NHS *RESET*
FOR THE FUTURE OF HEALTH AND CARE

NHSCONFEDERATION

LEAN, LIGHT AND AGILE GOVERNANCE AND REGULATION IN THE AFTERMATH OF COVID-19

August 2020

About NHS Reset

COVID-19 has changed the NHS and social care, precipitating rapid transformation at a time of immense pressure and personal and professional challenge. One message from leaders and clinicians across the UK has been clear: we must build on the progress made to chart a new course.

NHS Reset is an NHS Confederation campaign to help shape what the health and care system should look like in the aftermath of the pandemic.

Recognising the sacrifices and achievements of the COVID-19 period, it brings together NHS Confederation members and partners to look at how we rebuild local systems and reset the way we plan, commission and deliver health and care.

NHS Reset is part funded through sponsorship by Novartis Pharmaceuticals UK Limited.

Find out more at www.nhsconfed.org/NHSReset and join the conversation on social media using #NHSReset

About the NHS Confederation

The NHS Confederation is the membership body that brings together and speaks on behalf of organisations that plan, commission and provide NHS services in England, Northern Ireland and Wales. We represent hospitals, community and mental health providers, ambulance trusts, primary care networks, clinical commissioning groups and integrated care systems.

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Key points

- The last five months have empowered leadership teams across all sectors and the non-executive community to make dramatic changes to the way they operate. Virtual board meetings, clear lines of accountability, significant involvement with local resilience forums and leaner internal governance have sharpened and accelerated decision-making and radically altered NHS working cultures.

- The singular focus of COVID-19 and suspension of Care Quality Commission inspections and NHS England and NHS Improvement reporting afforded health leaders the space to transform at pace and provided a window into what could be achieved in future. The improved partnership working brought about by the pandemic built trust at speed and fostered a more constructive relationship with regulators, partners and commissioners. Our members are keen to maintain these lean and agile cultures so that they can continue to do what they do best without the hindrance of unnecessary oversight. But they will need national support and leadership from the top to secure this in future.

- The combination of the 2012 Health and Social Care Act and strategies described in the Five Year Forward View have left a confused national framework for regulation, assurance, reporting and performance management. Local leaders need simplicity and clarity of purpose to lead their teams effectively.

- There is an opportunity to align and integrate regulation and performance management better within NHS England and NHS Improvement (NHSEI) and across the health and care system. They are not separate functions, but two sides of the same coin. In particular, the introduction of a new NHSEI regional tier risks duplication of effort between NHSEI national programmes, local clinical commissioning group-led contract management and emerging forms of regional performance management and assurance. Efforts must be taken to ensure new tiers of organisation do not create more work that adds little to patient care.

- With legislative reform expected in 2021, health leaders want to move away from much of the existing health and care legislation that over-prescribes specific requirements and duties for commissioners, providers and regulators. Health leaders need the legislative culture and architecture to support partnership working and reduce unnecessary bureaucracy.

- The COVID-19 crisis has highlighted that the CQC regulatory model in place before the pandemic did not always reflect the NHS's ambitions towards integration and partnership working; NHS leaders welcomed the pared-back inspection regime introduced during the peak of the pandemic. Of course, safety is critical in healthcare and needs regulation and oversight. The call from our members is not to abolish regulation, but to reshape it to empower them to make progress for the benefit of patients.

- A new regulatory regime should explore a move to whole-system and pathway regulation inspection and reflect the NHS's move towards both integration and population health management. While assessment of providers in a systems context will always be required, the CQC is in a unique position to move beyond traditional organisational structures to support and drive this change. Providers and systems should be involved in co-designing with the CQC the appropriate way to inspect local health and care pathways.

- We welcome the Secretary of State's review of bureaucracy in the NHS and agree that the NHS can cut back on the bloated culture of reporting and reassurance that adds little to patient safety or care. The current regulatory and reassurance culture takes valuable time away from frontline managers and their teams, who are required to produce reports and data that simply "feed the reassurance beast". This is exacerbated by the lack of effective digital infrastructure for the NHS that could and should simplify much of this work.

Introduction

The COVID-19 crisis has required the NHS to operate differently. In days and weeks, our members – commissioners and providers across the healthcare sector – have transformed clinical practice on a scale that would ordinarily take several months and years.

Change happened at an extraordinary pace in every part of the health and care system, built from the bottom up by leaders who united around the shared challenges presented by the pandemic. This was facilitated, in no small part, by the removal of various bureaucratic stumbling blocks that have previously hindered progress, including in improving patient care.

As we move into the next phase of the pandemic and prepare for winter, healthcare leaders are keen to reflect on and learn from their experiences and develop a new and different regulatory environment. This report reflects the discussions, roundtables and webinars held with front line health leaders and partners, including the Care Quality Commission, since the start of the crisis, exploring the learning and what it means for a fundamental reset of governance and regulation in the NHS.

It tackles some of the burning questions of this period: how do we hold on to the lean, agile and transformative culture the NHS has developed during the pandemic as a result of reduced bureaucracy? What should governance and regulation look like in the future? And what changes do healthcare leaders want to see within organisations and the wider health and care system?

❚❚ We need to create the whole-system architecture and a national culture change that will allow these behaviours to flourish. For too long, innovation and change have been stifled, often by accident, by the lack of whole-system thinking in the way that we design and run the NHS.

NHS Leader

Opportunities and challenges

Throughout our engagement with members over this period, there has been a widely held view that many of the cultural changes adopted in the last five months can and should be carried forward. Leadership teams and the non-executive community across provider and commissioning organisations believe they have the power to make real and lasting change to the way they operate. But how can the sector hold on to the lean, agile and transformative culture the NHS has developed during the pandemic as a result of reduced bureaucracy?

Lighter and leaner governance

Leaders, especially those involved in NHS trust and CCG governing bodies, expressed a desire to carry their learning from the COVID-19 crisis forward to implement lighter and leaner governance models on a permanent basis. Meetings at board and executive level have made the switch to virtual easily and quickly. They have also taken place less often and been much shorter. This has sharpened focus and accelerated decision-making.

" We've created this monster where the exec team have to produce 500-page reports for us, which they hate – and we hate going through. We need lighter, more focused reporting. We need to stop feeding the beast.

NHS Trust Chair

Fewer committees

Members highlighted that before COVID-19 there were too many committees, described by one member as "reassurance masquerading as assurance" and a sense that the number could be cut back.

" We need a reduced number of committees and to drill down on what really makes patients safe and improves the quality of our service.

CCG Lay Member

Clear lines of sight and accountability

The creation of the emergency response hierarchy within trusts has meant that decisions could be made at pace. Clear, clean and simple lines of accountability enabled swift decision-making, with clinicians leading changes in working practice from the front line.

> **I'd ask for something and three hours later I'd have a decision and an approval. It's unprecedented.**
>
> NHS Trust Board Member

Governance rooted in communities

Leaders have said new models of governance that are stripped back, leaner and more focused must be genuinely based in, and informed by, the needs of communities. The COVID-19 crisis has cast into sharp focus the inequalities in health faced by local communities. Governance that walks the path of its local community is better placed to help develop and tailor local patient pathways for everyone.

> **You need to know your community and what their problems are and involve them, rather than just consult.**
>
> NHS Trust Board Member

Clinical leadership

Much of the transformation has been led and driven by clinicians. Without 'business as usual' services to deliver and the imperative to work at 100 per cent capacity, clinicians have had more space and time to think through change and enable transformation. This space to think must be retained, not only as the pandemic continues, but as normal service is restored. The level of transformation achieved would not have been possible without it. It is also important that clinicians leading change are appointed in the new 'whole system' context and that they have the confidence of the community. Care pathways that truly work for patients and service users are vital, and meaningful co-production is essential.

" For primary care networks (PCNs) to thrive, and for integrated provision to work effectively, leadership needs to be about listening, about being compassionate, and about empowering others to lead and to bring about the changes that they themselves want to see happen.

PCN Clinical Director

Partnership working, trust and assurance

Members have reported that the pandemic enabled services, stakeholders, providers and commissioners to collaborate better, and at pace. This closer working helped to build trust and a reduced need for checking and assurance. These new levels of trust should be built upon so that scarce resources can be used more effectively and unnecessary bureaucracy between commissioners and providers significantly reduced.

" Our relationships have changed. With partners, with regulators, with commissioners and all of our stakeholders.

CCG Clinical Chair

Resetting governance and regulation

Regulation and oversight are essential to good governance and accountability. Our 2013 report, Challenging Bureaucracy, highlighted the need to achieve the right balance of regulation and oversight so that providers, and commissioners, are not overwhelmed or distracted from patient care by requests for information and inspection. This is not a new issue, but the coronavirus pandemic has thrown this delicate balancing act into sharp focus. Seven years ago we wrote[1]:

> The national burden of bureaucracy is much bigger than originally thought – it's now crystal clear that we need to manage the burden better. While vast amounts of NHS data and information are relevant to patient care, the processes used to collect and record them are often outdated and concludes that those requesting data in the NHS must always be able to prove how that data will be used to support improvements in quality, safety and outcomes. It is only by sticking to these principles that we can truly lift the 'burden' of bureaucracy in the NHS.

What should governance and regulation look like in the future and what changes do healthcare leaders want to see within organisations and the wider health and care system? This section explores the steps needed to reset governance and regulation.

Creating architecture that supports lean and agile working

Leaders are clear that much of the work to change organisational culture comes from within their own organisations. They can own and lead this change, reducing unnecessary activity and focusing on where they can add real value, especially to patient care. But they

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1   NHS Confederation (2013), Challenging Bureaucracy
     www.nhsconfed.org/resources/2013/11/challenging-bureaucracy

also need help from the Secretary of State to design an external NHS environment that supports lean and agile working.

The role of clinical commissioning groups, NHSEI national and regional teams

Members said clinically-led commissioning is a core function if we are to pursue the Long Term Plan goal of a population health approach. This is different to the assurance role that many clinical commissioning groups (CCGs) have, which could be reviewed and, in some cases, reduced. Members said that the function of clinically-based commissioning is important, but that it often becomes confused with a culture of assurance and contract reporting that is less positive.

At the height of the COVID-19 crisis, several members reported that the relationship with NHSEI was constructive and that they were given the freedom to focus on delivering solutions. With the growing influence of NHSEI regional teams, we must ensure that performance management and assurance are not duplicated across CCG and national programme teams.

Focus on patient pathways, outcomes and partnership working to encourage collaboration

Members feel that shifting reporting and assurance away from an organisational focus to whole-patient pathways, or towards a whole-systems approach putting patients at the centre of an assurance framework, is the right way to secure many of the improvements in partnership working and collaboration that have been established during the crisis. CQC's work on local system reviews is a good start and this way of thinking should continue.

Finance

Leaders highlighted that the significantly reduced financial restrictions and policy amendments during the pandemic made change, transformation and improvement at pace much easier. Prior to the crisis, members had been working at full capacity for years and were posting financial deficits. The headspace created during the peak of the pandemic has enabled transformation that will, over time, create a leaner and more efficient system. It is difficult to plan for tomorrow if you do not have the resource to plan for today.

Reducing duplication and introducing a coherent national programme of regulation and assurance

Members told us they would like assurance to be scaled back, with more self-regulation. Regulators and commissioners would like to work together in a more coherent, consistent way to avoid duplicating effort, especially in light of the changing role of both commissioners and providers (and foundation trusts, in particular).

> Systems need to define their strategic objectives and regulators need to test that they are 'SMART', creating the data and reporting to really assess the vital few, rather than drown everyone in a thousand measures, many of which create little or no real value.

NHS Trust Board Member

But more than ever, our members want clarity. The current health and care system sits between the 2012 Act, which promotes competition, and a clear direction towards integration and whole-system working described by the Five Year Forward View – and further underpinned by the NHS Long Term Plan. This cannot continue. Time, energy and public money are wasted in this halfway house approach. Current regulatory, reporting and assurance functions are a good example of the confused architecture the NHS has to operate in.

Some of the assurance roles held by CCGs and NHSEI would need to be reconsidered within national frameworks, as well as those held by professional regulators (such as the General Medical Council and the Nursing and Midwifery Council), the safety regulators (such as the Health and Safety Executive) and the policy setters (including Public Health England and its successor, and the National Institute for Health and Care Excellence), which duplicate effort and contribute little to patient safety. NHS leaders support the continuation of a lean and agile healthcare service, with quality and safety designed and delivered by clinicians on the front line. Indeed, the improved partnership working brought about by the COVID-19 crisis has built trust, reduced the need for some assurance and fostered a more constructive relationship with regulators.

Resetting the role of the CQC

As part of the response to COVID-19, in March 2020 the CQC announced a pause to its routine inspections to support the health and care sector to prepare for the pandemic. This was followed by a change in its methodology, via the emergency support framework (ESF), to support the regulation of services.

The CQC announced in June 2020 it would resume inspections to high-risk services during the summer and for all other services from the autumn, using the ESF, with an increased focus on infection control measures.

Interim methodology during COVID-19

Several members welcomed the decision to pause CQC inspections during the peak of the pandemic. This allowed them to prioritise delivering care and keeping people safe, without worrying about preparing for an inspection. However, some expressed disappointment that planned inspections were put on hold, especially as they had spent time preparing, perhaps with the aim of improving their ratings. The only way ratings can be changed is through an inspection.

At the same time, the pause of inspections for adult social care (ASC) providers and the absence of safety and quality information during this period have been a particular concern for some, especially as a significant proportion of services the CQC regulates is from this sector (about 23,000 ASC services, from 32,000 services and providers the CQC inspects overall)[2]. This has been compounded by staffing issues in the sector, as well as family members not being able to visit relatives, removing the opportunity to raise issues about the quality and safety of services, if needed.

Some members reported positive relationship management between providers and CQC inspection teams during the pandemic, with regular conversations and updates on progress on the quality of services. Members would like this kind of engagement to continue beyond the pandemic. In particular, one member reported that updating draft inspection reports with their CQC inspection team in an iterative way was a better approach to updating information that was more reflective of their services. This is also something they would like to see become a feature of regulation.

Members feel it is important to find the right level of in-person inspection, particularly to avoid failures such as Winterbourne View or Whorlton Hall. They also want relationship management to be used more effectively with regular virtual meetings, as a way to continue monitoring services, as well as using intelligence and data to determine risk.

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2   Care Quality Commission (2019), The State of Health Care and Adult Social Care in England 2018/19 www.cqc.org.uk/sites/default/files/20191015b_stateofcare1819_fullreport.pdf

Moving towards systems regulation

The current regulatory processes assess at provider level, with inspections at core service level for NHS trusts and independent hospitals (population groups for GP practices). There was a strong message from members that the CQC should move to system- and pathway-based regulation, to reflect the changing health and care landscape. In particular, the pandemic has demonstrated the integrated and collaborative way of working among services, focusing more on pathways of care and population management that can expand beyond traditional organisational structures. CQC's work in this area is a good start and gives us solid foundations to build on.

The CQC is in a unique position to comment on the quality of services across both health and social care. This change to looking at regulation at system level should also emphasise looking at culture and leadership as part of the assessment process, with members saying that these aspects of regulation have a significant impact on the ability to integrate, transform and build patient-centred services.

When designing the whole-pathway approach to regulation, the CQC should still be mindful that there must be an assessment of how individual providers are operating. It should also avoid the assumption that all systems operate in the same way or that all areas have the same level of maturity; there might be a different definition of systems, depending on geography and other local complexities. Providers and systems should be involved in co-designing the appropriate way to inspect local health and care pathways and configurations.

" Recognise that not all services will fit into a standard model and assess them accordingly.

ICS Chair

Reducing the burden on providers

The CQC's self-described "right-touch" approach to regulation during the pandemic and a focus on relationship management and engagement have meant that staff have spent less time on paperwork. This has allowed providers to spend more time on caring for patients.

Our members would now like to see a reduction in paperwork for regulation purposes, as this takes them away from service delivery. Instead, they should be allowed to produce only the reporting that is absolutely necessary and concentrate on developing a culture of openness and transparency to enable better relationships and engagement with the regulator. This is in line with the CQC's current strategic direction of moving towards a risk-based, intelligence-driven approach.

Members told us that they would like to see a continuation of lighter-touch regulation, with less bureaucracy, aligned to quality outcomes and place-based working. Having a light-touch process working in genuine partnership with regulators during the COVID-19 crisis has enabled staff to concentrate on delivery and helped make fast and effective change.

Peer reviews and sharing best practice

Members have expressed that they would like to see regulation move away from tick-box exercises with the potential for punitive measures, and towards sharing best practice and improvement. They would also like inspection teams to listen more to junior staff members, as well as patients, their families and carers.

To recognise the importance of providers taking accountability and responsibility for making improvements in the equality, diversity and inclusion (EDI) space, it was also suggested that providers should not be awarded outstanding ratings unless they had been able to demonstrate that they were meeting health inequalities and EDI requirements.

Improving regulation, not preventing it

In this context, it is important that the language used focuses on how regulation can be improved, not prevented. Patient-led organisations have said they are open to discussing this.

More needs to be done (and be required by the regulator) in determining and informing communities on the best way to access services. We build pathways and often fail to adequately share how best to gain access and what the preferred and most efficient routes in and out of services are. The system and CQC will need to pay more attention to this. This definition of a system's 'access landscape' should form part of whether a system is truly well-led and can be considered 'outstanding'.

Recommendations

When setting out a future vision of healthcare, the Secretary of State was right to make a call to cut back a bloated culture of reporting and reassurance that adds little to patient safety or care. This is something our members have already called for. The last five months have presented a unique opportunity. They have provided the foundations on which a great deal can be built if we empower leadership teams and non-executive leaders to innovate, transform and engage. The next five months will be critical in realising this promise from the Department of Health and Social Care, and the Secretary of State must lead the charge.

Of course, safety is critical in healthcare and needs regulation and oversight. The call from our members is not to abolish regulation, but to reshape it to empower them to improve services for patients. If there is a silver lining to the events of the COVID-19 period it is that reducing unnecessary red tape has the potential to make us all safer. Duplicating reporting arrangements and targets not only stifles innovation, it provides false reassurance.

The next five months present a limited opportunity to heed the lessons of the pandemic, and there are signs that this is beginning to happen. Our work in 2013 hints at some of the issues that need to address and is relevant still.[3] The CQC is about to embark on an inspection regime consultation and has rightly recognised the need to recalibrate to achieve what it has termed "right-touch" regulation. Furthermore, a consultation on busting bureaucracy has been launched by the Department of Health and Social Care following the Secretary of State's speech on 30 July.

In 2013, we set out what actions should be taken to free the NHS from unnecessary bureaucracy and will work with members on this latest consultation. Many of the issues we have raised then are just as relevant today.

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3   NHS Confederation (2013), Challenging Bureaucracy
     www.nhsconfed.org/resources/2013/11/challenging-bureaucracy

Further updates will be issued to the NHS as it navigates the continuing COVID-19 crisis alongside the usual winter pressures. The Treasury has signalled the need for the Comprehensive Spending Review to prioritise new ways of working and adopt smarter cultures, and the Prime Minister has promised to "build the NHS back better".

Regulation and good governance are not opaque administrative structures far removed from clinical outcomes; they are the very foundations on which the NHS is built. It is vital that when the government and regulators consult during this period they listen to and embed the desire of health leaders to create a lean, agile, patient-focused regulatory framework for the NHS. One that is rooted in the needs of communities and allows leaders to lead. Given that the NHS will have to ramp up elective activity while still operating both COVID-19 and routine services as a potentially difficult winter looms, time is short to embed these changes and the opportunity could be lost at any moment.

A number of immediate steps are required to ensure the NHS has the headspace to get back on track. Health leaders cannot plan for tomorrow if they do not have the resource to plan for today. To do this, they need:

- **The CQC to continue a programme of "light touch or right touch" working and the suspension of routine inspections while it recalibrates its approach, in consultation with health leaders and patient groups**. The CQC made the right call to suspend routine inspections at the onset of the COVID-19 pandemic, but the challenges ahead in dealing with the ongoing crisis, a backlog of care, winter pressures including flu, and staff burnout mean we simply cannot afford for the old inspection regime to recommence until after winter and lessons learned have been fully followed through.

- All NHS organisations are looking to cope with the significant capacity implications of restoring services in line with the phase three letter and looking ahead to winter 2020/21. **Any further changes to reporting instructions, performance measures and**

targets that increase the burden on health leaders need to be frozen and expectations managed on what can be realistically achieved. It is understandable that the move to the third phase of the NHS's response to COVID-19 sought to tackle a mounting backlog of care, but the reporting requirements and target ambitions suggested a desire to go back to how things were without reflecting the benefits of letting local leaders lead and highlighted this learning still needs to be acted upon.

• To embed the transformation brought about by the pandemic, our members are keen to take on some of the responsibility for change themselves. They are keen to **encourage leaner and lighter governance structures,** with fewer committees, shorter and simpler board reporting, which look forward and plan for the future, and spend less time assuring and looking backwards.

• **Building governance that is better rooted in the communities we serve**. Our members emphasised that feedback mechanisms should be built into governance structures; our culture of engagement and consultation could be replaced with a more direct and open relationship with communities and leaders who are representative of and more strongly embedded in their communities. We need insight into the issues communities are really facing to understand them better.

Much of the change is required at national level. To hold onto this culture change, our members want national bodies to:

• **Align and integrate regulation and performance management**. Duplication needs to be reduced at NHSEI regional level in the short term and a review is needed of performance and assurance roles of CCGs, NHSE/I regional teams and professional and safety regulators to streamline reporting arrangements.

• **National bodies must work in partnership to create a whole-system architecture** for governance, performance management and regulation that is clear, simple and does not duplicate functions. There is too much overlap at the moment.

- **Reset the regulatory architecture towards system working and integration**. The CQC and others will struggle to recalibrate the inspection regime towards systems without legislation to reflect the new health and care landscape. If we are serious about moving to a population health approach and addressing health inequalities then this is a key part of the puzzle.

- **Regulation co-design and engagement**. Providers, patients and systems should be involved in co-designing the new inspection regime with the CQC.

- **Continuing relationship management**. The positive relationship management built up between providers and the CQC inspection teams during the pandemic needs to continue through more iterative processes and less inspecting.

- **Paperwork should be cut and intelligence increased**. Virtual meetings should be the first port of call, with increased intelligence and data to determine a reduced inspection pattern. Reporting requirements should be reduced to what is absolutely necessary.

- **Proportionate and risk-based regulation**. Our members accept the need for regulation and accountability, but if we fail to build on the light and agile governance and regulatory structure of the pandemic, we will fail patients. Ultimately, a regulatory system which discourages not fosters transformation does nothing for patient safety.

- **Maximise the integration of digital technology through increased funding**. The government's current commitment of £4.7 billion in the Digital Transformation Portfolio is not sufficient to transform services, which, if achieved, would simplify governance and regulatory work. Digital inspection methods should be increasingly used. The bureaucracy burden on frontline managers and their teams will not be eased until we have effective digital infrastructure. The government needs to take ownership of this.

It is unfortunate that it often takes a catastrophe for a spotlight to be shone on regulation and governance. The spotlight that came from the greatest challenge the NHS has faced in its history will gutter and fade over the next few months if we fail to make the most of it by transforming governance, reporting and the regulatory system.

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