Response from the
Institute of Biomedical Science

The Institute of Biomedical Science (IBMS) is the UK professional body for biomedical science. It represents approximately 20,000 members employed mainly in NHS pathology laboratories, NHS Blood and Transplant, Public Health services, private laboratories, research, industry and higher education. Biomedical scientists are regulated by statute with the Health and Care Professions Council and most work in laboratories that have Clinical Pathology Accreditation UK accreditation, or are accredited to ISO 15189 standards and whose services may also be regulated by the Human Tissue Authority and/or the Medicines and Healthcare Products Regulatory Agency. The IBMS welcome the opportunity to input to this consultation.

1a Do you agree with **the vision** we have set out for regulation of the quality of health and adult social care services in 2021? (see pages 6-11)

Strongly agree Agree Disagree Strongly disagree

1b what do you agree with, or not agree with, about the vision?

The IBMS supports the key messages of the vision, particularly in respect of reducing duplication of inspections by multiple national/professional bodies.

Our concern would be that the statement 'encouraging improvement' of quality should be reviewed and the inspections should be looking for 'continual improvement' to move away from the minimum benchmark mind set where 'this will do' until informed otherwise.

The consultation document does not provide detail about resources to be made available to providers to deliver appropriate services.

2a Do you agree with our proposal to **make greater use of data and information** to better guide us in how we identify risk, and how we register and inspect services? (see pages 14-16)

Strongly agree Agree Disagree Strongly disagree

2b What do you agree with, or not agree with, about greater use of data and information?

The IBMS agrees with the proposal to make increased use of data and sharing data with partner organisations. However, there would need to be measures in place to ensure the consistency of non-numeric data gathering and interpretation.

The targeting of 'potentially' poor services (i.e. increased rates of inspection) is an interesting idea. However, the reduction of inspections at better performing organisations must be counterbalanced with the potential for unannounced visits to all organisations to prevent stagnation in performance until the build up to an announced inspection. The use of unannounced visits should not be restricted to when there are concerns over the quality of care.

3a Do you agree with our proposal for implementing a **single shared view of quality?**
(see pages 17-19)

Strongly agree Agree Disagree Strongly disagree

3b What do you agree with, or not agree with, about a single shared view of quality?

The IBMS agrees with the notion of having a shared quality goal and aligning organisational quality standards against shared criteria to allow for comparison of care. There are three concerns with this:

- *Submitting evidence of compliance to the CQC quality goals must not be a substitute for frequent onsite, independent, inspections. This is crucial as targets/quality goals will not pick up all failings in every organisation.*

- *There may be a requirement to have shared 'headline' quality goals and then specific sub-speciality goals to allow for robust analysis of care in the diverse number of organisational settings assessed by the CQC (e.g. hospitals compared to a dental surgery).*

- *We have concern about the mechanism for holding a system to account where multiple agencies are involved.*

4a Do you agree with our proposal for **targeting and tailoring our inspection activity**, including reducing the frequency of some inspections so we target our resources on the greatest risk?
(see pages 19-21)

Strongly agree Agree Disagree Strongly disagree

4b What do you agree with, or not agree with, about targeting and tailoring our inspection activity?

The targeting and tailoring of inspections is a better use of finite resources. This would be complemented by intelligence sharing and memorandums of understanding with other regulatory providers. This should be used to mean that inspections to complex organisations

would mean that only specific areas would require CQC inspection if other areas (e.g. pathology) were fully compliant with their respective regulatory body.

However, the reduction of inspections at better performing organisations must be counterbalanced with the potential for unannounced visits to all organisations to prevent stagnation in performance until the build up to an announced inspection. The use of unannounced visits should not be restricted to when there are concerns over the quality of care to prevent missing organisations where there is a rapid deterioration in a short time period.

5a Do you agree with our proposal for a more **flexible approach to registration?** (see pages 22-23)

Strongly agree Agree Disagree Strongly disagree

5b What do you agree with, or not agree with, about a more flexible approach to registration?

As long as there is a robust risk stratification process in place this should mitigate the ability for an unsafe service to become registered. The creation of innovative service delivery models should be strongly encouraged and not prevented through the fear of not meeting a rigid CQC registration procedure. However, the unilateral quality standards required by the CQC must not be compromised as this will risk reducing confidence in the CQC from all stakeholders.

6a Do you agree with our proposal for **assessing quality for populations and across local areas?**
(see pages 25-27)

Strongly agree Agree Disagree Strongly disagree

6b What do you agree with, or not agree with, about assessing quality for populations and across local areas?

This will contribute to the NHS strategy of providing joined up care and services. It is possible that analysis of how organisations interact with each other may highlight cost savings and improvements in care. This could be particularly useful in reducing duplication of services (e.g. using diagnostics in a primary care setting and unnecessarily repeating in the secondary care setting).

7 What impact do you think our proposals will have on **equality and human rights?** (see our *Draft equality and human rights impact analysis* at: www.cqc.org. uk/2016strategyconsultation)

There is a risk that the 'Assessing how well hospitals use resources' work stream could result in rural health economies being disadvantaged if they are being compared to urban health economies, where services can be more easily shared over relatively small geographical locations. This could disadvantage the elderly and vulnerable in these rural catchment areas

if rationalisation etc. of service delivery is implemented in these areas using a model developed in an urban environment.

8 Are there **any other points** that you want to make about any of the proposals in this document?

Although not directly related to this document areas of organisations that are already very quality driven (e.g. pathology services) could be utilised as 'case studies' to show how quality regulation (particularly the shared view of quality) has improved standards within the services. Furthermore, these areas are a useful reservoir of knowledge within an organisation on how to implement effective quality management systems.