English Community Care Association

THE NEXT PHASE:
CQC STRATEGY FOR 2013 TO 2016

A response from the English Community Care Association

1 Introduction

1.1 The English Community Care Association (ECCA) 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 its strategy for 2013 to 2016.

1.3 We are disappointed that the narrow definition of "improvement" – from unacceptable to acceptable – with which CQC intends to operate is not one that providers and the public will recognise as improvement. We do, however, recognise that it has been imposed by the Department of Health (DH)[1] as a means of ensuring that the regulator gives its undivided attention to protecting the health, safety and welfare of service users.

1.4 The definition springs from an interpretation of the 2008 Act's S2(2) and S3(2) – a reading which takes to mean that the regulator's *only* functions are those set out there. In turn it would follow that these functions give the *only* circumstances in which the Commission is to encourage the improvement of services. We prefer a more inclusive interpretation which understands the

[1] Public Accounts Committee report, The Care Quality Commission: Regulating the quality and safety of adult social care, March 2012, Ev 26, Una O'Brien answer to Q.201

reference to the performance of CQC's functions in a non-specific sense, analogous to the wording in Part I (Page 5) of the Care Standards Act 2000 which sets out the previous regulator's functions in general terms.

1.5 This interpretation (which has emerged suspiciously late, despite innumerable opportunities to articulate it earlier) would have us believe that the change from:

> *The Commission shall have the general duty of encouraging improvement in the quality of Part II services provided in England … [CSA 2000, S.7(2)] …*
>
> to
>
> *The Commission is to perform its functions for the general purpose of encouraging—(a) the improvement of health and social care services [HSCA 2008, S.3(2)]*

was an act of deliberate drafting to exclude the possibility of CQC taking a course of action to encourage improvement in the quality of services similar to that adopted by its predecessor organisation.

But there is no sense of that intention to be found in the proceedings of the Public Bill Committee for the then Health and Social Care Bill. In fact, the contrary was the case; there was particular concern expressed about the need to ensure continuity of the regulator's service improvement function as between the outgoing CSCI and the incoming CQC. Asked specifically about the survival of star ratings, which at the time were about to be introduced, the Minister gave the following assurance:

> *On the ratings question … the quality ratings that the CSCI does will be able to continue under the legislation, and we anticipate that they will. Again, that is not something that we are laying down the law about, but that is certainly our expectation.*[2]

1.6 In evidence to the Health Select Committee CQC chief executive David Behan refined the interpretation thus:

> *"… the 2008 Health and Social Care Act … says that our job is to measure whether people are meeting these essential … standards … Then it goes on to say that we will do that for the purpose of encouraging improvements in services. So the very legislation that created the CQC gives a function which is to encourage improvement in the way that services take place. Holding up the light*

[2] www.publications.parliament.uk/pa/cm200708/cmpublic/health/080110/pm/80110s01.htm, Column number: 125

to services and saying, 'This is how you compare to the standards that are set and this is where we issue warning notices,' is an indication of where services need to improve and, of course, if services do not improve, we will take further action."[3]

1.7 *This* presupposes a consequential relationship between measuring compliance against essential standards and encouraging service improvement, one that we do not see reflected in the legislation.

1.8 However, Mr Behan has stressed the importance within CQC's repertoire of responsibilities of promoting the health, safety and welfare of users of health and social care services for the general purpose of encouraging improvement.[4] We agree, and point, once more, to the regulator's earlier commitment, which appears to have slipped under the radar:

"In addition to the assurance about compliance with essential standards that registration will provide, we have an important function in promoting improvement by providing independent, reliable and timely information about the quality of care in providers above essential standards ..."[5]

1.9 The theme of driving improvement in the quality of health and adult social care services runs through the strategy proposals like a watermark. We believe this focus is admirable but we remain concerned about the restricted horizons within which the process of improvement is to take place: principally by regulating and monitoring services and taking necessary enforcement action.[6]

1.10 CQC promises to "identify and highlight what works well in the services we inspect … to motivate providers to continuously improve."[7] However, there is no indication of the benchmarks against which it will exercise such judgements – other than essential standards, and we would question how they could possibly motivate continuous improvement. In which respect we would draw attention to an internal CQC report which recently drew what we believe to be a telling distinction between the Commission's *regulatory* standards and NICE's *improvement* standards (our emphases).[8]

1.11 Following on from that, we would welcome clarification on how the intention to motive providers to continuously improve will be delivered. Will CQC inspectors draw attention to NICE's quality standards? As we understand them, these

[3] Health Select Committee, Annual Accountability Hearing with the Care Quality Commission, 11 September 2012, uncorrected transcript of evidence, answer to Q.5
[4] Health Select Committee transcript of evidence, op cit, answer to Q.139
[5] CQC, Guidance about compliance with essential standards, p.6
[6] CQC, The next phase: our consultation on our strategy for 2013 to 2016, p.5
[7] Ibid, p16
[8] CQC, Adult Care System Reforms – Implications for CQC, paper presented to September 2012 meeting of CQC Board, p.4

standards will be aspirational; they will not be independently verified, rather their adoption will be declared unilaterally by providers. So, for example, does the Commission intend to verify providers' audits of compliance?

1.12 We share the hope that the Commission's reports will provide the necessary momentum to improve how services are provided and commissioned – the "bow-wave effect"[9]. However many of these are located firmly in the context of compliance with essential standards and we believe more evidence is required to demonstrate that they can be described as a force for improvement.

1.13 In order to be registered and maintain registration, providers must meet essential standards, which have been described as a "bedrock from which improvement can be made towards the higher levels of practice and outcomes"[10] And yet CQC has defined its "vision of success" as being limited to "fewer providers dropping below the national standards of quality and safety, and where they do they are picked up quickly and improve."[11] We would ask if it is reasonable to expect people to accept that compliance with essential standards, or a return to compliance, represents improvement in the sense in which we believe providers and the public would understand, i.e. performance gains not at but beyond the basic, legally required level.

1.14 As such we would argue that "clarity" on the regulator's role and purpose for the public and others should be demonstrated by the Commission being explicit, beyond any possible doubt, on the parameters within which essential standards operate and from which improvements in service quality can reasonably be expected. It should make clear in particular that it lacks the leverage to drive improvements above essential standards. Further, we suggest that might best be demonstrated graphically by reproducing the illustration of the quality curve in the National Quality Board's recent report on quality[12], which places essential standards on the quality spectrum, on the line dividing substandard from adequate.

1.15 We have regularly expressed our concern as to who monitors local authority commissioner behaviour. We regret that the CQC has no official role in assessing commissioning but believe that CQC can, through its evidence from inspections of providers, seek to influence how well commissioning is undertaken. It is vital that all information and views are accounted for in improving commissioning for the benefit of individuals and, where care is inadequate and the causes can be traced to poor commissioning, the CQC needs to be quite clear in saying this. For example, where care is consistently

[9] Health Select Committee transcript, op cit, answer to Q.5
[10] Department of Health, Transparency in outcomes: a framework for adult social care, p.29
[11] The next phase, op cit, p.6
[12] National quality Board, Quality in the new health system: maintaining and improving quality from April 2013, p.14

poorer in one local authority area, CQC should publish its findings. It will then be the turn of the local authority to address its commissioning practice.

1.16 The Commission must understand that providers have become disenchanted by the regularity with which it has flip-flopped on policy – for example, from light-touch, risk-based regulation to annual inspections (and now apparently a return to the former in the shape of "differential" regulation); from star ratings to no quality recognition, then a brief interregnum for discussion of the ill-conceived excellence award before returning to zero again. What they need from the regulator is a commitment to a consistent direction that is firmly based on sound evidential grounds.

2 Consultation questions

Question 1

What are your views on us making greater use of information and evidence to guide us in regulating services, which may mean we regulate different services in different ways?

2.1.1 While we recognise that different ways of regulating different services could be legitimate we do not expect similar situations arising in different settings (for example around safeguarding) to be treated differently with respect to action and enforcement being taken by CQC to address the issues found.

2.1.2 The Winterbourne View serious case review concluded that hospitals for adults with learning disabilities and autism should be regarded as high-risk services that required "frequent, more thorough unannounced inspections, more probing criminal investigations and exacting safeguarding investigations."[13] We would expect the same values, the same rigour encapsulated by words like "thorough", "probing" and "exacting", to define all inspections. That, in our view, is non-negotiable. Nothing should be taken for granted in terms of assuming some settings/groups of people are more 'vulnerable' than others.

2.1.3 We absolutely support the general aim of using better data and evidence in regulating services. We expect that providers will remain engaged by CQC as this develops and that feedback is regularly sought on how the new ways of working are impacting in practice. We would expect the ability of providers to be

[13] http://hosted.southglos.gov.uk/wv/report.pdf, p.136

able to appeal and challenge how and what data has been used and for what purpose.

2.1.4 The importance of seeing a greater confidence in evidence based inspection cannot be emphasised enough when we consider the number of local authorities who have developed their own 'quasi' inspection teams to monitor provider services. These council inspections duplicate the role of CQC. Such local initiatives are often justified by councils who feel they cannot 'trust' CQC to inspect services adequately. We see no evidence that the resulting additional cost and resource burden to the system (providers and commissioners) is justified in terms of better outcomes for people receiving services in independent care settings.

Question 2

What are your views on our approach to managing our independence and working with our national strategic partners and other organisations? Does it strike the right balance?

2.2.1 We welcome the setting out of strategic relationships. In one area in particular we are not convinced the Commission will be able to manage its independence. We refer to the formal relationship with the DH, which is the defining one for CQC. Can the reference in the document to "an autonomous and devolved system, in which the Department of Health has a different and more strategic role"[14] really impact on the Commission's relationship with its sponsoring department? Rather, it feels as if the DH has direct control of CQC through the existing governance arrangements.

2.2.2 We would also point to the significant potential for conflicts of interest in the arrangement whereby CQC as regulator of the NHS reports to the same individual (in the person of the health secretary) who holds overall responsibility for the NHS. We believe that this arrangement compromises the operational independence of the Commission, and we have already suggested to the DH that the nature of the relationship between itself and CQC should be reviewed, considering whether the Commission ought to be reconstituted, for example, as a non-ministerial government department, like Ofsted, working at arm's length from health ministers and accountable directly to Parliament.

2.2.3 As to relationships with other organisations, we are satisfied with the approach, so far as it goes, but would want to see proof that it is working effectively in practice. We are, nevertheless, particularly concerned about the extent to which

[14] The next phase, op cit, p.16

the unquestioned dominance of the NHS in health and social care may come to be reflected in Monitor's relationship with the Commission.

2.2.4 We welcome in particular undertaking to work with partner organisations to avoid duplication and lighten the regulatory load carried by providers.

2.2.5 However, members fear that the additional burden they already bear as a result of CQC registration monitoring being duplicated by commissioners' contract compliance may be exacerbated further by Monitor's licensing regime, in all its aspects. There is a perception that this scheme is a flawed plan and a worry amongst members that Monitor's involvement may be both unnecessary and unhelpful in the delivery of quality front line services. In order to move the debate on we need to know more about what licence conditions would be imposed on social care registered providers commissioned to provide NHS care.

2.2.6 We would welcome an assurance that in the course of the "constructive relationships" that CQC means to build with local authorities and CCGs the Commission will make determined efforts to encourage these agencies to avoid the duplication referred to above. We must point out that such efforts to date have not been successful in this respect. In addition any system put in place around sharing of information should ensure that providers will know what information is being shared about them and the circumstances and framework for sharing.

2.2.7 We welcome the opportunity to discuss accreditation with relevant organisations to be used by CQC however this should not just be used to assess against essential standards but to also recognise that a provider has exceeded the standards required for accreditation and how this will contribute to determining frequency, price and intensity of inspections.

Question 3

What are your views on our approach to building better relationships with the public?

2.3.1 We are encouraged by the general approaches set out in the document. We certainly agree that CQC must raise its profile with the public. In addition we would repeat the point above that there is a need for transparency and openness so that providers know what data is being shared and have an opportunity to challenge inaccurate or misleading data.

2.3.2 We would urge the Commission to regularly review how this is working to ensure this genuinely reduces the regulatory burden in terms of provider resources to deal with data returns and administrative input.

Question 4

What are your views on our proposed approach to tackle complaints?

2.4.1 We agree about the confusion caused by the present arrangements and would support any efforts to resolve it.

Question 5

What are your views on whether our proposals will build respect and credibility among providers?

2.5.1 We support efforts being made to build respect and credibility which, as we have indicated already, have been severely damaged in the recent past. The strategy is very much part of a work in progress and we hope that it will have a positive impact on the views held by providers of CQC.

2.5.2 We welcome the proposal for inspectors to include in their reports what is working well at the service but we refer again to our preliminary comments on 'improvement' and clarity on what is possible in this respect. It is a positive development that CQC investing in training of inspectors with an emphasis on consistency of regulatory judgements. We would like CQC to publish how this aspect of their work is being monitored with any proposals to improve this.

Question 6

What are your views on our approach to strengthening how we meet our responsibilities on mental health and mental capacity?

2.6.1 Providers need clearer markers for what constitutes good MCA compatible care. CQC sometimes seems to give a range of perhaps incompatible messages, or vague messages to care providers. As a result inspectors need to be confident that they understand what MCA compliant care looks like in practice and how to identify it.

Question 7

What are your views on how we might most effectively measure our impact?

2.7.1 While we are generally encouraged by the Commission's commitment to an open culture, see our response to Question 5. It would have been helpful had the document enlarged upon the measures that are already being developed to measure impact. From our perspective, it is imperative that the Commission builds constructive relations with providers and their representatives at all levels, local as well as national, in order to tap into their views, ideas and comments and to hear what is being said.

2.7.2 In addition to the current KPIs for registration, compliance and enforcement, some further indicators of success could be:

- Guidance issued by CQC is easily accessible and effective - there are less calls to the CQC national contact centre for clarification (both for providers and people who use services)
- There are less complaints raised, particularly by corporate providers, about inspector inconsistency in the judgements they make and the application of the regulations
- Surveys (people who use services, provider feedback, CQC staff surveys) confirm that CQC listens and takes action as a result of feedback

Question 8

What are your views on our proposal to become a high-performing organisation? Are there other factors that we need to take into account?

2.8.1 While the aspiration is laudable, we suggest the Commission should concentrate, first, on establishing solid foundations. A high-performing organisation firstly makes clear what it wants to do and secondly achieves what it sets out to do.

Final

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