Regulating, Inspecting and Rating Health and Social Care Services – Residential Care

A consultation by CQC

A response from Care England

1 Introduction

1.1 Care England is the leading representative body for community care in England. Our members provide a wide range of services for adults with care and support needs including residential and nursing settings, homecare, housing and community-based support. Our members also deliver specialist care home services such as rehabilitation, respite, palliative care and mental health services.

1.2 We are grateful for the opportunity to comment on CQC's proposals on the shape regulation will take in the near future. Before responding to the consultation questions we take the opportunity to make some general comments.

1.3 We are concerned by the tight time frame that has been allotted for the consultation. We are aware that the Commission has a particularly heavy workload as new legislation is enacted, new regulatory models developed and new work practices introduced; however, we believe the priority should not be to meet largely arbitrary deadlines but to get the end product right. Doing so will require ensuring that the widest possible range of interested parties are given sufficient time to subject these complex proposals to rigorous examination and give their considered responses. In light of the density of the material presented in the lengthy documents, it is our view that a two-month consultation period is inadequate. It has not allowed providers to get a wider staff view and is on top of numerous other consultation processes underway around the Care Act.

1.4 We want to acknowledge CQC's refreshing involvement of stakeholder representatives in preparing for the new working models. We would make one note of caution however in that the term 'co-production' suggests a relationship of equals in which each of the participants is actively involved in, and jointly responsible for, the creation of the end product. That is not the case – indeed, given the Commission's statutory position, it cannot be the case.

1.5 We welcome our involvement in the consultative process and as members of the CQC Co Production Group for social care but our membership, as CQC will understand, is not endorsement as we must work with members on any final response to consultation documents.

1.6 While we understand the inevitability of a piece-meal approach to consultation in the current circumstances, we nevertheless regret that no attention appears to have been paid to the need

to arrange the publication of consultation documents in sequence to enable respondents to set each piece of subject matter in context. For example, our response to the DH consultation on fundamental standards (February 2014) suffered in the absence of supporting detail that CQC guidance would have provided. It would have been helpful had the draft regulations been published for consultation contemporaneously with the guidance – in the same way that explanatory notes are attached to draft legislation. This response has been similarly hampered by the absence of that guidance because, when considering the characteristics for each key question – in particular, for 'inadequate' and 'requires improvement' – we have lacked the fundamental baseline on which to anchor our assessments.

1.7 Much of what is proposed is a reworking of past methodologies and we hope that lessons from these previous ways of working will be built into the current proposals to drive improvement for people and ensuring a straightforward, proportionate and responsive system of regulation for providers.

1.8 We believe that the approach to "quality" that is implicit in the context of quality ratings, in particular the relationship with compliance with fundamental standards will need very clear explanation. As set out fundamental standards are at a level below which care should never fall. We believe therefore that residents and families will see this as a set of absolutes, set apart, and as such difficult to qualify in any way – neither lower nor, significantly higher. For example, is a service either safe or not? As set out in relation to the quality ratings, it could be less safe, safer or safest ie varying degrees of compliance. On the other hand, we expect people will see "quality" in terms of value added to the level set by the fundamental standards.

1.9 It is not clear how the characteristics will be applied in the formulation of a rating. It is said that "they are not an exhaustive list' and that "not every characteristic has to be present for the corresponding rating to be given". These statements beg the questions: is there a minimum number of characteristics that have to be present to justify the corresponding rating? And will other, informal – unpublished – characteristics be taken into consideration? We would appreciate clarification.

1.10 We are disappointed at the absence from the characteristics of what might be called quality of life factors. Some quality of life measures are subsumed into the others, particularly the 'effectiveness' measure but maybe a separate measure should be considered. A good quality care environment can be defined in many ways. For example, in residential social care settings the size of rooms, range of amenities and the quality of their upkeep are especially important for the wellbeing of residents." To which they might have added other examples, like accommodating individual preferences on food and drink. We believe the importance of such factors should be reflected explicitly in the characteristics of 'good' and 'outstanding'.

1.11 Providers need to be absolutely clear how the time-tabling for reports and ratings – from inspection through to publication of the final report – will accommodate the various challenges that they can mount together with attendant resolution procedures. There is no such clarity in the consultation document. We suggest that the substantive version of the handbook should contain this information – perhaps by way of a flowchart – with relevant time scales appended. In which respect, for the avoidance of doubt, we would welcome clarification on whether the published "report" that is referred to on page 39, second paragraph, under the section "Request for rating review" is the final or the draft report.

1.12 We would welcome hearing more about CQC plans for ensuring it has the staff and experts by experience necessary to undertake the ambitious programme of reform set out in this consultation document. In addition, the training and supervision of inspectors, including the experts by experience will be critical in ensuring a consistent and credible inspection

regime. The efficacy of the training academy will therefore play a key role and providers will be pleased to contribute to the training programme design and delivery within the Academy and Care England would be happy to explore this further with CQC.

1.13 We would hope that the ratings will be seen as a positive way forward by local authority and NHS commissioners, to ensure that they are seen as an independent source of information on quality and thereby prevent LAs/CCGs undertaking duplicate quality monitoring systems. Commissioners should be ensuring that individuals for whom they pay are receiving the outcomes set out in their care plan and not 'inspecting' whole services along the same remit as CQC. A CQC remit that is now being broadened out to assess both compliance with regulations and value added care with an attached quality rating thus, we believe, ensuring the burden of duplicate regulation on the provider can be reduced.

1.14 In support of the point above providers report that the current CQC Inspectorate process is fair and clear but that the Local Authority (LA) in many incidences appeared to undermine the Inspection process and had been able to recall and request re-inspection after the event. There is also evidence of lack of consistency across the 152 local safeguarding authorities which is problematic for providers and, even more so, contradicts the CQC process which therefore then undermines the value of the inspection. This is very unhelpful, particularly for potential new residents or their relatives looking for homes and appropriate providers.

1.15 The question under Section 4, Intelligent Monitoring, is missing from the enumerated list collated in Appendix 3 of the Overview to the provider handbook for adult social care. We have included it below at 2.6A.

1.16 Detail would be required to understand if and how the ratings would change once a non-compliance /action was inspected and found to be compliant. Some members expressed concern at a possible priority/preference being given to re-inspections if the provider were paying and that this could disadvantage the less affluent providers, thereby increasing the time that these homes could be listed on the CQC website as poor quality.

2 Consultation questions

Key lines of enquiry

2.1 Do you feel confident that the key lines of enquiry and the prompts will help our inspectors to judge how safe, effective, caring, responsive and well-led residential care services are? Is there anything we are missing?

2.1.1 We believe the KLOEs *can* help inspectors make appropriate judgements, but the quality and consistency of their application gives us cause for concern.

2.1.2 Providers are concerned as to the current lack of data to support the reports which are brief, and do not, when there is a negative outcome, assist with an improvement process, with the ability to record, be re-inspected and move on quickly.

2.1.3 Providers want to see customer feedback influencing and/or be part of the Inspectorate process; in that all recent compliments, comments and complaints should be reviewed and also what the service provider has done in response to the latter. Have they responded, introduced change, acknowledged the concern and justified the position? The inspection should reflect that they have sought to review the balance of compliments and complaints, and residents' and relatives' views are also respected and considered.

2.1.4 There was support for the following key identified areas for inspection:

a) Induction
b) Staff training – mandatory and core training needs (both very different)
c) Evidence of competency
d) Staff support and supervision
e) Incidents/Accidents – evidence of follow-up actions taken

There was also some, but not universal support, for national guidance on numbers of staff per resident, with specific reference to:

a) Residential
b) Residential Dementia
c) Residential Nursing
d) Residential Dementia with Nursing etc.

2.2 Do you think that inspecting against the mandatory key lines of enquiry, plus additional ones, selected on the basis of what our intelligence tells us, will enable us to make credible and comparable judgements about services?

2.2.1 The Manchester Business School's evaluation report on CQC's new acute hospital regulatory model has suggested that there is considerable scope for inconsistency. For example, their research detected that "domains and grade descriptors were interpreted differently within and across inspection teams". We see no good reason why this should not be repeated by inspection teams in adult social care.

2.2.2 There is clear potential for variability of outcomes in the discretion given to inspectors to draw on KLOEs additional to the mandatory set – which itself is cited as a means of ensuring consistency and "vital for reaching a credible rating that will allow comparison between services." CQC needs to be more explicit on how inspectors will choose the additional KLOEs for inspection beyond the mandatory KLOEs. Will this be based on some criteria?

2.2.3 The Commission pledges commitment to consistency through the application of certain key elements and gives an assurance that consistency of decision-making on ratings will be assessed through "our national quality assurance process." We are told that process will involve panels being set up to check consistency by examining a sample of rating judgements. We note, however, that there are no plans to include providers/providers' representatives on these panels. We believe that without their presence proceedings will be unbalanced and we urge the Commission to rectify that oversight.

2.2.4 The absence of detail on the quality control process begs a number of questions. Will it be exercised centrally, or regionally with central oversight? Will there be scope for an independent element of monitoring – independent of all interested parties, that is – to ensure equity and transparency? How, and how frequently, will the outcomes be shared with the regulated community? We look to the Commission to clarify.

2.2.5 Will the recent separate consultations on 'Duty of Candour and 'The Fit and proper persons Test' be in mandatory KLOEs?

2.3 We have described characteristics of good, outstanding, requires improvement and inadequate for each key question. Do you agree that these characteristics are what you would expect to see in:

2.3.1 **A good residential care service? If not, what are your suggestions for improvement?**

2.3.1.1 Fundamental standards of safety and quality have been created to act as a baseline "below which care should never fall" and yet it seems that compliance with fundamental standards has become the new 'good'. We believe that this could cause confusion for people and families as well as providers.

2.3.2 **An outstanding residential care service? If not, what are your suggestions for improvement?**

2.3.2.1 We see it as crucial that all key questions in composite ratings of 'outstanding' must also be rated as 'outstanding'. See also our later comments

2.3.3 **A residential care service that requires improvement? If not, what are your suggestions for improvement?**

2.3.3.1 See our later comments.

2.3.4 **An inadequate residential care service? If not, what are your suggestions for improvement?**

2.3.4.1 See our later comments

Monitoring the use of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards

2.4 How best do you think we can ensure that providers improve the way they conform with both the wider Mental Capacity Act and the Deprivation of Liberty Safeguards?

2.4.1 **Make sure we give sufficient weighting to this in our characteristics of good?**

2.4.1.1 That is undoubtedly a logical way to do so, where relevant.

2.4.2 **If providers do not meet the requirements of the MCA and the Deprivation of Liberty Safeguards, apply limiters (meaning a service could not be better than requires improvement) in a proportionate way to ratings at key question level?**

2.4.2.1 We are concerned that the reasoning underlying the proposed limiters may not be fully understood. It is essential that it must be understood by all relevant parties, and the interpretation of "proportionate" must be applied consistently.

2.4.3 **In other ways?**

2.4.3.1 While the recent briefing note from CQC on the Supreme Court ruling was helpful, it serves to underline the need for ongoing support for providers to help them understand the complexities and changes that will flow from any future adjudications.

Local relationships

We have described the key people and organisations we will work with and how we will do this.

2.5 Do you think that this approach is likely to be effective in supporting our work?

2.5.1 It is essential, in our view, that CQC establishes and maintains good, effective relationships not only with individual providers of all sizes but also with their representatives at both local and national levels. We would welcome an indication from the Commission as to how, in working with providers and local authorities, it intends to gather information on the quality of commissioning. Will it, for example, do so on a routine basis – as we believe should be the case? If not, with what regularity? And we would welcome an assurance that: (1) experts in

commissioning will be recruited and deployed for that specific purpose; and (2) in that process, inspectors will draw on the intelligence held by the (local) care home community?

2.6 What other ways could we gather the views of all the people we need to hear from including seldom heard groups?

2.6.1 CQC must ensure that providers are not numbered among "seldom heard" people. Their presence is needed not only to provide perspective, complete the picture, as it were, but to avoid the emergence of a "them and us" approach.

Intelligent monitoring

2.6A How confident are you that the sources of information we plan to look at will identify risks of poor quality care and good practice?

2.6A.1 We reserve judgement on this till the system is in place. There must be sharing of information between agencies that ensures providers do not have to respond to duplicate information requests from CQC and other agencies. In respect to the information required from providers it is important to be proportionate and reflect on recent studies on the administrative burdens faced by providers such as the JRF report, *'Is excessive paperwork in care homes undermining care for older people'*. http://www.jrf.org.uk/sites/files/jrf/administration-care-homes-full_0.pdf

2.6A.2 If the frequency of inspections is to be determined by the current ratings, CQC needs to be more explicit about how it will 'intelligently monitor' to ensure that the ratings do not slip between inspections. The 10% random selection will help, but this needs to be publicly promoted to gain confidence that risk based frequencies are appropriate. CQC also need to ensure that transparent providers who openly share data with CQC are not disadvantaged / penalized. Finally how will CQC address / recognise the issue of failure of some providers to share the necessary data? .

Provider information return

2.7 Do you think the best time to request information from providers is:

2.7.1 **In the weeks before the inspection?**

2.7.1.1

2.7.2 **Annually**

2.7.2.1

2.7.3 **Annually but with the opportunity for providers to update at any time?**

2.7.3.1 It is very important that changes and improvements are fed through to CQC so that they can be acknowledged quickly and not take months for these to be recognized. The purpose of the PIR needs to be clearly explained as we believe providers will find the process time consuming and adding little value to the process

Judgements and ratings

2.8 Do you agree that the five questions are equally important and should be equally rated when reaching our overall rating for the service?

2.8.1 No, safety is paramount and it must be the key criterion for this purpose. In consequence, the overall rating should never be higher than that awarded for the safety question. In addition, wherever possible – and certainly in the case of the key question on responsiveness – the views of residents and/or their representatives should be the determining factor in the award of an overall rating of 'outstanding'.

2.9 Do you agree with the principles, guidelines and limiters for arriving at an overall rating? Is there anything else we should include?

2.9.1 We are anxious to acknowledge the problems inherent in the process of aggregation. We understand how difficult it is to design an aggregation system that is capable of reflecting the various, and perhaps conflicting, priorities of residents. Just as there is no such thing as an average individual, neither do they live their lives in the aggregate. As such an aggregate rating involves compromise that needs to be explicit.

2.9.2 In the event that CQC decides to proceed with composite ratings, we make the following observations about current proposals. The proposal that where two of the five key questions are rated as 'outstanding' the location also would "normally" qualify as 'outstanding' could significantly devalue the term. 'Outstanding' speaks of such exemplary quality, that it might seem odd if location ratings admit any key question ratings that are themselves less than 'outstanding'. And while it must be defined to be attainable, it is likely to be achieved by relatively few – thus increasing its desirability.

2.9.3 We believe the gap between 'good' and 'outstanding' to be too wide. Should our suggestion immediately above be accepted, it would widen still further. The gap could be bridged by an intermediate rating at both key question and location levels – say, 'very good'. At location level, this rating could be determined as follows: no fewer than two of the five key questions rated as 'outstanding' with the remainder rated no less than 'good'.

2.9.4 We also believe that the level of compliance with fundamental standards in 'inadequate' and 'requires improvement' is unclear. The label 'requires improvement is not satisfactory'; by definition, a service that is rated 'inadequate' requires improvement. People will want clarity on the system that makes it understandable. For example, how will a service be explained in which one or more elements are failing – in breach of regulations – but can be rated at a level that is higher than the bottom of the scale.

2.9.5 The 'requires improvement' category will cover a range between providers who are on the cusp of 'good' to those who are on the cusp of 'inadequate'. There will need to be a commitment to rapid re-inspection for those at either extreme of the spectrum.

2.9.6 As we see it, "requires" – an imperative, with associated implications of failure – is a most significant word. We suggest that, if 'inadequate' registers that the service is in breach of several regulations – and therefore failing/not compliant – the next level in the scale should be 'compliant', perhaps qualified by 'with scope for improvement' to achieve 'good' and better.

2.9.7 The use of the word "normally" throughout the principles gives the regulator enormous, undefined scope in determining overall location ratings. We would appreciate clarification, if only by example.

2.9.8 On limiters, the circumstances in which they will be applied are equally vague – "Inspectors will make *proportionate* judgements". Again, we would welcome clarification.

2.9.9 The final paragraph on page 36 foresees the possibility of the judgement "balancing" available evidence. This needs further explanation.

2.10 Do you agree the test of 'severity of harm' is the right test for our inspectors to apply when determining whether the key question should be rated requires improvement or inadequate?

2.10.1 This is undoubtedly correct. However, it involves yet another (unchallengeable) judgement.

Reporting and quality control

2.11 Are there ways in which we could promote learning between providers and services, particularly where we have identified outstanding care?

2.11.1 Imaginative use of the media would be one way in which learning might be spread and positive messages communicated to the wider public. We would be happy to collaborate with CQC to promote learning events and publications.

Ratings reviews

2.12 Do you agree with the grounds on which providers can challenge their inspection reports and ask for a review of their ratings? Do you feel confident that the proposed reviews process is sufficiently clear and robust?

2.12.1 Emphatically no on both counts. Having supported the regulator's move from a tick-box approach to one based on reasoned judgements, providers expect CQC to be willing to justify its judgements in the event of a dispute. The proposed process may indeed be clear and – from the Commission's perspective at least – robust, but it manifestly is not fair. We can have no confidence in such a process.

2.12.2 We are confused by the statement on page 38, preliminary to outlining the elements of the review process: "The following routes are open to providers to challenge our judgements." Clearly, this contradicts the position made explicit under "Request for a rating review" on pages 39 and 40.

2.12.3 As a matter of fact, the statement on page 38, second paragraph, under the section "Ratings review process', that "ratings are awarded on the basis of the evidence …" is incorrect. Ratings are awarded on the basis of *judgements* of the evidence. This not a minor difference and, in our view, it emphasizes the illegitimacy of excluding judgements from the grounds for review.

2.12.4 We are puzzled by the statement on page 39, under "Request for a rating review, first paragraph, that disagreements with judgements – under current proposals, which are disqualified for ratings review purposes – would have been dealt with through factual accuracy checks and warning notice representations. If this is the case, the factual accuracy process needs to be bolstered and have better criteria to allow providers to talk to CQC constructively about differences of opinion in judgment vs factual accuracies. Only by doing this will providers get a chance to have fair dialogue with CQC about views on their judgments versus factual accuracies. In such circumstances dialogue would be welcomed rather than simply filling in a form. It will make for a fairer system where the voice of the provider has an appropriate channel. While it may be that the outcomes of these processes will impact the rating, it will, as we understand it, only be the content of both documents that will be legitimate subjects of representations, not the judgements. Clarification and consistency is required.

2.12.5 As judgements, in one form or another, pervade the entire ratings system, we believe that grounds for appeal/review which are designed to deliberately exclude them are incomplete. Judgements are the central defining components of that system and the decision to avoid their exposure to scrutiny by engineering their exclusion, suggests something less than complete confidence in their credibility.

2.12.6 We are equally concerned by the absence of a provision for a direct appeal to an independent reviewer. The more so since the appeal regimes operated by Ofsted and the Advertising Standards Authority – both of which were said to have informed the CQC model – do have such arrangements. And, of course, appeals against regulatory judgements are heard by an independent body.

2.12.7 The proposal to set up an internal review panel under independent chairmanship – a fallback position from the proposal put to the Board in March – is unsatisfactory. As the Executive Team concluded in its proposal to the CQC Board for the appointment of wholly independent reviewers: "reviewing appeals within either CQC's executive or non-executive [carries] significant risks in terms of … the potential perception of a closed, self-serving arrangement". We agree: these reviews – with the consequences they are likely to have for providers' businesses – should not be conducted in house, with or without an "independent" chair.

2.12.8 In addition, we believe that appellants must be able to make their case in person, with legal representation should they require it.

2.12.9 In our view the outcome of appeals/reviews should be displayed prominently on the CQC website.

2.12.10 The Commission appears to have concluded that there is no better way of making their judgements defensible than by writing the grounds of appeal to ensure they don't actually have to be defended. Attaching the adjective "professional" is not sufficient; it needs to be justified. Judgements are the linchpins in the ratings system and we can state quite categorically that a process in which they are excluded from the grounds for review will not be seen as credible by providers, neither will the system command their support. Our legal advice is that such a process is likely to be ruled as unreasonable at judicial review. We urge the Commission to reconsider.

Equality and human rights

2.13 We want to know whether you agree with our approach to human rights. Please see our separate human rights approach document, in which we are asking a number of questions.

2.13.1 We agree.

2.14 We would also like your comments on our equality and human rights duties impact analysis

2.14.1 We have no comments.

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