any or all of the KLOEs on inspection, ensuring people are receiving safe, high quality care. However, as our inspections will be more targeted and focused around areas of risk, we may not always cover all aspects of our five key questions and our KLOEs. As a result, our inspections may not always lead to a change in rating for a service.

We remain limited by the pandemic in our ability to carry out physical inspections. Our ability to re-rate services is also limited by our published methodologies for how we rate and report on services. Although we will be able to re-rate in a limited number of cases, how this will apply varies between the sectors we regulate.

What this means for how we regulate in the future

We are constrained by how far we can go due to the need to consult on aspects of how we regulate. As a result, a number of aspects of our transitional approach will provide invaluable learning for our next iterations, as well as how we want to regulate in the future. These include:

- Moving from on-site inspections being the focus of our assessment approach to one that makes greater use of monitoring and current intelligence to maintain an up to date view of quality in a service
- Better use of intelligence and data, including what we hear from people who use services, to guide our regulatory activity
- Piloting new ways of working on how we can gather information outside of physical inspections
- How we can move from an approach based on published inspection frequencies to one that is more dynamic and risk based
- The role strengthened relationship management can play
- Drawing a clearer link between our monitoring activity and what we look at on inspections.

We will continue to iterate our transitional regulatory approach in response to feedback from the public, providers and our partners. The questions and areas above will also provide further insight for areas we will want to explore as part of our conversations on our future strategy, building towards a formal consultation in January, and publication in May 2021.