Strengthening Corporate Accountability in Health and Social Care: Consultation on the Fit and Proper Person Regulations

A response from Care England

Introduction

1.1 Care England, a registered charity, is the leading representative body for independent care services in England. Our membership includes organisations of varying types and sizes, amongst them single care homes, small local groups, national providers and not-for-profit organisations and associations. Between them they provide a variety of services for older people and those with long term conditions, learning disabilities or mental health problems.

1.2 We welcome the opportunity to respond to this consultation. In his foreword to this consultation document, the Minister for Care and Support states that to restore confidence in the health and social care system, 'one of the things we need is a sharper focus on holding providers to account for failures in the care they deliver'. However, as the Minister says, this is just one of the things necessary and as a consequence, as well as focusing upon provision of care, we strongly believe that this Test should be applied to commissioners also.

1.3 Just as the new Chief Executive of NHS England noted when he said that the current model of partitioning bodies in the delivery of services doesn't 'make much sense', the same approach must be taken in terms of improving care services.[1] By recognising that corporate accountability has to change on the provider side but neglecting the impact that poor commissioning practice has upon the quality of services, the Government decreases the scope that this Test has to actually improve quality.

1.4 We consequently believe that these regulations should be applied to those who commission services, as well as those that oversee the provision of them and our case for the wider application of these regulations will be laid out in the responses to the consultation questions below.

Consultation Question One: Do you think the fit and proper person regulations at Annex C reflect the policy aims?

2.1 As stated, we understand the importance of ensuring corporate accountability following the inability for prosecutions to be brought against any board members of Castlebeck. However, if one of the aims of this amendment is to 'reduce the risks of poor quality care', we do not fully understand how a Fit and Proper Persons Test will contribute towards achieving this.

2.2 The complex ownership models that underpin the governance of many commercial organisations, including some across the care sector, may have the effect of making this Test

[1] Stevens, Simon, *First Speech as NHS England Chief Executive* (Tyneside, April 2014), http://www.england.nhs.uk/2014/04/01/simon-stevens-speech/

hard to apply. In addition to models in the private sector making the applicability of this Test difficult, consideration also has to be given to providers run by local authorities. Logically, the accountability for such organisations lies with elected councillors and just as these regulations make corporate boards within the independent sector accountable for the frontline performance of the services for which they have oversight, so councillors should be accountable for the services that their local authority has ownership of.

2.3 Such a test may also encourage risk aversion amongst provider organisations, which may have a negative impact upon quality. When making an appointment of a director, a board may dismiss an excellent candidate for fear that they are not fit and proper in accordance with the regulations – when they are– and instead opt for a perceived safer candidate. Such a move would decrease the potential that the board in question would have to perform one of their primary functions of driving up the quality of the frontline services that they are accountable for. Furthermore, in a climate of resource constraints and the increased competition that this brings, providers have to innovate in order to survive; if the fear of falling foul of an aspect of regulation discourages innovation through increased risk-aversion, it is not a stretch to say that as well as the Test having a negative impact on the quality of the board as an internal regulator of quality, it may also impact upon the sustainability of the care services in question.

2.4 The cost associated with this new regulation will also directly impact upon sustainability. Although we acknowledge that the direct costs in terms of both time and money are likely to be small for compliant providers, CQC's costs are not likely to be so. In the impact assessment, it is stated that the Fit and Proper Person Regulations are likely to form part of CQC inspections and in the same assessment, it is estimated that carrying out this aspect of an assessment will take approximately half an hour of an inspector's time, which if aggregated out amongst all inspections, would cost the regulator £500,000 per year in total. When one considers that this figure does not take into account the administrative costs for ensuring that every CQC registered service in the country has fit and proper people as directors; the legal costs that CQC (and providers) will face when taken to tribunal by dismissed directors who claim unfair dismissal; or the cost of factoring in the regulations into the registration of all new services; the cost to the regulator could end up becoming quite high. Considering that the aim is for CQC to reach full cost recovery from the providers that it regulates, an increase in expenditure on their behalf would result in a corresponding increase in the fees that providers have to pay the regulator. Considering that virtually all providers across social care have already been forced to make the maximum number of economies possible due to cuts in funding, an increase in CQC fees could be the difference to a provider retaining current staffing levels or them having to lose a member of staff. This would be guaranteed to increase rather than reduce the risk to the quality of care provided. We expect to be able to respond in more detail once we see the plans CQC has for implementation of these regulations.

2.5 The cuts in funding also raise questions regarding how widely applied these new regulations should be. If the main aim of this amendment is to reduce the risk of poor quality care, then surely as well as focusing upon provision, these regulations must also cover commissioning

due to the fact that the behaviour of commissioners in recent times has been the primary factor in increasing the risk of poor quality care. When local authorities pay only on average £480 for a residential care place, which is a full £140 less than a fair market price calculated by a fair price calculator, this must be the factor that is causing the greatest amount of risk to the provision of high quality services.[2] Whilst we completely acknowledge the difficulty posed by the democratic mandate in doing so, we believe that local authorities themselves have not acted in a 'fit and proper' manner, and as such, this Test should be extended to cover them also. By making elected councillors directly accountable to CQC for commissioning practices, such individuals would have a vested interest in ensuring that services are commissioned responsibly for fear that the adverse personal consequences if they are not, could have a detrimental effect on any political/commercial aspirations that they might have. We also feel that applying the Test to elected councillors would not hinder the democratic process in any way as by definition, any endorsement/denouncement by CQC would give the electorate more information by which to judge the merits of the candidate in question to perform the job that they are being elected to do, which can surely only be a good thing?

2.6 Subsequently, although the motivations behind establishing these regulations are both well-founded and well-intentioned, we feel that it is necessary to extend their scope to allow CQC hold commissioners as well as board members to account for abuse/neglect that occurs within social care.

Question two: Are there any other criteria for deeming a person unfit which should be included in Schedule 1 in the draft regulations?

3.1 We feel that the criteria stated in the regulations is sufficiently broad, but as noted in the previous answer, a person should be deemed unfit if they have commissioned services in an unfit manner, as well as provided them as such. We do understand that if the regulations were to be applied to elected officials, they would have to be caveated to some extent. For instance, the regulation that states that an individual must 'have the qualifications, skills and experience which are necessary for carrying on the regulated activity or (as the case may be) for the relevant office or position', would of course be a matter for the electorate to decide. However, as noted, once elected the regulations could provide an additional means to the democratic method of assessing the performance of an official. We see no reason however why the regulations should not apply in their current form to unelected local authority civil servants.

Question three: Do you agree that breach of the requirement should constitute an offence?

4.1 We think that it should do, but providers and the bodies that these regulations will apply to should either be given time to explain mitigating circumstances, or should be allowed to deal

[2] Laing and Buisson, *Care of Elderly People UK Market Survey 2012/3* (London, 2013).

with a breach of the requirement privately and internally as part of a standardised process, which CQC would monitor closely and offer guidance on.

4.2 Providers feel that CQC was at its most effective when it adopted the 'critical friend' approach to regulation, and by giving providers that acknowledge that they have breached the requirement the time and space to work with the CQC to resolve the issue, the Commission will stand to gain far more in terms of respect from the provider, which will contribute towards a more harmonious relationship and a desire on the part of the service to comply even more fully with this and other regulations issued.

Question four: Do you have any other comments about the draft regulations?

5.1 As we have emphasised with our answer on commissioning, although corporate accountability is an important factor in mitigating the risk of poor quality care being delivered, it is not the only factor. As with commissioning, we believe that funding is an important driver in raising quality.

5.2 Considering that current spending on the NHS amounts to just over 8% of GDP, whilst spending on adult social care is projected to be 1.19% of GDP in 2015/6, it is plain to see that despite 40 years' worth of rhetoric regarding moving services from the hospital and into the communities in which people live, this change is a long way from happening.[34]

5.3 The clear disparity in terms of the funding bases is compounded by the chronic underfunding of social care. Age UK's Care in Crisis report demonstrated the clear funding crisis that adult social care faces in England. In order to restore the social care system to the level at which it was at in 2010/1, spending would have to increase from £7 billion to £9.61 billion, and to do the same for the year 2020/1, spending will have to increase further to £11.49 billion.[5]

5.4 High quality care is increasingly being defined by central government as care that enables individuals to retain independence, remain at home for as long as possible, and avoid reaching crisis levels if at all possible. The same Age UK report notes that in 2005/6, 35% of local authorities offered support for those with moderate social care needs; this number decreased to 10.5% in the year 2013/4. If local authorities are only going to provide support when an individual's needs reach substantial or even critical level , more and more service-users are going to find themselves reaching crisis levels, placing increasing strain upon services, and naturally limiting the quality of services provided.[6]

[3] The King's Fund, *Spending on Health and Social Care over the Next 50 Years: Why Think Long Term?* (London, 2013), p.4.
[4] The Guardian, *Elderly Care: The Key Data From the Dilnot Report* (July 2011).
[5] Age UK, *Care in Crisis 2014* (March, 2014), p.16.
[6] *Care in Crisis*, p.13.

5.5 We recognise that the economic situation is difficult and that despite the fact that local authorities are cutting the amount that they pay to providers, the amount that they spend on social care as a proportion of their overall budget is increasing. We therefore feel that the power to improve services not only lies with changing commissioning patterns within local authorities, but in altering the way in which they can raise revenue to spend on adult social care. By increasing the amount of money provided in the local government finance settlement, and not putting pressure on councils to freeze council tax, central government can responsibly enable local authorities to commission at representative rates that do not force both them and providers to do more for less – which in an environment of rapidly increasing demand, cannot be done to the extent expected.

Question five: Do you have any concerns about the impact of the proposed regulations on people sharing protected characteristics as listed in the Equality Act 2010?

6.1 We feel that the 'after reasonable adjustments' stipulation mitigates any concerns that we might have had about individuals with disabilities or mental health conditions not putting themselves forward or being nominated to sit on boards.

Jamie Balbes – 3rd April 2014