Care England response to Shaping the Future: CQC Consultation Document

1 Introduction

1.1 Care England is the leading representative body for independent care services 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 consultation on strategy for 2016-2021. Before answering the questions put in the consultation document, we make some general observations.

1.3. This strategy is purported to be a natural development, representing progress from the present strategy. It is to be delivered in the context of funding reduction, the implications of which a member of the House of Commons Public Accounts Committee summed up in this way:

> "What is essentially being said is that the CQC does not have enough money to do what it wants to do at the moment, let alone to make cuts as a result of a reduction to its grant in aid."[1]

1.4 In our view, however, resource limitations, far from being in the background of the strategy's drafting, have been very much in the foreground as one of the primary driving forces, alongside understaffing issues and failure to meet targets. The resultant re-balancing of regulatory priorities in the strategy is a compromise devised specifically to make savings, which we believe will be at the expense of effective regulation.

1.5 We are deeply concerned by the proposal, at the heart of the strategy, to (re)introduce a model – a risk-based approach to inspection – that has already been tried and found wanting. We question whether this strategy would have taken the shape it does had not CQC's resources been put under pressure.

[1] data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/public-accounts-committee/care-quality-commission/oral/23822.pdf, page 29

1.6 We protest at the manner in which CQC announced (for consultation) its fees for 2016/17 when this five-year strategy was still unpublished and plans to extend the scope of fee charging, though not yet fully developed, were imminent. By doing so it has, in effect, asked registered providers to buy blind what has now been revealed as a severely curtailed service. They are being asked to pay more for significantly less. That is not acceptable. We urge the regulator to reconsider its fee proposals in light of the new attenuated strategy.

1.7 CQC has claimed that the disconnect between publication of the strategy and fee proposals was "unavoidable"[2], due to a Department of Health deadline. We would remind the Commission that on at least two occasions it has been permitted to delay deadlines, after discussion with the Department of Health: its market oversight function, which should have been taken up in April 2015, was in fact deferred for six months; and its responsibility for assessing how NHS trusts use resources, scheduled to take effect in April 2016, will not be implemented until January 2017. It appears that deadlines – even those embedded in statute – are not inviolable. For the future, therefore, we would urge CQC to do as it would be done by – indeed, as it has already been done by – and ensure greater sensitivity in the timing of related consultations.

1.8 We recognise the utility of a structured questionnaire in the compilation of summary reports, but regret that CQC should have used methodology, which we would argue is better suited to an opinion poll, in this consultation. The object of the exercise is to give interested parties an opportunity to make informed comments, not to shepherd them into pre-determined answers, which have been drafted to facilitate the compilation of a summary. Comments are likely to be nuanced, with multiple shades of grey rather than simple black or white; the skill of the summariser lies in encapsulating these tones into an accurate representation of the views expressed. Some, perhaps many, people may feel compelled to mark a box – any box – and we fear that a summary assembled on the basis of the pre-defined answers alone could produce a misleading account. We would be most disappointed were that to happen.

For our part, we have declined to limit ourselves to the tick boxes in the "a" questions. We trust, nevertheless, that our responses will be taken fully into account in both decision making and reporting. We would urge CQC not to use this format for future consultations.

1.9 Finally, there is a typo on page 21, final bullet point: "information received *by* a provider" should read "*from* a provider".

2 Consultation questions

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?

In a period of retrenchment, there are significant respects in which this Strategy is overambitious. For a summary of our reservations see 1b below; greater detail is provided in our responses to subsequent questions.

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

The outline for the way forward over the next five years has much to commend it. However, we have been here before. We would be disappointed to find it compromised or under-delivered in yet another case of promise unfulfilled. This must also encompass getting good value for money from CQC not just for taxpayers but also providers, from whom the majority of CQC funding will be delivered over the next five years.

[2] www.cqc.org.uk/sites/default/files/20151102_cqc_fees_from_2016_consultation_final.pdf, page 9

The Commission has acknowledged that "many of the supporting systems and processes we use [in our existing model of regulation] are not yet efficient enough". The rectification of that unsatisfactory situation must be an urgent priority.

The Commission will not need to be reminded of the criticism it attracted in the most recent report from the Public Accounts Committee.[3] Suffice to say the fact that, at this advanced stage of CQC's development, they still include failures in the performance of basic functions is particularly disturbing.

The Commission has given an assurance that it will demonstrate, among other things, that it is "fair". In light of that, we urge it to take a fresh look at ratings reviews, in particular at grounds for review which appear to have been designed to defend inspectors' judgements rather than establish the truth of the matter. Although the system clearly "works" for the regulator – insofar as the severely restricted grounds for review effectively eliminate a multitude of prospective appeals – it is a system that, on any reasonable measure of fairness, must fail.

CQC has accepted that: "as an increasing proportion of our budget comes from the fees we charge services that are regulated by us … so we must demonstrate evidence of … value for money". We look forward to seeing that evidence.

We recognise that CQC has been directed by the health secretary to scrutinise the use of resources by NHS trusts – under an objective laid down in the 2008 Act to encourage "the efficient and effective use of resources in the provision of health and social care services". This consultation itself is ambiguous on the intended scope of such assessments – the parameter used is to "health and social care".

Elsewhere, in a document addressed specifically to NHS trusts[4], the Commission has said it has "no current plans for assessing use of resources in … adult social care providers (beyond our existing market oversight role)". It would have been helpful had the Commission made that explicit in this consultation. However, that statement still holds out the possibility that the regime will be extended to adult social care services, perhaps within the next five years. With that in mind we make the following comments.

David Behan has explained (in evidence to the Public Accounts Committee) that CQC would be focusing on "whether the trust is using the resources to add value to the quality and safety of care provided."[5] Should a similar value for money (VFM) test be considered in future for providers of adult social care, we would remind the Commission that, unlike the publicly-funded NHS, adult social care is funded by a mixture of private and public money.

In this consultation, CQC has spoken of plans to "focus on understanding what improves quality, including how resources are used", albeit apparently, for the time being, only in the context of the assessment of NHS trusts. We would emphasise that the "light" the regulator means to shine on NHS hospital provision can also be used to illuminate the persistent disparity in adult social care between the resources that are needed and what are actually made available – be that by central or local government, or for that matter by CCGs. (For the significance of the Commission's "independent voice" in this regard, see also under Q.8.)

3 www.publications.parliament.uk/pa/cm201516/cmselect/cmpubacc/501/501.pdf

4 www.cqc.org.uk/sites/default/files/20151028_delivering_cost_effective_care_in_the_NHS.pdf, page 6

5 data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/public-accounts-committee/care-quality-commission/oral/23822.pdf, page 14

As to the possibility of this function being extended into adult social care at some point, we question the wisdom of adding this task to its workload, in a period of ongoing financial constraint, when there are other, arguably more pressing, problems for the Commission to manage. For all that the objective was laid down in the 2008 statute, the fact that it was ignored by the regulator in respect of both health and social care until the health secretary's intervention, suggests it was regarded more as a diversion than a priority. That is a view with which we would concur. We look forward to learning precisely if, how and when, CQC means to proceed on this issue.

As a final word on the Commission's "vision", we would remind the Commission of what Andrea Sutcliffe wrote in one of her early blogs.[6] On the subject of leadership, she quoted Nelson Mandela as follows: "vision without action is merely day dreaming, but vision with action can change the world." We would commend that sentiment to CQC, laying particular emphasis on the need to take effective action in order to deliver on fundamentals. Overall, our view is that CQC should concentrate its efforts on delivering its core purpose.

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?

An evidence-based approach would be welcome – but see our qualifications below (2b) and also our comments at 4b.

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

No matter how sophisticated the data handling and analysis, we believe there are inherent problems with a risk-based approach to regulation. In particular, we question whether it is possible to develop a system that is sufficiently responsive to changing circumstances.

As a general principle, we recognise the degree to which the use of data can contribute positively to more efficient regulation and welcome this renewed thrust. However, we would underline the need for caution to be exercised to ensure that enhanced data gathering *does* not add to providers' existing burdens – and see our previous comments on duplication. Controlled data sharing with trusted partners could assist.

However, we would counsel CQC against over-reliance on this type of evidence. Constant vigilance will be required as not all data is reliable. Data can be distorted or even corrupted by many factors – prejudice and the simple passage of time are two that come readily to mind. In addition, we would welcome an assurance from the Commission that the reliability of data from other sources will be checked rigorously, particularly where the data is held by third parties. First-hand knowledge is always preferable.

Finally, since CQC has already acknowledged that existing data is "not yet robust enough", and that "many of the supporting systems and processes we use are not yet efficient enough", we would remind the Commission that there can be no assumptions on the score of reliability. And we will want to learn how CQC proposes to exercise rigour in its data usage.

3a Do you agree with our proposal for implementing a single shared view of quality?

We are attracted by the notion of a single shared view of quality. But we have reservations about some of CQC's proposals (see 3b).

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

[6] www.cqc.org.uk/content/leadership-and-values

On the subject of "co-regulation", we must remind CQC that, properly considered, the concept involves mutual trust in achieving agreed objectives. We do not believe co-regulation of care services with providers to be desirable, and it may be unlawful. In any case, we suggest that "collaboration" better describes what is aspired to. For the record, lest there be any doubt, Care England is implacably opposed to self-regulation – be it by providers or commissioners – whatever name it goes by. We believe it would have no public credibility whatever.

However, that would appear to be academic. CQC has signalled variously: "there continues to be a need for independent quality regulation"; "we would continue to inspect services to see for ourselves the quality of care being delivered"; "we would check … information against what we know and what others … are telling us about that provider". We agree.

In the name of a single, shared view of quality, CQC has proposed that providers should use its framework as the basis for internal monitoring of quality, the outcomes of which should then be communicated to the regulator. Providers telling "in their own words" sounds appealing, but would it (with its inevitable lack of consistency) be effective, we ask. More importantly, will it amount to anything other than information recorded to satisfy CQC rather than to improve the service?

We would remind CQC that, on whatever basis providers design their internal quality monitoring processes, they will "demonstrate" high quality by actually delivering it – performance that is there to be inspected by CQC – not by recording self-assessment outcomes.

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?

We are extremely concerned by these proposals. In our view, they represent an unacceptable dilution in the quality of regulation. We regret that we are unable to accept the Commission's assurances on the continuing effectiveness of its discharge of core statutory duties. For details see 4b.

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

On a positive note, we welcome CQC's commitment (yet again) to work with partners to "reduce the burden from duplication in data collection". We look forward to that finally becoming a reality but remain concerned that the needs of the ASC sector will again play second fiddle to the acute sector. The recent report from Lord Carter on aligning performance frameworks for the NHS acute sector to define 'one version of the truth', and the focus of CQC's own wording (pages 9, 17 and 19), imply that duplication will be examined in ASC after the issue has been addressed in the acute sector. ASC has had to deal with multiple monitoring via CQC, LAs and CCGs and now others such as Healthwatch for far too long. We have been raising these issues for over 10 years and previous promises to deliver a more aligned system that does not add burden to providers but instead adds value for people and providers has simply not happened.

Routinely inspecting all providers and targeting those that have been identified as higher risk are two sides of the same coin. In our view, both are essential activities if the Commission is to meet its statutory obligations.

However, we are anxious about the future prospects for comprehensive inspections once the first round is completed next year. We are concerned that they might not survive in their present form, either by design or as a by-product – perhaps an unintended by-product – should

the current tranche of proposals be implemented as drafted. We regret the absence of an unequivocal assurance that these inspections will remain in place in their present form.

Consider the implied threat to comprehensive inspections set out in BSF (page 20): "the potential for a more radical shift in the long term that would involve reducing some aspects of comprehensive provider assessment, once all services have been inspected". That section of BSF went on to say: "… [a place-based approach] could also lead to a corresponding reduction in information about individual providers meaning people might have less up-to-date information to help them choose services. The more we shift in this direction the more we will need to redirect resources away from our existing provider-based approach." This sort of generalised conjecture is not helpful.

There is little point repeating concerns expressed by respondents to the BSF consultation – for example, that comprehensive inspections should be kept in place, since "an outstanding service could rapidly deteriorate and a proactive inspection regime would be needed to pick this up" – without a clear statement of how the Commission means to proceed in that regard. It would be much easier for us to respond definitively to this and other points in the document if we didn't have to keep second-guessing CQC's intentions. We need CQC to spell out its intentions unambiguously.

Comprehensive inspections have an important dual role: supplying people with information that enables informed choice of providers and providing the security that comes from routine, rigorous inspections of service quality. Should they be weakened or, worse still, dismantled, many of the gains made since the inception of the system would be lost. We fear that what could amount to a wind-down of comprehensive inspections will seriously impair the ability of the Commission to discharge its statutory duties. More than that, it will also diminish – perhaps eliminate – the credibility of the entire process of regulation. How could service users reasonably be expected to welcome changes which could threaten their sense of security?

CQC must not underestimate the reassurance for residents provided by routine scrutiny. It is one thing for the Commission to react promptly (and properly) to potential deteriorations in care quality; something else to abandon routine, pro-active comprehensive inspections and rely entirely on intelligence-led inspection. We believe that doing so would represent an unacceptable risk. We urge the Commission to preserve its inspection complement and seek savings elsewhere.

Regarding the proposal to inspect "good" or "outstanding" services less frequently or less intensively than others, we would be very wary of assumptions that changes in such services could be picked up by other means to prevent a sudden downward change in service quality. It was also the previous 'risk based' inspections that lead to so much confusion and multiple approaches across LAs and CCGs to which ASC providers are still subject – a huge waste of public money that might have been better invested in a proper comprehensive and regular system of inspections for all providers.

We note, but are unable to accept, assurances that proposals which "are likely to reduce the frequency with which we inspect and the size of inspection teams overall … would not compromise the core aspects of our role that matter most to people … We will continue to perform the full range of our statutory duties in all the providers and services we regulate." In our view, these assurances, however genuinely given, are not realistic.

We would remind CQC of the priorities that were outlined in an interview given in 2011 by its then chief executive, Cynthia Bower, as she explained why the organisation had renounced a "risk-based, light-touch" approach to regulation:

> "Bower said that the CQC had favoured a 'proportionate, risk-based, light-touch' approach to regulation – in which services were left uninspected for up to two years in the absence of issues coming to light – but service users, providers and staff favoured more inspections.
>
> 'What people want, particularly people who use services, is for us to put our boots on the ground,' she said. 'Inspections are a really positive quality assurance for providers.'"[7]

We would argue that "what people want" now is no different to what it was five years ago. The path followed by comprehensive inspections represents one of the Commission's fundamental duties – targeting the risks to which service users might be vulnerable by way of routine scrutiny. This must continue to be the Commission's preeminent priority. To do so would be a betrayal of the people a national regulator was created to protect.

In evidence given to the Public Accounts Committee in October 2015, David Behan explained the single-minded stance he had taken to issues around staff recruitment:

> "… it was absolutely essential … that we raised the bar on the quality of the staff that we were recruiting. That is what we have done, and the consequence of that is that it became harder to recruit people. There was a trade-off here: do we hold a standard and recruit people to the standard, or do we go for a lesser standard? I have gone for holding the bar at the standard."[8]

We would urge him to be equally resolute on the "standard" of comprehensive inspections.

5a Do you agree with our proposal for a more flexible approach to registration?

We welcome the intention to "ensure a more positive registration experience". The proposal regarding changes to a head office location is eminently sensible, indeed, so self-evident that it should always have been the case. However, to the extent that "flexible" implies less rigour, we disagree (see 5b). See also comments made at 4b.

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

We have reservations about using a simplified procedure where providers have a "strong track records" and "evident expertise". The argument put in 4b about reputational vulnerability also applies here. Clearly, a good reputation needs to be well-established over time, but it can only be as good as its most recent scrutiny/rating – and then, much like a vehicle's MOT, as a snapshot of performance on that day, not a permanent guarantee.

We would echo the concern already expressed (in response to BSF) "that [risk assessment] could result in services falling through the net".

6a Do you agree with our proposal for assessing quality for populations and across local areas?

Considered in general terms, this is an admirable aim, but it must not be a priority in the present financial climate. Even then, we have a number of reservations (see 6b).

7 www.communitycare.co.uk/2011/07/15/cqc-to-double-inspections-of-adult-care-services/

8 Ibid, page 21

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

We are encouraged by the assurance that the current provider-based approach will "continue to be necessary." However, we are concerned by the implications of the statement (p.31): "The extent to which we can develop [place-based activities] will depend on our ability make savings elsewhere." That statement had been amplified earlier in BSF (page 20): "… [a place-based approach] could also lead to a corresponding reduction in information about individual providers meaning people might have less up-to-date information to help them choose services. The more we shift in this direction the more we will need to redirect resources away from our existing provider-based approach."

The prospect of reductions in information about providers and of resources for the maintenance of a provider-based approach is troubling. Innovation is commendable, but we fear the Commission might be running ahead of itself – and its resources – to the general detriment of effective regulation. We believe CQC needs to pause – the current period of retrenchment would appear to be a suitable occasion to do so – and consider precisely where its priorities lie, separating the essential from the desirable.

We would urge CQC to bear in mind that provider-based inspections generate much of the material upon which the foundations of place-based assessments are built. Provider-based and place-based approaches are not alternatives; they should work in tandem – but with the latter, only if/when resources permit.

We cannot envisage a whole-system approach (what is in effect being proposed) being successful without provision for formal review of commissioners' performance – within which providers must be a source of evidence. This is something the Commission might usefully promote with its "independent voice" (see also under 8 below).

In the changing landscape of health and social care, there will, apparently, be no one-size-fits-all solution for delivering services to meet the unique needs of people living in a given place. Commissioning responsibilities and structures of accountability are already becoming immensely complex and variable – for example, some "communities" will have combined (local) authorities, others formal relationships between the NHS and locally elected politicians – and different configurations of services are emerging.[9]

The Kings Fund has already questioned whether CQC (and other regulators) will have the capacity and resources needed to tailor its approach to such varied local circumstances.[10] We would ask how the results of a host of place-based assessments can usefully be integrated into a national whole? Can lessons be learned from comparisons of outcomes/ratings – which is being considered by CQC[11] – when they are the products of a wide range of different administrative structures?

We believe this area of activity is for another day. As valuable as it might be, it is not a priority at this time. However, as and when finances improve, we look forward to discussing CQC's proposals in more detail.

7 What impact do you think our proposals will have on equality and human rights?

We have no comments to make.

[9] www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/devolution-briefing-nov15.pdf, passim

[10] Ibid, page 13

[11] www.cqc.org.uk/sites/default/files/20160203_North%20Lincs%20main%20report_final.pdf

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

The Commission has already been alerted to the concern that "local authorities risk sacrificing quality in favour of policies designed to make financial savings" (page 12). Further, at the launch of the latest State of Care report, David Behan said he would alert government when he believed that a lack of funding to the social care sector was negatively impacting quality. Our members tell us that situation already exists. We ask, therefore, has he spoken out?

That we have to ask the question at all is a problem in itself. The Commission claims to "provide an independent voice on the state of health and adult social care in England on issues that matter to the public, providers and other stakeholders." We would prefer CQC to use its voice publicly; what is said in private will be unrecorded and therefore unverifiable. We need that independent – and authoritative – voice to speak truth to power. And to do so fearlessly.

We would urge CQC to use that voice also to emphasise the need for independent oversight of commissioners' performance, not just in place-based assessments but more generally, carried out on a routine basis.

We are concerned by the statement that "Our priority initially will be to continue to improve how we carry out our core role …" (page 28). We believe that this should always be CQC's priority, not just "initially". Finally, we would want to reinforce the views expressed in the final sentence of the text in the shaded box on page 28.

Care England

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For more information

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