English Community Care Association

Quality in the new NHS system -

Maintaining and improving quality from April 2013

Response from the English Community Care Association (ECCA)

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 ECCA welcomes the opportunity to comment on this important consultation around quality in NHS services. This is a relevant consultation because many ECCA member care homes are commissioned by the NHS to provide such services is continuing health care and intermediate care. According to Laing and Buisson there are 33,000 people funded by the NHS in 4900 independent care homes with nursing in the UK. These care homes with nursing have over 213,000 places and more attention should be paid to this critical sector without which the NHS would not function effectively. Continuing healthcare represents £2 billion of NHS spend.

1.3 It is important to understand however that care homes, commissioned by the NHS to provide continuing healthcare, are social care registered providers, who will also provide care and support commissioned by local authorities and self funders. In this context, ECCA is keen to ensure consultations are not solely focused on the implications for NHS acute care. We do not believe, however, that enough effort is made in this and other such consultations to understand the implications for social care registered providers who also provide NHS services. This is a very diverse and indeed geographically dispersed sector.

2. Improving Quality

2.1 With the many diverse initiatives announced in the recent Social Care White Paper around improving quality, it is vital, in our view that the whole health and social care system can coalesce and agree on a definition and vision for quality.

The paper begins by saying that the NHS is organising itself around a single definition of quality. Whilst there is nothing we would disagree in terms of ensuring that care is safe, effective, and provides a positive experience as possible, we would have preferred to see how this marries up with a social care definition of quality based on wellbeing. Of course, it will be helpful in the NHS to have a single definition of quality but if this is not aligned with the experience and vision of social care practitioners then those operating in both fields will be placed in a difficult and confusing position.

2.2 We welcome the emphasis on organisations, both commissioners and providers, looking beyond their organisational boundary concerns and their autonomy, to always consider the needs of the patient first. We have become increasingly concerned that commissioners are compromising quality in a rush to drive down prices. This is usually done without proper discussion with providers and the people they care for. On preferred provider lists independent providers can be ranked in price order, cheapest first, rather than 'best placed to provide the required service at the right level of quality'. Independent providers should be seen as equal partners with NHS commissioners in ensuring a quality service to people in need.

2.3 There seems to be a dissonance between the Social Care White Paper's reliance on people using provider data and other sources of information to hold the system and providers to account. This paper however says that it cannot rely on patients alone to hold the system to account even with the increasing information that is being made publicly available.

2.4 We support the need to shift the culture from one of blame to one of learning and continuous improvement. Our experience however is that commissioners of care home services are quick to blame and punish. We would hope that a culture as espoused by this document, where providers and commissioners work together to improve services, is developed as soon as possible. The poverty and immaturity of some commissioner/provider relationships has been highlighted by ECCA on many occasions. This needs to be seriously addressed by leaders within the health and social care system.

3. <u>NHS Funded care</u>

3.1 This paper needs to be absolutely clear on its definition of NHS funded care. We assume this relates to NHS commissioned care such as continuing health care and intermediate care and not to the FNC monies paid to individuals via the care home. The latter, of course represents no more than a contribution to nursing care and the fee is not open consultation between providers and commissioners, but is instead set by the Department of Health.

3.2 Although the paper mentions on occasions social care, as previously alluded to it can be a confusing read for those social care registered providers providing NHS

commissioned care. There is a constant reference to patients and wards and not people/individuals. Care homes are people's homes and not hospitals.

4 Quality Surveillance Groups

4.1 This confusion becomes more apparent when talking about the new Quality Surveillance Groups (QSGs). From an overall reading it appears these groups will discuss social care registered providers only in the context of them providing NHS services such as continuing health care. This is because the document talks about QSGs operating to the footprint of the NHS Commissioning Board local area and regional teams. It also talks about surveillance across front-line operations in the NHS. Equally the NHS Commissioning Board is charged with developing a guide on how to run the groups and will train its own staff to provide the support and facilitation role for the groups. Finally it talks about the model not being 'silver bullet' in terms of serious failure in the NHS. On the other hand QSGs will have membership from local authorities and the groups are referred to as 'a forum for local health and care economies'. It is necessary to be absolutely clear which social care registered providers will have their care examined by QSGs. Until such clarity is provided it is difficult for us to give comprehensive comments on the groups and how they might work.

4.2 We do have some general questions on the QSGs which we would hope will be taken into account:

- How will providers be informed they are the subject of discussion at these groups?
- Will there be neutral observers/members to assure natural justice and fairness?
- If not how will we be assured that QSGs do not treat NHS providers more leniently than independent providers and instead that there is consistency of approach regardless of provider ownership?
- What will be the criteria for judging the quality of the information being discussed about individual providers and do individual providers have the opportunity of a right of response or reply to the evidence been used against them? There is a danger of disparity and subjectivity when assessing the quality of individual providers over and above essential standards.
- Will there be any provider input to the group whether from NHS trusts or other independent providers?

We would not want to see the QSGs becoming like Star Chambers in judging and punishing independent care homes that will have little right of redress unless there are independent members involved.

5 Aligning Quality Monitoring

5.1 We welcome the efforts in the report to define the roles of the different quality bodies and how they align. Unfortunately for social care registered providers however, this is only half the picture. It seems a missed opportunity not to have examined the whole health and social care system together. The care home sector, in particular, is subject to a wide variety of overlapping and duplicating quality monitoring systems-the local authority commissioner, the NHS commissioner, CQC, possibly Monitor, and Links (HealthWatch), alongside the providers own quality monitoring processes. We have bemoaned the lack of leadership and commitment to address these overlapping systems many times, which not only present a confusing picture to individuals and their families and providers, but are also a waste of public money where bodies duplicate each other's roles.

5.2 Currently many providers do strive to both measure and improve the quality of care delivered. It is disappointing that no national set of metrics/ outcomes are readily available to provide an appropriate measure of care outcomes beyond essential standards and which could be applied consistently by any provider of NHS commissioned care within care homes.

6 NICE Standards

6.1 We must currently reserve judgement on how the NICE standards will work for the social care registered providers. The first NICE social care standard for dementia is only just at the point of consultation and we are equally unsure as to how NICE standards for the NHS are compatible with, or achievable within, social care registered providers.

7 CQUIN Standards

7.1 Unfortunately we are also struggling to collate and understand data around CQUIN indicators for social care registered providers such as care homes. We have seen examples of good practice - CQUINs which are concise and developed in partnership with care home providers. We have however equally seen CQUINs that seem entirely inappropriate, lengthy and irrelevant to care home settings. Using 30 or more CQUIN indicators for the small care homes caring for no more than one or two people commissioned by the NHS, is disproportionate and simply does not recognise that a care home is somebody's home and not a hospital.

8 Health and Well Being Boards

8.1 There is equally no recognition of the role of independent providers within Health and Well Being boards. Providers have a unique and close understanding of what local communities need and are asking for, and what solutions are appropriate to meet identified needs. Yet there seems to be no

acknowledgement of the role providers or their representatives might play in helping these boards prepare needs assessments and health and well-being strategies.

9 NHS Care Home contract

9.1 The NHS standard care home contract is not fit for purpose for the commissioning of NHS services from care homes. We have engaged in the development of this contract but many of our comments were not taken on board, with the result that we still have many concerns about the length, inappropriateness and purpose of many of the contract requirements. We would still urge the DH to simplify the care home contract, working in partnership with provider representative bodies. The NHS Contract runs to several hundreds of pages (plus various associated documents embedded within the web-links) which care homes are bound to sign up to if they wish to provide any NHS CHC business. As such it has become substantially larger, and more complex than the circa 200 pages of CQC Essential Standards, (which of course are a legal requirement for providers).The NHS Contract, must be carefully considered (with appropriate paid for professional advice) by each provider in conjunction and in context with a myriad of other standards, contracts and similar documents – irrespective of the level of NHS business the PCT may procure from the care home, which could be as little as one placement.

10 Safeguarding

10.1 Safeguarding against abuse is vital and we support the leadership role of local authorities in safeguarding adults in all settings. However we believe safeguarding is being used inappropriately and as a blunt tool against providers when in reality the issue is not one of safeguarding. The previous Social Care Minister, Paul Burstow, recognised the unsatisfactory nature of some safeguarding investigations, which actually reduces the resources local authorities can use to tackle real abuse. In addition, we believe that independent and NHS providers are not always treated equally with respect to safeguarding, and that issues that are raised as safeguarding within independent care homes would not have been seen as safeguarding issues within an NHS hospital.

ECCA

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