English Community Care Association

Strengthening corporate accountability in health and social care: A consultation

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 welcome the opportunity to comment on the Department of Health's proposals for strengthening corporate responsibility in health and social care, before which we make some general observations on associated issues.

1.3 While we are fully supportive of the principle of corporate accountability, we do not believe it should be restricted to health and social care; it should be extended across all sectors of the economy.

1.4 In the Foreword to this consultation, the Minister for Care and Support identified corporate responsibility for failures in the following terms: "who let it happen, how the conditions were created that enabled it to happen…" In agreeing, we would argue that the enabling conditions must include the provision of adequate public funding.

1.5 In its initial response to the findings of the report into the Mid Staffs NHS Foundation Trust Public Inquiry, the Government made an uncompromising statement of its preferred order of priorities, and this statement of common purpose below was agreed amongst others by the Permanent Secretary at the Department of Health and the Chair of the LGA:

> *"Blind adherence to targets or finance must never again be allowed to come before the quality of care. We need to use public money well and we need to be efficient and productive but these are a*

means to an end safe, effective and respectful care, compassionately given."[1]

1.6 Much the same point was made subsequently by Robert Francis QC in a BBC radio interview:

> *"… there's been an increasing emphasis on management doing a systems business, which is balancing the books, following various policies and so on. And I think it's quite easy in those pressured circumstances, particularly perhaps when resources are under challenge, to forget what the whole purpose of the system is, which is to help patients."*[2]

1.7 Although in both the cases cited the references were to the NHS, the mindset described is equally prevalent among local authorities.

1.8 Commissioning systems must be fit for purpose. We remain concerned about the tacit assumption that it is legitimate to keep asking more of providers – to continuously improve the quality of the care they provide – without factoring in the need for their costs to be covered by the provision of appropriate resources. Consultations like this tend to treat resource allocation, where they acknowledge its significance at all, as though it is an activity that takes place in a different universe from the provision of services.

1.9 We offer a solution at 2.2.4 below.

2 Consultation questions

Q1

Do you have any evidence about the likely costs and benefits of these proposals?

2.1.1 There is not enough information given in the consultation document to properly consider what might be the costs and benefits. Whilst membership feedback so far indicates that providers feel their Board recruitment processes are robust, it is not clear what the threshold will be to meet the 'fit' person test.

2.1.2 There will be costs to CQC to assess and take action as necessary in accordance with these proposals. The DH has indicated that it is in discussion with CQC as to what this will entail. It is therefore again not possible to comment in detail, other than to say that any extra costs for CQC will be no doubt be passed on to providers. These extra costs to providers should be taken into account in the cost benefit assessment of the proposals.

2.1.3 Depending on the threshold it is not possible to say whether the preventative aspects of these proposals will ensure that care for individuals is improved for

[1] Patients, First and Foremost, p.10

[2] Interview on BBC Radio 4 'Today' programme, 24 June 2013

the better if Boards members are assessed as 'fit' persons. As for preventing unfit Board members taking future Board positions then this must be proportionate and understand the context in which individuals work as Board members.

2.1.4 As we indicate later we are not convinced such proposals will truly impact on the culture of an organisation, and would instead see guidance and support to ensure a Board works well as a corporate body, using the joint skills, knowledge and experience of all its members to bring about a comprehensive leadership of the organisation. The proposals as set out do not offer the support to improve the governance of the organisation through encouraging an organisation to ensure individuals on a Board work together as a team.

2.1.5 These proposals could lead to over regulation in the sector, given that some care providers have more than one regulator that regulates them and with whom they need to comply. There is a risk of duplication and increase in bureaucracy instead of attention and resource being concentrated on and directed to the delivery of excellent practice in the sector.

2.1.6 As we have pointed out repeatedly, in this response and in other representations to the DH, we expect that any proposals be implemented on a consistent basis across health and care services. There should be no difference in the way independent sector, NHS and LA provision is treated. We do not see how differences of approach can be justified in law and would need clarity on this point. In addition there should be no barrier to providers tendering for services due to the fact that they must meet regulatory requirements of a different order to other providers tendering for the same service.

2.1.7 We would be concerned if the requirements as set out prove onerous and disproportionate to the extent that people are put off applying for Board positions. There must also be the opportunity to ensure Board places are open to service users, families, people with physical, learning disabilities and mental health issues who can add greatly to an understanding of the service being offered.

2.1.8 Finally is there any indication as to the actual numbers of Board members who might not meet a fit and proper person test and has this been set against the cost of actually implementing these proposals across all Board members?

Q2

How should we define which positions the new requirements apply to? Should only directors of Boards be required to be fit and proper persons or are there other principal officers who might not be part of the Board to whom this test should also apply?

2.2.1 There are mixed views on this. If the new requirements are to be implemented even though, as we have previously indicated we are not convinced of the benefits and believe the costs are not adequately known, then some feel that it is difficult to find a rationale for limiting this to the statutory directors of the

Board of the top-most company within an organization, and not the management board for example. Others would argue that it is for Board members to ensure officers are accountable to them for the quality of the service and therefore there is no need to extend the requirements beyond Board members.

2.2.2 In the context of individual Board Members of provider organisations being held accountable for their organisation's performance in the delivery of care services, we would expect councils that act as service providers to be held similarly accountable before the law.

2.2.3 Although the consultation document makes no specific reference to local authorities in relation to corporate accountability, the final report on Winterbourne View Hospital compiled by the Department of Health included as one of its "Key Actions":

> "*Directors, management and leaders of organisations providing NHS or local authority-funded services must ensure that systems and processes are in place to provide assurance that essential requirements are being met and that they have governance systems in place to ensure they deliver high quality and appropriate care."*[3]

We take it, therefore, that the regime will be applied to relevant local authorities, and that it will extend beyond senior managers to include elected members.

2.2.4 Following which, we believe it would be entirely consistent for questions about "effective leadership" and "fair and transparent culture" that will be asked of councils with reference to their responsibilities as registered providers also to be addressed to **all** local authorities in respect of their funding decisions for independent sector services – see 1.4 to 1.9 above. To paraphrase the question put in the CQC consultation document, 'A new start' (page 10): Does an authority make decisions about funding based on sound evidence and information about its services, and are concerns discussed in an open and frank way?

Q3

What considerations should be taken into account in applying the fit and proper persons test? Do you agree this should include the concerns mentioned in paragraph 19 or are there other concerns that need to be addressed?

2.3.1 It would be helpful to have more clarity on how the fit and proper person test will work in practice, who makes the decisions at CQC, what judgement framework is used and how the right of appeal will work.

Q4

Do the proposed introduction of fundamental standards and a new fit and

[3] Transforming care, page 31

proper person test, together with existing legislation, set an adequate framework for holding providers to account for unsafe care? If not, what other measures are required?

2.4.1 In our view, there is no need for "fundamentals of care" to be detached from expected standards in the manner proposed. Their practical utility does not appear to have been questioned. We are not confident that members of the public will be able to understand the qualitative difference that is intended to separate fundamentals from expected standards.

2.4.2 In a recent House of Lords debate on the Care Bill, Lord Bichard, chair of SCIE, promoted the significance of the concepts of dignity and respect – which are not included in CQC's current draft of fundamental standards – as he argued for them to be placed on the face of the Bill:

> *"Dignity and respect are the basic rights which those in care have the right to expect, but they also provide the benchmark by which professionals should be judged as they go about their work."*[4]

This suggests that, even among those who favour them, there is not a consensus on the contents of fundamental standards.

2.4.3 Required improvements will be brought about not by re-categorising standards but by changing providers' organisational cultures and ensuring that regulators have the expertise and experience relevant to their responsibilities.

2.4.4 As for the implementation of appropriate sanctions, there is, in our view, no need for fundamental standards to be created as a pre-requisite to immediate prosecution. Given that CQC's entire system is to be judgement-based, this would merely be another occasion for judgement to be exercised: on whether the breach of "expected" standards is sufficiently serious – measured by the impact, or potential impact, on the individuals(s) concerned – to warrant a prosecution without first issuing a warning notice.

2.4.5 We do not believe there has been adequate exploration of other possible alternatives to new requirements eg the role of the current nominated individual; or the use of existing powers to impose conditions of registration.

2.4.6 Subject to the suggestions made above, we believe that the new framework would indeed be sufficient to hold providers to account for unsafe care.

ECCA
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[4] www.publications.parliament.uk/pa/ld201314/ldhansrd/text/130703-0002.htm#130703103000132, Column 1262