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Health Committee

Annual accountability hearing with the Care Quality Commission

Ninth Report of Session 2010–12

Report, together with formal minutes, oral and written evidence

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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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Additional written evidence may be published on the internet only.

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¹ Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).
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1 Introduction

1. The Care Quality Commission (CQC) was established under the Health and Social Care Act 2008. It is a non-departmental public body, and the first regulator to cover both health and social care in England. The CQC is responsible for the registration, review and inspection of health and adult social care services and monitors the operation of the Mental Health Act in England. The 2008 Act set out the CQC’s objectives as follows:

   (1) The main objective of the Commission in performing its functions is to protect and promote the health, safety and welfare of people who use health and social care services.

   (2) The Commission is to perform its functions for the general purpose of encouraging—

       (a) the improvement of health and social care services,

       (b) the provision of health and social care services in a way that focuses on the needs and experiences of people who use those services, and

       (c) the efficient and effective use of resources in the provision of health and social care services.

2. For the first six months of its existence the CQC shadowed its predecessor organisations (the Healthcare Commission, the Commission for Social Care Inspection, and the Mental Health Act Commission). The CQC took over and merged the responsibilities of those bodies on 1 April 2009.

3. On Thursday 9 September 2010 the Committee held a pre-appointment hearing to assess the proposed appointment of Dame Jo Williams (then a CQC commissioner and acting Chair of the organisation) as permanent Chair. The Committee approved the appointment, but our Report raised several points of concern that we expected the CQC to address, including: issues arising from the merger of the three predecessor organisations; the need to provide robust procedures for whistleblowers; and the use by the public of information arising from the registration process. In that Report we signalled our intention to review the work of the CQC on an annual basis, given the breadth of the CQC’s agenda and the vital place it occupies in ensuring standards of care. Dame Jo Williams and Amanda Sherlock, Director of Operations Delivery, consequently appeared before the Committee on 28 June.

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2 Further information on the duties of the CQC can be found in the Department of Health’s memorandum to the Committee, Ev 14.

3 Health and Social Care Act 2008, Ch 1, s.3.

4 See Health Committee, Appointment of the Care Quality Commission, HC (2010–12) HC 461. The transcript of the session can be found on the Committee’s website (http://www.publications.parliament.uk/pa/cm201011/cmselect/cmhealth/uc461-ii/uc46102.htm)
2 The balance between registration and compliance activity

4. A significant proportion of the memoranda we received raised concerns about various aspects of the work of the CQC. The overall impression is one of frustration with the CQC and a lack of confidence in its ability to execute its main functions efficiently.

5. The most striking and concerning aspect of the CQC’s operations over the past year is the decision to divert resources from inspection and review activities towards meeting the demands placed on it by the process of registering providers, to the extent that the number of inspections fell far below usual levels.

6. The Committee concluded that the bias in the work of the CQC away from its core function of inspection and towards the essentially administrative task of registration represented a significant distortion of priorities. Although the evidence presented by the CQC acknowledged this distortion of priorities and argues that corrective action has now been taken, the Committee believes it is important to understand how this misallocation of resources arose, not least in order to reduce the risk of the same thing happening again.

7. The Committee has identified the following factors which contributed to this distortion of priorities:

   • The CQC was originally established without a sufficiently clear and realistic definition of its priorities and objectives;
   
   • The timescale and resource implications of the functions of the CQC, in particular the legal requirement to introduce universal registration of primary and social care providers, were not properly analysed;
   
   • The registration process itself was not properly tested and proven before it was rolled out; and
   
   • The CQC failed to draw the implications of these failures adequately to the attention of ministers, Parliament and the public.

Moving to a registration model

8. As well as establishing the CQC, the Health and Social Care Act 2008 also set out a new model for regulation. Under the new model, providers of health and social care would be registered against a set of essential standards of quality and safety. The CQC would then monitor registered providers against compliance with these standards, undertaking inspections in response to indications of risk. On its establishment the CQC was therefore faced with the task of registering the tens of thousands of providers it was due to regulate.

9. The timetable for registration of providers by the CQC was dictated by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registration of different providers was staggered to enable the CQC to ‘work with providers to build capability, so that the registration and ongoing compliance processes are implemented efficiently and
effectively’. In the financial year 2009–10 the CQC registered all 378 NHS providers; by April 2011 the CQC was due to have registered 13,000 adult social care and independent health care providers, 8000 dentists and 350 private ambulance services; and by April 2012 the CQC was required to have registered some 8000 providers of primary care, including GP practices, out-of-hours primary care services and NHS walk-in centres. These deadlines were challenging (the British Dental Association told us that the Government had set the CQC ‘an almost impossible task to perform’ in registering its sector) and were hampered by shortcomings in the registration process itself (see Chapter 4). In consequence the CQC did not complete registration of dentists and private ambulance services by the statutory deadline of April 2011 and it was estimated that only 75% would have been registered by the end of June. At the CQC’s request, the Government conducted a consultation into postponing until April 2013 the deadline for registration of GP practices, to give the CQC time to catch up and improve its processes. The Government released a statement in August to the effect that since 96% of respondents had supported the proposal, the deadline would indeed be rescheduled.

10. By July 2011 the CQC had registered about 23,000 organisations in 40,000 locations. Dame Jo told us that: ‘overall, we have delivered our targets in terms of registering the sector’.

The fall in compliance activity

11. This process of registration had the effect of substantially distorting the priorities of the CQC so that in the course of 2010–11 the number of CQC inspections fell far below usual levels. For example, 6840 site visits to providers were undertaken in the six month period between October 2009 and end of March 2010, but only 2008 site visits were carried out in the same six month period in 2010–11, a fall of 70%. In adult social care specifically, 10,856 care home inspections were carried out in the 2009–10 financial year, but only 3805 took place in 2010–11, a 65% drop.

12. This fall in compliance activity has been acknowledged by the Government in its consultation document on postponing GP registration (‘the focus on registering new providers has [...] impacted on the CQC’s capacity to monitor compliance with essential levels of safety and quality of those providers that are already registered’) and by Cynthia Bower, Chief Executive of the CQC, in a letter to the Financial Times contesting the reporting of the phenomenon:

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6 Ev 29
7 Ev 16
8 Department of Health statement, 12 August 2011.
9 Q 152
10 Ev 57 (Joint Trade Unions)
11 Ev 44 (Action on Elder Abuse)
12 Department of Health, Registration of primary medical services providers with the Care Quality Commission—a consultation on a proposed change to the date of registration, June 2011.
Your story gives the inaccurate impression that the recent reduced number of inspections carried out by the CQC is due to resource restraints and is representative of the level of inspection that will apply in the foreseeable future. [...] Inspection activity has dropped to lower levels while we have been engaged in registering care providers under the new regulatory system required by the Health and Social Care Act 2008. This process has involved assessing all providers to check that they meet essential standards of quality and safety designed to protect people receiving care. In addition to providers of adult social care, we have also registered NHS, private healthcare and dental providers in the past 15 months, involving a total of about 30,000 care services. This has been an enormous task and we have concentrated our resources accordingly. The rate of inspections is rising again and will reach substantially higher numbers once we establish a normal operating level.13

13. Ms Bower told the Health Service Journal in a later interview that the number of inspections in this period had ‘completely collapsed’.14 Dame Jo told us that ‘meeting the demands of this complex legislation with a reduced workforce—factors outside of our control—means we have worked with speed at the expense of quality’.15

14. Dame Jo acknowledged that the registration process was simply preparing the ground for the CQC’s main role, and did not in itself fulfil the CQC’s functions.16 As such it is concerning that compliance activity was allowed to suffer to such an extent. The Royal College of Nursing, which has 200 members working at the CQC, some 10% of the workforce, told us that their members believed ‘that the organisation wrongly places stronger emphasis on its role in registration than it does on ongoing compliance and inspection’.17 Mencap have also called for the CQC to bolster inspection work.18 The joint submission by trade unions representing those working at the CQC told us that the fall in inspections was also caused by ‘an early emphasis on site visits as a last resort which had to be authorised by managers’19 and cautioned that case loads for inspectors had become so high that they had services on their caseload about which they had no knowledge because they had not had time to look at them.20

15. We are extremely concerned that CQC’s compliance activity fell to such low levels in the course of 2010–11. We recognise that the CQC was obliged to work within the deadlines for registration imposed by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We also recognise that it was in order to meet these deadlines that resources were diverted from compliance activity to registration. Yet the fact that this was done to the extent that inspections fell by an unacceptable 70% demonstrates a failure to manage resource and activity in line with the main statutory objective of the CQC to ‘protect and promote the health, safety and welfare of people

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13 Financial Times, Reduced checks on care homes were temporary, letter from Cynthia Bower, 1 June 2011
14 Health Service Journal, CQC to inspect trusts annually in a shift away from the ‘risk based’ approach, 21 July 2011
15 Ev 77
16 Q 154
17 Ev 40
18 Ev 53
19 Ev 57
20 Ev 56
who use health and social care services’. In the current climate of financial constraint and reorganisation of the health service it is more important than ever to have a regulator that maintains a clear focus on its primary duties. In this instance that did not happen.

**Vacancies**

16. The CQC has a significant number of long-term vacancies, and the number has crept up over the past year, with total establishment vacancies moving from 148 in June 2010 to 297 in June 2011, and compliance inspector / registration assessor vacancies moving from 96 to 133 over the same period.\(^{21}\) We have heard from the joint trade unions at the CQC that the reduction in compliance activity was also due to reduced staffing.\(^{22}\) Compliance inspectors and registration assessors were not considered by the Department of Health to be ‘front-line posts’ and were subject to the public sector recruitment freeze that came into effect in May 2010. The CQC was therefore unable to fill these vacancies until October 2010 when the Government gave permission for 70 inspectors to be recruited from within the NHS, arm’s-length bodies or the Audit Commission. In June 2011 the CQC told us that job offers had been made to fill these 70 posts ‘in the last few weeks’.\(^{23}\) Dame Jo told the committee that the recruitment process had taken so long because:

> we have had to work within guidance to ensure that, when we were changing our systems internally, people being displaced from one job had to be given the opportunity to come into other jobs.\(^{24}\)

The CQC has said that the reorganisation of its head office structure in 2010–11 also led to delays in recruiting certain categories of staff.\(^{25}\) The CQC states that it exhausted the original pool in June 2011, which prompted the Government to grant CQC permission to recruit more widely. Dame Jo told us that the CQC would now ‘recruit with alacrity’.\(^{26}\)

17. The long-standing vacancies for CQC inspectors are a further cause for concern. The eight months taken to recruit the extra 70 inspectors for which the Department of Health gave permission in October 2010 is unacceptable given the urgent need to raise compliance activity. The CQC should also have been pushing the Government for permission to recruit outside the initial limited pool much sooner. These delays indicate a failure to react with urgency to a problem that was severely undermining the organisation’s compliance function.

**Changes to the regulations**

18. It is evident that the deadlines and elements of the other requirements included in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 have, on
implementation, caused difficulties for both the CQC and the providers it registers. It is these regulations that the CQC blames for having to prioritise registration activity over compliance activity. As we have mentioned, at the request of the CQC in the summer of 2011 the Government consulted on and consequently agreed to delay by a year registration of GP practices. The Government has also announced a consultation on certain other aspects of the registration process.

19. The senior management of the CQC has regular opportunities to engage with Government and press for action:

The Department monitors CQC’s financial and operational performance and risks at a general and strategic level through regular formal accountability meetings. [...] Regular meetings are also held between both Ministers and the Permanent Secretary and Chief Executive of the NHS and the Chair and Chief Executive of CQC, as well as meetings at officials’ level.

20. Dame Jo tells us that she argued on her appointment that the deadline of April 2011 for registration of providers of primary dental care and adult social care was ‘not the right course of action’, but says this was rejected ‘in part because of timing—the deadline for opening registration of the sector was imminent’. The precise and full reasons for the rejection of Dame Jo’s suggestion are not clear. It is also not clear what alternative Dame Jo proposed, or whether the CQC senior management pressed for change on other occasions.

21. The CQC should have identified the difficulties inherent in the regulations early in the registration process and made clear to the Government that unless modifications were made it would not be able adequately to fulfil its duty to monitor and inspect providers. The senior leadership of the organisation had a responsibility to communicate this to the Government persuasively and persistently. The decisions to delay GP registration and review the regulations for registration have come too late. The Government and the CQC should set out what discussions were had and why action was not taken earlier to modify the regulations.

**Progress in 2011**

22. Dame Jo told us that there had been a ‘step change’ since January 2011. Inspection levels were now rising and the CQC was currently undertaking 600 inspections per month. If this level was sustained over a twelve month period it would still be significantly lower than the 13,000 inspections the CQC carried out in 2009–10. Dame Jo told us she

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27 Department of Health, *Registration of primary medical services providers with the Care Quality Commission – a consultation on a proposed change to the date of registration*, June 2011; and Department of Health statement, 12 August 2011.

28 Department of Health, *Consultation on proposed changes to regulations for the Care Quality Commission registration*, 18 July 2011.

29 Ev 14 (Department of Health)

30 Ev 77

31 Q 149

32 Q 155

expected that the number of inspections to continue to rise and was aiming for a total of 1200 per month. Amanda Sherlock told us:

Now that we are into a “business as usual” way of working—the bringing of these huge changes and services into registration is by and large completed—approximately 20% of our time is spent on registration and 80% on compliance, enforcement and follow-up, post registration and being brought into the regulatory system.

23. The trade unions told us that ‘greater emphasis is [now] placed on site visits and on the inspector’s professional judgement about when and how often site visits are needed. But with the increase in caseloads and the staffing shortages the ability to conduct site visits and the amount of time available to spend on them are constrained’.

24. It is encouraging that inspection levels are again rising, but the challenging context for CQC work remains. Even following the Government’s decision to defer GP registration until April 2013, the CQC will still need to spend 2011–12 registering the remaining dental providers and ambulance services, and then out-of-hours primary care, not to mention addressing the constant flow of applications to vary registration. The balance between registration and compliance activity will always remain an issue and if it is to maintain the confidence of the public and this Committee the CQC must demonstrate that it is prioritising its compliance activity.

25. Furthermore the Committee regards it as regrettable that the CQC should have launched the process of registration of dental practices without undertaking adequate proving of the registration model. It strongly recommends that each future extension of the scope of registration should be preceded by a properly planned and executed piloting process.

26. We expect to see clear evidence by next year of the CQC leadership openly acknowledging challenges and setting priorities that reflect its core duty to ensure the safety and quality of care.

Budgetary constraints

27. In 2009–10 the CQC operated on a budget of £164.4m (compared to a combined budget for its three predecessors in 2005–06 of £240m). Following the 2010 spending review the 2010–11 budget was revised down to £161.2m. The CQC’s budget is composed of a combination of grant-in-aid from the Department of Health and fees income from providers. The budget is capped, meaning that any additional income generated through fees results in a corresponding reduction in the grant-in-aid from the Department. The CQC told us that in the course of 2010–11 it had undertaken an efficiency programme.

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34 Q 156
35 Q 191
36 Ev 57
38 Care Quality Commission, Business Plan 2010–11, p27
seeking to direct resource towards frontline activities and reduce back-office costs.\textsuperscript{39} In spite of these efforts, Dame Jo told us in September 2010 that the CQC was ‘struggling’ to stretch its resources.\textsuperscript{40} Even so, she stated that:

\begin{quote}
We know that there is absolutely no point in asking for more resources. [...] I would be failing the public if I did not draw attention to the limits of what we can achieve if we overstretch. There is no doubt about it: the challenges that we have at the moment are very stretching, but if we go further, we cannot play our part as the regulator in safeguarding and bringing about change and improvement.\textsuperscript{41}
\end{quote}

Several memoranda to the Committee have raised concerns over whether the CQC has sufficient resources to fulfil its functions.\textsuperscript{42} The Government stated that the CQC’s financial position is kept under constant review during the financial year.\textsuperscript{43}

\textbf{28.} In June 2011 Dame Jo told us that the CQC had requested an extra 10% (approximately £15m) of extra resource from the Government to allow the recruitment of more inspectors with background experience, and to boost support systems for the inspection process.\textsuperscript{44} Yet she also asserted that the CQC did not need extra resources in order to carry out its functions.\textsuperscript{45} Subsequent CQC statements have indicated that the extra funding would be used to support a new inspection regime based on annual unannounced inspections (see Chapter 3).\textsuperscript{46}

\textbf{29.} We note the CQC’s request for an additional 10% of resources to fund its inspection regime. We already have concerns about the way the CQC has handled and prioritised its existing resources and do not believe that additional resources will address these concerns unless they are deployed as part of a clear strategy. We would therefore welcome a breakdown from the CQC of how it arrived at the figure of 10% and exactly how it would intend to deploy these resources.


\textsuperscript{40} Health Committee, First Report of Session 2010–12, \textit{Appointment of the Care Quality Commission}, HC 461, Q 5

\textsuperscript{41} Health Committee, First Report of Session 2010–12, \textit{Appointment of the Care Quality Commission}, HC 461, Q 46

\textsuperscript{42} See for example Ev 41–42 (RCN), Ev S8 (Joint Trade Unions), Ev 69 (NHS Confederation).

\textsuperscript{43} Ev 14

\textsuperscript{44} QQ 208–9

\textsuperscript{45} Q 210

### The inspection and review process

30. Having considered the effect on the work of the CQC of the distortion of priorities between inspection and registration, the Committee has also considered the objectives which it believes should inform the inspection and review work of the CQC.

31. The CQC state that they fulfil their objectives by ‘undertaking extensive risk assessment backed by a rigorous programme of inspections’. We have already noted the effect on this ‘rigorous programme’ of the diversion of resources away from inspections to support the registration process. A knock-on effect of this is the increasing caseload of CQC inspectors. The average inspector’s caseload has increased from approximately 50 locations per compliance inspector as at 1 April 2010 to 62 locations per inspector on 1 April 2011. The long-standing vacancies for inspector posts (see Chapter 2) will have aggravated this problem. Both the RCN (representing 200 CQC workers) and trade unions expressed concern about the growing caseload and its implications. The trade unions told us that the heavy caseloads are leading to a ‘watering down’ of compliance activity, a focus on firefighting rather than reviews of services, and unfamiliarity with providers. The CQC must seek to address growing inspector caseloads through recruitment and should also bolster the support provided to inspectors to allow them to focus on their core frontline duties.

32. The size of an inspector’s caseload has an impact on the frequency with which inspectors are able to undertake site visits. The CQC now operates a compliance system based on a combination of regular reviews and risk assessment:

Under the CQC’s current methodology, every provider should be reviewed at least every two years. However, in line with the principles of proportionate, risk-based regulation, the CQC carries out site visits based on its judgement of risk and where a site visit is the most effective way of gathering information about compliance. This enables the CQC to target its resources on providers where the risk is highest, while reducing the regulatory burden on providers where the risk is low. Site visits will therefore take place wherever necessary to gather information about compliance.

The CQC’s priority remains that, where it has evidence of a risk to quality and safety, it will deploy resources to react swiftly and take appropriate action.

33. There has hitherto been no statutory minimum frequency for site visits, and providers that have a good record and do not show evidence of risk may not even be visited as often as every two years. The charity Action on Elder Abuse notes that the routine reviews of providers ‘will not necessarily involve ‘face to face’ inspection i.e. a desktop exercise relying

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47 Ev 19
48 See Chapter 2
49 Written Parliamentary Question, 8 June 2011, 58077
50 Ev 55
51 Written Parliamentary Question, 7 June 2011, 58086
52 Written Parliamentary Question, 8 June 2011, 58080
upon information obtained from provider completed assessments and other documentation that may have been obtained’.53 Adass also expressed concern about ‘the reliability of remote intelligence systems as opposed to face-to-face contact’.54 It is difficult to see how assessments can be considered complete, even of apparently good providers, if no visit is made to the premises. The CQC themselves told us:

the people who perpetrate consistently poor care or the type of cruelty that we saw at Winterbourne View55 are often very skilful at hiding it.56

34. This underlines the need to undertake regular unannounced inspections, even of providers where there is no obvious risk.

35. The number of providers regulated by the CQC means that the organisation must necessarily operate a risk-based system. It is also right that the CQC should focus its resources on providers where there is an indication of a problem. However, it is difficult to see how the CQC can have confidence in a provider meeting standards if it has not visited the organisation for more than two years, no matter how good its record. Unannounced inspections must form the core of compliance assessment.

36. Since we took evidence from Dame Jo, the CQC has announced that it intends to move to a regime of annual unannounced inspections for providers, including adult social care, subject to the outcome of a twelve week consultation to be launched in September. In an interview with Nursing Standard, Amanda Sherlock, Director of Operations at the CQC, said that the decision was made following ‘a groundswell of opinion that our best evidence comes from stepping over the threshold at locations and speaking to service users and staff’.57 The CQC is intending to fund this change of regime from the additional £15m requested from the Department of Health (see Chapter 2).58

37. The Committee welcomes recent announcements that the CQC intends to undertake annual visits of all NHS and social care providers, irrespective of the performance of the provider. We note that the CQC is seeking to operate as a ‘light touch’ provider, but we do not consider an unannounced annual inspection of NHS and social care providers to be an unreasonable expectation, even for the best providers. The CQC should carefully monitor its performance against this annual target and ensure that its key performance indicators are published on a quarterly basis.

38. A freedom of information request made by the Financial Times in May 2011 was refused by the CQC “saying that its systems and processes were ‘not [yet] set up in such a way as to allow the reliable and robust collation of statistical information on [enforcement]
activities’.59 This does not give confidence in the ability of CQC central management to monitor, review and manage its compliance activity in the field, and we expect this issue to be addressed.

39. The CQC has been developing alternative models of review and assessment, to complement its primary model. The 2011 programme of inspections into dignity and nutrition involved working with ‘experts by experience’ ‘who have either experienced health care themselves or with someone they cared for, and also with professionals—nurses’.60 The CQC expect this model to grow and is developing a programme (to be called ‘Acting Together’) to involve such experts in future assessments.61 We welcome the CQC developing alternative assessment models that involve ‘experts with experience’, provided that this approach complements rather than supplants CQC inspections.

Quality and Risk Profiles (QRPs)

40. A risk-based system of inspection can only be effective if inspectors have access to accurate, timely, and targeted information to help them detect risks. In this respect, the CQC is reliant on information from members of the public (see next section), and a tool called a Quality and Risk Profile (QRP).

41. CQC inspectors use QRPs to monitor providers remotely. The QRPs are mostly populated with data harvested from existing sources rather than data assessed by the CQC itself. The QRP is intended to draw inspectors’ attention either to data that indicates a risk, or to an absence of data. Each QRP is composed of a series of outcomes relevant to that particular sector, and each outcome is then made up of a series of data items that are considered to indicate risk or compliance within that outcome. The successful use of a tool such as the QRP depends firstly on the quality of the data it contains, and secondly on how well this data is analysed. The Mid Staffordshire Public inquiry has brought to light certain limitations of QRPs, such as:

a) QRPs mostly rely on third-party data collections62 rather than ones tailored to the CQC’s particular purpose.

b) A significant proportion of data items are contributed by data collections that have an element of self-assessment, such as Patient Environment Action Team (PEAT) assessments.63

59 Financial Times, Britain’s private care faces crisis, 30 May 2011.
60 Q 156
62 Ev 75 (the Patients’ Association)
63 A Patient Environment Action Team (PEAT) assessment is an annual assessment of inpatient healthcare sites in England that have more than ten beds. It is a benchmarking tool for non-clinical aspects of patient care including environment, food, privacy and dignity. Assessments are carried out by NHS staff (nurses, matrons, doctors, catering and domestic service managers, executive and non-executive directors, dieticians and estates directors). Patients, patient representatives and members of the public are also part of this assessment process. Evidence to the Mid Staffordshire Public Inquiry showed that 52,000 out of 165,000 data items collected in NHS QRPs came from PEAT assessments – see day 86 of the inquiry, Richard Hamblin (CQC), exhibit 1

c) Some outcomes are measured by very few data items, not all of which may be relevant in each case.  

42. The limitations of the sort of data used on QRPs is demonstrated by the case of Mid Staffordshire, where PEAT and NHS Litigation Authority figures (which together account for a significant proportion of QRP data points) failed to flag up problems. The NHS Confederation told us that its members are concerned about the accuracy of information in QRPs and specifically ‘whether QRPs take sufficient account of the intrinsic risks associated with certain procedures and types of care or the vulnerability of service users’. The Committee has also been told that, compared to the health sector, there is little established data to draw on in the social care sector, leading to poorly populated or out of date QRPs.

43. Quality and Risk Profiles have the potential to be a useful auxiliary tool for inspectors, but in their present form the quality of data is limited in its reliability and coverage. The CQC should work towards broadening the range of data included, in particular where there is little data available to support a particular outcome.

44. Staffing ratios can have a significant impact on the quality of care received. At the moment data on staffing ratios is available from NHS providers (and included on QRPs), but not in the private sector. Given the CQC’s focus on outcomes rather than inputs, this means that the CQC would only hear of poor outcomes caused by low staffing in a private care home if it was directly notified by a member of the public, or if the effect on the outcome was evident in the course of an inspection. In our evidence session with Dame Jo we discussed the possibility of the CQC setting minimum staffing levels, in particular in adult social care settings. The CQC responded:

We actively look at staffing levels where they affect the quality of care and do take action where necessary to ensure services are staffed at a safe level. The Commission is not, however, in a position to mandate staffing levels across a complex range of care settings and sectors. In many cases, Royal Colleges and professional regulators have been unable to specify these ratios within their own profession. I do not believe CQC is in a better position to make these judgements.

45. The CQC’s annual report states that it has extended its social care QRPs to include certain staffing indicators of ‘staff turnover and vacancy rates, and proportions of...’

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64 For example, in the list of data items used to measure acute and specialist NHS trusts
http://www.cqc.org.uk/_db/_documents/Acute_and_specialist_NHS_trusts.pdf some outcomes have many items of data that contribute to build the QRP (e.g. Outcome 1, Respecting and involving people who use services, is measured by 78 data items, and Outcome 4, Care and welfare of people who use services, is measured by 109 items), while others are measured by only a handful of data items (e.g. Outcome 2, Consent to care and treatment, is measured by 4 data items—one of which regards Mental Health services, so will not always be relevant, and another of which concerns endoscopy services only—and Outcome 5, Meeting nutritional needs, by 8). In the case of Outcome 7, Safeguarding people who use services from abuse, only three data items feed into the QRP, one of which is a PEAT assessment on whether or not the hospital has a family visiting area ‘with a selection of toys and games’.

65 Q 200
66 Ev 70 (NHS Confederation)
67 Ev 44 (Action on Elder Abuse) and Ev 57 (Joint Trade Unions)
68 Ev 77
temporary and professional staff\textsuperscript{,69} but it is not clear whether this includes a measure of the overall staffing level.

46. We acknowledge that the CQC operates within a regulatory framework that focuses on outcomes rather than inputs. However, low staffing ratios can have such an exceptional impact on the quality of care that we believe monitoring of staff levels is an essential part of ensuring quality outcomes. The CQC should work to develop a mechanism whereby it can keep a closer track of staffing ratios in private care homes, in a way that can feed through into the QRP. Although it would be difficult for the CQC to mandate minimum staffing levels, it should develop indicative ratios that will assist inspectors to identify potentially inadequate staffing.

47. The CQC must ensure inspectors are not reliant on QRPs. Cynthia Bower, the CQC’s Chief Executive, told the Mid Staffordshire Public Inquiry:

> The last thing we want is an inspector to be sitting there waiting for a dial to go red [on the QRP] and that then prompts them to do something. It is a tool for the inspector, but the inspector is the one who makes the judgment about both what to do and a judgment about the service itself.\textsuperscript{70}

48. Nevertheless there is a risk that, especially given the increase in inspectors’ caseload detailed earlier, inspectors may be less able to cultivate and monitor other sources of information to complement the QRP. The threshold at which a risk pattern on the QRP is considered significant enough to trigger a visit could also rise. It is important that the CQC is able to rely on its inspectors’ judgement in these cases but there needs to be consistency of approach. The trade unions represented at the CQC told us:

> we have detected differing interpretations among members in different parts of the country about the extent to which provider self-assessment declarations routinely need to be independently verified, as opposed to verified and checked out only where a risk or contra-indication has been identified.\textsuperscript{71}

49. The CQC must ensure its inspectors do not become over-reliant on QRPs. Even if the quality of data included in QRPs was excellent, such a tool could only ever present a patchy picture of the quality of care.

50. It is right that the CQC places trust in the judgement of its inspectors when assessing risks and deciding on appropriate action. But this judgement can only be consistently exercised if the CQC provides a clear framework and guidance. It would be easy for active inspection activity to regress at this time of increased pressure on inspectors. The CQC must therefore ensure there is a consistency of approach by reiterating risk thresholds.


\textsuperscript{70} Mid Staffordshire Public Inquiry, day 87, 19 May 2011, pp 45–6

\textsuperscript{71} Ev 57
Importance of an open culture

51. In several of its recent reports the Committee has drawn attention to the importance of establishing the right culture in any organisation which delivers health and social care. This priority is important in the work of the CQC for two reasons:

- CQC inspections should be a key part of the drive, which has been endorsed both by ministers and senior NHS management, for a more open management culture. Indeed, CQC inspectors are often much better placed to identify major failures of institutional culture in a complex NHS organisation than they are to identify individual aspects of service failure.

- The establishment of an open institutional culture is not only right in itself; but it also provides a secure framework so that staff working in the organisation, particularly healthcare professionals, have the confidence to discharge their obligation to report observed service failures without fearing reprisals from management or colleagues.

52. In its recent reports on the work of the General Medical Council72 and the Nursing and Midwifery Council,73 the Committee emphasised the importance which it attaches to the obligation which rests on all healthcare professionals to raise concerns if they recognise, or ought to have recognised, evidence of failure of professional standards. The Committee believes it should be a key objective of CQC inspections to ensure that the culture of each provider organisation recognises and respects this professional obligation, and provides proper security to those professional staff who discharge it effectively.

53. Although healthcare professionals have a particular obligation, arising from their professional status, to take an interest in the quality of care being provided around them, this obligation is, in truth, a particularly focused form of the general duty of care owed by all staff of care providers to their patients, and indeed of the natural human desire of all citizens to see high quality care provided to the sick and vulnerable. Information is available from all these sources to measure the performance of care providers. The Committee believes it should be a key part of the inspection process to ensure that proper processes are in place in each care provider, including proper Board accountability, to ensure that these responsibilities are met.

54. Although it is clearly preferable for information about service failures to be reported and acted upon within the organisation responsible for providing care, it is also important for the CQC to be able to respond to such information if the care provider does not respond itself. In order for it to be able to discharge this function the CQC must be able to harness the information and put it to effective use. The Committee does not believe that it passes either test.


55. The CQC reiterated time after time how dependent it is on this information but described successfully harnessing such feedback as ‘a major challenge’. There is a problem of public awareness of the CQC itself. In June 2011 Dame Jo told the Committee how the number of calls of concern received by the CQC had increased substantially since Winterbourne View, from less than 200 in the whole of 2009–10 to ‘well over 100’ since May 2011. When asked to account for this rise, Dame Jo told us:

we are a relatively new organisation and it may well have been that, for the first time, people understood what the CQC was, who we were and how to get hold of us.

56. The calls coming in following Winterbourne View could be only the tip of the iceberg. We look to the CQC, in addition to encouraging cultural change within care providers, to take action to encourage direct information supply in cases where local structures fail.

57. A key part of building confidence is to give reassurance that calls of concern will be acknowledged and followed up. Yet the Residents and Patients Association told us that members of the public struggle with jargon and terminology used by the CQC and were frustrated at receiving no response to their complaints. In the case of Terry Bryan, the nurse who contacted the CQC to express concerns about Winterbourne View, the CQC failed to contact Mr Bryan to verify his allegations or to obtain a full account which could have informed the CQC’s own investigation. The CQC must ensure it makes the most of information provided to it. All relevant communications should be followed up in order to establish the usefulness of the information and to inform the CQC’s own judgement. This sort of information should be a trigger for CQC action—a note appearing on the QRP is not enough.

58. The case of Winterbourne View demonstrated that the CQC’s whistleblowing procedures still leave much to be desired. In line with its policy, the CQC identified that the local authority had received a complaint and that its safeguarding board was handling the situation. CQC guidance states that in these circumstances ‘we will follow our safeguarding procedure and actively follow up the alert. The inspector for the service will monitor the progress and outcome of the local authority’s investigation’. The failing in this particular case was that the relevant CQC inspector failed to follow up the alert. The local authority had notified the CQC at the end of November of Mr Bryan’s complaint to them (with Mr Bryan contacting the CQC directly on 6 December), and the CQC had assumed the local safeguarding board was handling the case. But the meeting of the local safeguarding board did not take place until February. Action in the case of Winterbourne View was woefully inadequate: the CQC failed to ‘actively follow up’ the local authority process, or
conduct its own assessment, or even contact Mr Bryan for further information. The CQC should have done all of these things. Dame Jo noted that an ‘error of judgement’ was made in this case:

The individual concerned wrongly made an assumption that, because it was resting with the safeguarding board, action was being taken. That should have been chased up. Indeed, she should also have made her own separate assessment of the risk. That did not happen.\[^{81}\]

59. The CQC told us that reports submitted by staff or members of the public would now be sent not only to the relevant inspector but also to their manager.\[^{82}\]

**HealthWatch**

60. The Committee believes that the CQC should develop HealthWatch in a way that enhances its access to and use of information from the public. Dame Jo told us:

HealthWatch is an opportunity for us to have a very effective way to gather further information from the public. That relies on the development of local HealthWatch organisations, which will, I hope, be able to hold organisations to account, be gathering information and listening to people in their communities. I would not want it to be exclusive. We get a lot of information from other organisations in communities and so we do not want that to stop. It will enable us, we believe, to do our job even better.\[^{83}\]

61. The CQC is currently working with the Department of Health to design HealthWatch, setting up the structures and systems for its full establishment in October 2012. HealthWatch England will be a statutory, distinctive part of the CQC, forming a sub-committee of the CQC board and able to request the CQC to conduct investigations. The Government told us:

[HealthWatch’s] role will be limited to advising that CQC carry out an investigation into service provision in particular cases. Although HealthWatch England will provide vital information to support CQC’s monitoring role, CQC will retain the power to decide whether or not to conduct an investigation when a recommendation is made.\[^{84}\]

62. The Committee believes that the CQC should be obliged to carry out an investigation in response to a recommendation from its HealthWatch sub-committee that the CQC investigate the quality of care provided by a particular provider.
4 The registration process

The operation of the registration system

Initial registration

63. The Committee has already reported its views that the priority attached by the CQC over the past 12 months to the registration of new providers represented a distortion of priorities. If this extension of registration activity was required management should have ensured that it was resourced in a way which did not affect the core existing activity of the CQC and should have resisted pressure from ministers or elsewhere to adopt a registration policy which it is now clear was inadequately prepared or resourced.

64. There have been several significant problems with the registration process, especially once the CQC began registering the large numbers of social care providers and the relatively unfamiliar area of primary dental services. The CQC noted:

At times we did struggle with the sheer amount of processing and recording of data involved, and as backlogs of applications built up, we were unable to issue notices and certificates for the new registrations as quickly as we had hoped. This also had a knock-on effect on our ability to update providers’ registration details on our website.85

65. The British Dental Association told us that the process involved ‘poor communication, with conflicting information, combined with an unrealistic deadline for registration [...] The uproar in the profession once the progress began was unprecedented’.86

66. The registration process has been criticised as cumbersome and over-bureaucratic,87 in particular because the CQC applied a one-size-fits all model, applying the same single process to health, adult social care and dentistry. The NHS Confederation told us that:

[the CQC’s] generic model underpinning registration means that sometimes guidance does not make sense in the context of the particular service being inspected or inspectors do not understand the services they are inspecting adequately. This is a particular concern for providers of mental health, ambulance and community services, who often state that the CQC’s approach is too acute and social care focused. For example, it took significant time to resolve issues for the registration of air ambulances.88

67. The British Dental Association also criticised as ‘frustrating and disturbing’ the CQC’s lack of understanding of how small dental practices operate, a further indication of

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86 Ev 29
87 For example, see Ev 66 (NHS Confederation).
88 Ev 69
problems with the single model for registration. Dame Jo acknowledged to us that tailoring the process to different sectors could be one way to improve matters:

> If there are things we can do to make that process of application simplified, we are aiming to do that. For instance, it strikes me that, when we fill in a tax application, we are used to saying, “This is not applicable”—one of the things dentists were saying was that particular areas weren’t applicable—making it easier to process in that way.

68. Poor communication was a further complaint. Both the British Dental Association and the National Care Association told us that documents intended to guide providers through the registration process arrived only a short time before the registration window opened, allowing little time for preparation. The BDA told us that staff at the CQC’s call centre were often unable to help with queries: ‘there appeared to be a distinct lack of knowledge about the particular issues affecting dentistry in CQC and advice from the helpline was often contradictory with CQC advisers interpreting requirements differently’. This appears to be supported by evidence from trade unions represented at CQC that call centre staff ‘report poor working conditions and high staff turnover’.

69. These difficulties contributed to CQC delays in processing applications. The most striking example of this is that the registration of dentists and ambulance services was not completed by April 2011, as stipulated by regulations. Instead, the CQC estimated that only 75% of these providers would have been registered by the end of June 2011.

70. Both the CQC and the Government have acknowledged the shortcomings of the initial registration process. Indeed, the Government decision to delay registration of GP practices until April 2013 was at the request of the CQC. The Government intends the delay to ‘give the CQC space to modernise and streamline its regulatory methods resulting in an improved experience for providers of primary medical services when they are registered and a more responsive service for those providers already registered with the CQC’.

71. On publication of the consultation reviewing certain further aspects of the registration process, the Government noted that ‘the first year of operating the system has highlighted a number of issues in the regulations that either do not function as initially intended, lack clarity or which impose an unjustified burden on providers’. The consultation document proposes exempting certain particular categories of provider from registration and allowing the CQC to specify the format for certain statutory notifications. The

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89 Ev 31
90 Q 176
91 Ev 30 (British Dental Association) and Ev 37 (National Care Association)
92 Ev 30
93 Ev 56
94 Ev 16 (Department of Health)
95 Ev 16
96 Department of Health, Written Ministerial Statement, Consultation on Care Quality Commission Registration, 18 July 2011.
97 Department of Health, Consultation on proposed changes to regulations for Care Quality Commission registration, 18 July 2011.
Government has also carried out an initial review into the registration system and intends to commence a more comprehensive review of the regulations governing registration later in 2011. The CQC have described this review as ‘our first opportunity to tackle legislation that has made our model more onerous than it needs to be’.98

72. The current regulations governing registration have imposed difficult and occasionally inflexible restrictions on the CQC’s procedures. It is regrettable that this was neither foreseen nor addressed before the vast majority of providers had already fought through the process. Nevertheless we welcome the Government’s review of the regulations. We urge the CQC and the Government to work closely together and with providers during this consultation period to ensure that all future registrations (and in particular that of primary care providers) can be conducted in a proportionate manner within adequate timeframes.

73. The CQC must also accept responsibility for its poor handling of registration and adapt its processes accordingly. In particular, the process could have been made significantly simpler and swifter for all involved had the CQC adapted registration procedures to different types of services. It is astonishing that it could ever have been considered sensible for small dental practices to work through the same process as a large hospital.

74. Following the postponement of the deadline for registration of GP practices until April 2013 the Government and the CQC have some time to put things right. But this is no time for complacency. Action must be swift if procedures and especially regulations are to be reviewed, altered and put into practice in good time. We expect to see significant progress on this matter by the time of our next accountability session with the CQC.

Applications to vary registrations

75. The trials of initial registration are only the first hurdle for providers and the CQC. The CQC also has a statutory duty to approve variations in registrations. The NHS Confederation told us that this process imposes a ‘significant burden’ both on providers and on the CQC.99 In May 2011 the CQC was reported to be receiving 155 applications per day from adult social care, independent healthcare and NHS providers wishing to vary their existing registration.100

76. This burden inevitably translated into delays and backlogs. In February 2011 the CQC was reported to be taking on average 18 weeks to process these applications (under normal circumstances, this window is cited as the maximum time an application should take).101 The delays are particularly frustrating for care providers and users because until new services are registered they cannot be used. The English Community Care Association told us that they had:

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98  Ev 77
99  Ev 70
100 Health Service Journal, CQC fears its regulation model is not sustainable, 26 May 2011.
101 Community Care, Big registration delays frustrate care providers, 17 February 2011.
evidence of people waiting for admission to homes and being unable to be cared for in their chosen setting because services have not been registered. Providers meanwhile have invested in new buildings and staff but are deprived from earning any income until CQC has completed the registration process.  

The backlog of routine registration work was cited by the Government as a reason for postponing registration of GP practices.  

77. Dame Jo told us that the CQC had been working to improve the processing of variations to registrations, stating that system was now ‘much slicker’ and that the CQC was ‘largely hitting’ an eight week processing target. The CQC is also aiming to move to a system where variation applications are submitted electronically, but expects this to take two to three years to develop.  

78. It is right that the CQC approval should be required for significant variations to registrations, but this requirement will remain a significant burden on both providers and the CQC unless the procedure is greatly streamlined. We welcome the action the CQC has already taken to improve the system and bring processing times down to a more reasonable level. The CQC should do all it can within the regulations further to improve the procedures, including consulting with providers and professions and bringing forward development of a system of electronic submission and processing. The CQC must work closely with the Government’s review of the registration regulations to identify where changes are necessary.

102 Ev 26  
103 Department of Health, Registration of primary medical services providers with the Care Quality Commission—a consultation on a proposed change to the date of registration, June 2011, p7.  
104 Q 159  
105 Ibid.
5 Provision of information to the public

Information on adult social care providers

79. The CQC also plays a role in helping the public to choose between providers by giving them access to the information it holds on providers and, specifically, the results of its reviews and inspections. Following our pre-appointment hearing with Dame Jo Williams the Committee noted its concerns regarding the quality and accessibility of this information, in particular that regarding adult social care providers. In September 2010, Dame Jo had told us that:

One of the most important things that we can contribute is information on our findings that is understandable so that people can use it to make really informed choices. Translating some of the mechanisms that we are building—such as our quality and risk profile—into a usable set of messages for individuals in a local community is one of the things that we are looking at very carefully. You will know that our predecessor organisation had a star rating for providers of social care.106 We are currently consulting on what might be the most appropriate system for the future and anticipate that that will be concluded this year, with the new system probably starting next May.107

80. This has not been the case. The promised successor to the star rating system (see ‘The Excellence Award’, below) is currently being consulted upon and is not intended to be in place until April 2012, while the ‘user-friendly provider profiles’ setting out more of the data CQC holds on each provider108 have been put back from January 2011,109 to summer,110 and then again to autumn 2011.111

81. The CQC website now offers a searchable ‘Care Directory’, with information on each provider, but the information that is available is limited and often out of date. The CQC acknowledged these limitations in its annual report.112 Entries for typical adult social care providers currently show their last star rating (in line with legislation, the CQC stopped awarding star ratings in July 2010, so even the most recent star ratings are over a year old) and past inspectors’ reports (which may also be several years old). The only information

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106 These standards were awarded under the Care Standards Act 2000, which expired in September 2010. The CQC stopped awarding star ratings in July 2010.
107 See Health Committee, Appointment of the Care Quality Commission, HC (2010–12) HC461, Q 31. The transcript of the session can be found on the Committee’s website (http://www.publications.parliament.uk/pa/cm201011/cmselect/cmhealth/uc461-ii/uc46102.htm)
108 The CQC state that the provider profile will ‘tell people at a glance whether each service is meeting the essential standards. If they are not, it will state what improvements we require to make sure they do meet the standards involved. People will also be able to see when we have carried out a formal check of a service, whether it was directly in response to concerns or a routine check. Most importantly, each profile will include information about what people told us during our last formal check’. Care Quality Commission, Annual Report and Accounts 2010–11, p17.
110 Care Quality Commission news story, New excellence scheme for Adult Social Care, 28 February 2011 http://www.cqc.org.uk/newsandevents/newsstories.cfm?widCall1=customWidgets.content_view_1&cit_id=37165
111 Q 236
112 Care Quality Commission, Annual Report and Accounts 2010–11, 13 July 2011, HC 1212, p17
relating to the CQC’s current system is a statement that the provider has been registered and licensed against CQC standards of quality and service. The charity Action on Elder Abuse noted that this could be misleading:

The new system of registering social care providers [...] did not test compliance other than by self declaration. The process therefore gave a false sense of reassurance as it could only confirm a provider’s assertion of compliance.\textsuperscript{113}

82. Amanda Sherlock, Director of Operations Deliver at the CQC, told us that as of 5 July a statement would appear on a provider’s entry if they were under review by the CQC.\textsuperscript{114}

83. The paucity of information and, in particular, the delay in developing a successor to the system of star ratings, has been subject to criticism. The English Community Care Association accused the CQC of a ‘singular lack of urgency’,\textsuperscript{115} while Adass noted that the ‘considerable time-lag restricts the public from making informed choices about providers at a time when national policy supports choice as a core value’.\textsuperscript{116}

84. The information currently provided by the CQC on adult social care providers is unhelpful and often out of date. We welcome the introduction of an ‘under review’ label where the CQC is investigating a provider, but we find it surprising that it has taken so long to provide the public with such essential information. The delay in developing provider profiles is particularly frustrating as they could have been a useful interim guide for the public until a successor is developed for the star rating system. The constant slippage in the planned roll-out of the profiles is further evidence of a lack of control within the organisation.

**The Excellence Award**

85. The Adult Social Care Excellence Award is the proposed successor to the star rating system that operated under the Care Standards Act 2000, and which came to a close with the expiry of that Act in 2010. CQC is developing the scheme at the invitation of the Department of Health. The award is intended to demonstrate where providers meet a standard of ‘excellence’ above and beyond the CQC’s essential standards. The CQC is currently consulting on the principles behind the award, the definition of excellence, and suggested assessment procedures. It intends to launch the new award in April 2012. Under the consultation proposals (and as set out in the Government’s own consultation on social care services\textsuperscript{117}) assessment for the award would be voluntary. Assessment would be carried out by a third party organisation on behalf of the CQC, and the provider would pay an additional charge for assessment towards the award.

86. Evidence to the Committee was widely critical of the proposals. The Relatives and Residents’ Association told has that they ‘totally reject’ the concept ‘on grounds of cost,\textsuperscript{113, 114, 115, 116, 117}

\textsuperscript{113} Ev 44
\textsuperscript{114} Q 213
\textsuperscript{115} Ev 28
\textsuperscript{116} Ev 62
\textsuperscript{117} Department of Health, *Transparency in outcomes: a framework for adult social care*, November 2010
equity and total inappropriateness’,118 while Adass cautioned that the voluntary nature of
the system would ‘not help the public with easy to access and understandable ratings of all
care providers’.119 The English Community Care Association, Action on Elder Abuse, and
the National Care Association also opposed the scheme.120 The imposition of an additional
charge for the assessment raised concerns that smaller providers could be financially
excluded from the award.121 There are also questions over the suitability of using a third
party to carry out the assessment: ‘surely when inspecting providers of care CQC is best
placed to identify which provider is delivering an excellent service’.122

87. The proposed Adult Social Care Excellence Award has been roundly rejected in
evidence submitted to us. We share these concerns and recommend that the project is
dropped.

118 Ev 74
119 Ev 62
120 Ev 28 (English Community Care Association), Ev 38 (National Care Association), Ev 45 (Action on Elder Abuse)
121 Ev 45 (Action on Elder Abuse), Ev 38 (National Care Association).
122 Ev 38 (National Care Association)
Conclusions and recommendations

The balance between registration and compliance activity

1. The Committee concluded that the bias in the work of the CQC away from its core function of inspection and towards the essentially administrative task of registration represented a significant distortion of priorities. Although the evidence presented by the CQC acknowledged this distortion of priorities and argues that corrective action has now been taken, the Committee believes it is important to understand how this misallocation of resources arose, not least in order to reduce the risk of the same thing happening again. (Paragraph 6)

2. The Committee has identified the following factors which contributed to this distortion of priorities:

- The CQC was originally established without a sufficiently clear and realistic definition of its priorities and objectives;
- The timescale and resource implications of the functions of the CQC, in particular the legal requirement to introduce universal registration of primary and social care providers, were not properly analysed;
- The registration process itself was not properly tested and proven before it was rolled out; and
- The CQC failed to draw the implications of these failures adequately to the attention of ministers, Parliament and the public. (Paragraph 7)

3. We are extremely concerned that CQC’s compliance activity fell to such low levels in the course of 2010–11. We recognise that the CQC was obliged to work within the deadlines for registration imposed by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We also recognise that it was in order to meet these deadlines that resources were diverted from compliance activity to registration. Yet the fact that this was done to the extent that inspections fell by an unacceptable 70% demonstrates a failure to manage resource and activity in line with the main statutory objective of the CQC to ‘protect and promote the health, safety and welfare of people who use health and social care services’. In the current climate of financial constraint and reorganisation of the health service it is more important than ever to have a regulator that maintains a clear focus on its primary duties. In this instance that did not happen. (Paragraph 15)

4. The long-standing vacancies for CQC inspectors are a further cause for concern. The eight months taken to recruit the extra 70 inspectors for which the Department of Health gave permission in October 2010 is unacceptable given the urgent need to raise compliance activity. The CQC should also have been pushing the Government for permission to recruit outside the initial limited pool much sooner. These delays indicate a failure to react with urgency to a problem that was severely undermining the organisation’s compliance function. (Paragraph 17)
5. The CQC should have identified the difficulties inherent in the regulations early in the registration process and made clear to the Government that unless modifications were made it would not be able adequately to fulfil its duty to monitor and inspect providers. The senior leadership of the organisation had a responsibility to communicate this to the Government persuasively and persistently. The decisions to delay GP registration and review the regulations for registration have come too late. The Government and the CQC should set out what discussions were had and why action was not taken earlier to modify the regulations. (Paragraph 21)

6. It is encouraging that inspection levels are again rising, but the challenging context for CQC work remains. Even following the Government’s decision to defer GP registration until April 2013, the CQC will still need to spend 2011–12 registering the remaining dental providers and ambulance services, and then out-of-hours primary care, not to mention addressing the constant flow of applications to vary registration. The balance between registration and compliance activity will always remain an issue and if it is to maintain the confidence of the public and this Committee the CQC must demonstrate that it is prioritising its compliance activity. (Paragraph 24)

7. Furthermore the Committee regards it as regrettable that the CQC should have launched the process of registration of dental practices without undertaking adequate proving of the registration model. It strongly recommends that each future extension of the scope of registration should be preceded by a properly planned and executed piloting process. (Paragraph 25)

8. We expect to see clear evidence by next year of the CQC leadership openly acknowledging challenges and setting priorities that reflect its core duty to ensure the safety and quality of care. (Paragraph 26)

9. We note the CQC’s request for an additional 10% of resources to fund its inspection regime. We already have concerns about the way the CQC has handled and prioritised its existing resources and do not believe that additional resources will address these concerns unless they are deployed as part of a clear strategy. We would therefore welcome a breakdown from the CQC of how it arrived at the figure of 10% and exactly how it would intend to deploy these resources. (Paragraph 29)

The inspection and review process

10. The CQC must seek to address growing inspector caseloads through recruitment and should also bolster the support provided to inspectors to allow them to focus on their core frontline duties. (Paragraph 31)

11. The number of providers regulated by the CQC means that the organisation must necessarily operate a risk-based system. It is also right that the CQC should focus its resources on providers where there is an indication of a problem. However, it is difficult to see how the CQC can have confidence in a provider meeting standards if it has not visited the organisation for more than two years, no matter how good its record. Unannounced inspections must form the core of compliance assessment. (Paragraph 35)
12. The Committee welcomes recent announcements that the CQC intends to undertake annual visits of all NHS and social care providers, irrespective of the performance of the provider. We note that the CQC is seeking to operate as a ‘light touch’ provider, but we do not consider an unannounced annual inspection of NHS and social care providers to be an unreasonable expectation, even for the best providers. The CQC should carefully monitor its performance against this annual target and ensure that its key performance indicators are published on a quarterly basis. (Paragraph 37)

13. This does not give confidence in the ability of CQC central management to monitor, review and manage its compliance activity in the field, and we expect this issue to be addressed. (Paragraph 38)

14. We welcome the CQC developing alternative assessment models that involve ‘experts with experience’, provided that this approach complements rather than supplants CQC inspections. (Paragraph 39)

15. Quality and Risk Profiles have the potential to be a useful auxiliary tool for inspectors, but in their present form the quality of data is limited in its reliability and coverage. The CQC should work towards broadening the range of data included, in particular where there is little data available to support a particular outcome. (Paragraph 43)

16. We acknowledge that the CQC operates within a regulatory framework that focuses on outcomes rather than inputs. However, low staffing ratios can have such an exceptional impact on the quality of care that we believe monitoring of staff levels is an essential part of ensuring quality outcomes. The CQC should work to develop a mechanism whereby it can keep a closer track of staffing ratios in private care homes, in a way that can feed through into the QRP. Although it would be difficult for the CQC to mandate minimum staffing levels, it should develop indicative ratios that will assist inspectors to identify potentially inadequate staffing. (Paragraph 46)

17. The CQC must ensure its inspectors do not become over-reliant on QRPs. Even if the quality of data included in QRPs was excellent, such a tool could only ever present a patchy picture of the quality of care. (Paragraph 49)

18. It is right that the CQC places trust in the judgement of its inspectors when assessing risks and deciding on appropriate action. But this judgement can only be consistently exercised if the CQC provides a clear framework and guidance. It would be easy for active inspection activity to regress at this time of increased pressure on inspectors. The CQC must therefore ensure there is a consistency of approach by reiterating risk thresholds (Paragraph 50)

19. In its recent reports on the work of the General Medical Council and the Nursing and Midwifery Council, the Committee emphasised the importance which it attaches to the obligation which rests on all healthcare professionals to raise concerns if they recognise, or ought to have recognised, evidence of failure of professional standards. The Committee believes it should be a key objective of CQC inspections to ensure that the culture of each provider organisation recognises and respects this professional obligation, and provides proper security to those professional staff who discharge it effectively. (Paragraph 52)
20. Although healthcare professionals have a particular obligation, arising from their professional status, to take an interest in the quality of care being provided around them, this obligation is, in truth, a particularly focused form of the general duty of care owed by all staff of care providers to their patients, and indeed of the natural human desire of all citizens to see high quality care provided to the sick and vulnerable. Information is available from all these sources to measure the performance of care providers. The Committee believes it should be a key part of the inspection process to ensure that proper processes are in place in each care provider, including proper Board accountability, to ensure that these responsibilities are met. (Paragraph 53)

21. The calls coming in following Winterbourne View could be only the tip of the iceberg. We look to the CQC, in addition to encouraging cultural change within care providers, to take action to encourage direct information supply in cases where local structures fail. (Paragraph 56)

22. The CQC must ensure it makes the most of information provided to it. All relevant communications should be followed up in order to establish the usefulness of the information and to inform the CQC’s own judgement. This sort of information should be a trigger for CQC action—a note appearing on the QRP is not enough. (Paragraph 57)

23. Action in the case of Winterbourne View was woefully inadequate: the CQC failed to ‘actively follow up’ the local authority process, or conduct its own assessment, or even contact Mr Bryan for further information. The CQC should have done all of these things. (Paragraph 58)

24. The Committee believes that the CQC should be obliged to carry out an investigation in response to a recommendation from its HealthWatch sub-committee that the CQC investigate the quality of care provided by a particular provider. (Paragraph 62)

The registration process

25. The Committee has already reported its views that the priority attached by the CQC over the past 12 months to the registration of new providers represented a distortion of priorities. If this extension of registration activity was required management should have ensured that it was resourced in a way which did not affect the core existing activity of the CQC and should have resisted pressure from ministers or elsewhere to adopt a registration policy which it is now clear was inadequately prepared or resourced. (Paragraph 63)

26. The current regulations governing registration have imposed difficult and occasionally inflexible restrictions on the CQC’s procedures. It is regrettable that this was neither foreseen nor addressed before the vast majority of providers had already fought through the process. Nevertheless we welcome the Government’s review of the regulations. We urge the CQC and the Government to work closely together and with providers during this consultation period to ensure that all future registrations
(and in particular that of primary care providers) can be conducted in a proportionate manner within adequate timeframes. (Paragraph 72)

27. The CQC must also accept responsibility for its poor handling of registration and adapt its processes accordingly. In particular, the process could have been made significantly simpler and swifter for all involved had the CQC adapted registration procedures to different types of services. It is astonishing that it could ever have been considered sensible for small dental practices to work through the same process as a large hospital. (Paragraph 73)

28. Following the postponement of the deadline for registration of GP practices until April 2013 the Government and the CQC have some time to put things right. But this is no time for complacency. Action must be swift if procedures and especially regulations are to be reviewed, altered and put into practice in good time. We expect to see significant progress on this matter by the time of our next accountability session with the CQC. (Paragraph 74)

29. It is right that the CQC approval should be required for significant variations to registrations, but this requirement will remain a significant burden on both providers and the CQC unless the procedure is greatly streamlined. We welcome the action the CQC has already taken to improve the system and bring processing times down to a more reasonable level. The CQC should do all it can within the regulations further to improve the procedures, including consulting with providers and professions and bringing forward development of a system of electronic submission and processing. The CQC must work closely with the Government’s review of the registration regulations to identify where changes are necessary. (Paragraph 78)

Provision of information to the public

30. The information currently provided by the CQC on adult social care providers is unhelpful and often out of date. We welcome the introduction of an ‘under review’ label where the CQC is investigating a provider, but we find it surprising that it has taken so long to provide the public with such essential information. The delay in developing provider profiles is particularly frustrating as they could have been a useful interim guide for the public until a successor is developed for the star rating system. The constant slippage in the planned roll-out of the profiles is further evidence of a lack of control within the organisation. (Paragraph 84)

31. The proposed Adult Social Care Excellence Award has been roundly rejected in evidence submitted to us. We share these concerns and recommend that the project is dropped. (Paragraph 87)
Draft Report (Annual accountability hearing with the Care Quality Commission), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 87 read and agreed to.

Resolved, That the Report be the Ninth Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

[Adjourned till Tuesday 13 September at 9.30 am]
Witnesses

Tuesday 28 June 2011

Dame Jo Williams DBE, Chair, and Amanda Sherlock, Director of Operations Delivery, Care Quality Commission.

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5 English Community Care Association Ev 25
6 British Dental Association Ev 29
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Oral evidence

Taken before the Health Committee
on Tuesday 28 June 2011

Members present:
Mr Stephen Dorrell (Chair)
Rosie Cooper
Yvonne Fovargue
Andrew George
Chris Skidmore
David Tredinnick
Dr Sarah Wollaston

Examination of Witnesses

Witnesses: Dame Jo Williams DBE, Chair, and Amanda Sherlock, Director of Operations Delivery, Care Quality Commission, gave evidence.

Q149 Chair: Good morning. I apologise for keeping you waiting outside. We were dealing with some other unrelated issues. It was not that we were spending too long working out how we were going to cross-question you. We had something else that we wanted to talk about.

Thank you for coming this morning. I would like, if I may, to open the meeting by referring back to the report we issued following your last appearance here, Jo, about nine months ago. It was fairly clear, in that session, that the CQC had quite a big internal agenda in terms of bringing together the predecessor organisations, creating a common culture, working out exactly how the new body was going to work internally and, ultimately—and, of course much more importantly—relate to providers in the system. I would like to begin by asking you to update the Committee on where you feel that process has got to.

Dame Jo Williams: Thank you very much, Chair. In the last nine months we have moved on a great deal, particularly since January this year. I would describe it as a step change. One of the things we addressed, during the January to Easter period, was making sure that our processing was improved. We had a backlog, so we worked on that. Also, from Easter this year through now, we have made another step change in terms of getting out and doing significantly more inspections. We have said to those we register that it will be, and is, an eight-week turnaround from them contacting us, which is half the time that was taken by the predecessor organisation, the Commission for Social Care Inspection. Internally we continue to train and develop our workforce and create a common culture but we also look at the regulatory framework and the way in which we are conducting our business.

Q150 Chair: That is a report of the atmospherics in the organisation, if you like, that you feel you are making progress.

Dame Jo Williams: Yes.

Q151 Chair: Are there key performance indicators reported to your board, which are available to the public and can be seen—

Dame Jo Williams: Absolutely.

Chair:—whereby you measure that progress?

Dame Jo Williams: Yes.

Q152 Chair: Do you discuss those with your registered providers in order to see where the genuine key performance indicators are and discuss the performance with them as well?

Dame Jo Williams: Overall, we have delivered our targets in terms of registering the sector. We have now registered about 23,000 organisations in 40,000 locations. Of course, we have challenges to make sure that we are doing proper risk analysis for each of those locations where services are being undertaken. Thus, in terms of our public board meetings, we have had regular reporting and we look at our performance in relation to activity as to inspections, as well as to our Mental Health Act duties and a whole raft of other things. Have we openly engaged in conversation with provider organisations about that? We have a Provider Advisory Group. Probably the conversations have centred on registration processes and glitches in that system rather than sharing with them, in full, the performance measures, but our meetings—when those performance measures are discussed—are in public.

Q153 Chair: Do you think it would be desirable for the CQC to engage beyond the registration process?

Dame Jo Williams: Of course.

Q154 Chair: That is merely preparing the ground. It is opening the way to allow you to do your job. It is not doing the job itself, is it?

Dame Jo Williams: No. That is right. Of course, we are having an ongoing dialogue with a range of provider organisations—the NHS Confederation, foundation trusts and the adult social care market—to talk about the issues that they are facing as well as the way in which we are carrying out our functions.

Q155 Chair: It would be useful to the Committee to understand what you see as being the key performance indicators, how your performance is moving against those objectives—indeed, where you think it needs to go in the future—and the extent to which those objectives are shared by the provider community. Is that something you can provide to the Committee?

Dame Jo Williams: We can. Certainly one of the key issues—not only for the provider community but, importantly, for the public—is an increased appetite for us to be seen on the ground carrying out
inspections. For instance, we are now operating in the region of 600 inspections a month. That is a huge change from where we started at the beginning of the year. That is one of the key indicators which I think both the public and providers are critically interested in.

Q156 Chair: Do you have a view as to where you would like that to get to?

Dame Jo Williams: We would probably like to double that, at the very least. Of course, we operate a risk-based model. That means we look at information flowing into the organisation and each inspector then determines whether or not there are indicators suggesting an inspection should be carried out.

We are also developing a different style of looking at the way in which organisations are performing, which we will continue to develop. We undertook 100 inspections of hospitals, looking at dignity and nutrition. We did it in conjunction with people we called “experts by experience”, who have either experienced health care themselves or with someone they cared for, and also with professionals—nurses. That model, we believe, is something we will continue to grow. It certainly captures what we regard as critical information—listening to patients themselves or with someone who experience services. Therefore, again, the way in which we engage with voluntary organisations and specific interest groups to help us carry out that work is very important.

Q157 Chris Skidmore: Dame Jo, in terms of being able to cope with the current situation, what is your current backlog of registrations with, for instance, organisations that wish to vary their existing registration? I believe you are receiving 155 applications a day and I know you have mentioned the eight-week waiting period. As of today, can you shed any light on how the current situation stands?

Dame Jo Williams: That is where we are now.

Q158 Chris Skidmore: On top of the registration period, you have obviously had episodes such as Winterbourne View. I must admit, as a constituency MP, it lies just outside my constituency in Kingswood, and I hope you don’t mind me asking a couple of questions about that particular case.

Dame Jo Williams: Not at all.

Q159 Chris Skidmore: Do you feel you can strike the right balance between this demand for registration—which may be constant, given that practices are always wanting to vary their current registrations—and, realistically, getting to that level of 1,200 inspections in a month?

Dame Jo Williams: It is important to say that the processing of variations to registration is something we have spent a great deal of time looking at and improving. Certainly, there is much more work to be done there. One of the issues for us—again this will need working with the sector—is the extent to which, in the future, we will look to them to send information electronically to us, and it will probably take two or three years for everyone to be able to communicate in that way. However, the processing is getting much slicker and that has enabled us to get to this eight-week turnaround. There will be occasions when there is a very complex situation which may take longer than that, but, apart from those exceptions, as I said, eight weeks is now the target we are largely hitting. That is the processing.

If it is a new registration, then, quite clearly, it requires the skills of someone who inspects services and will even engage in a site visit. The work of our inspectors is very much about looking at their caseload, doing a risk analysis and determining whether they need to make a visit. My aspiration for more inspections is largely based on us making sure that flow of information is effective to them and they have the tools to do their job, but also—there is no doubt—we are talking with the Department of Health about the extent to which we need to have additional resources to enable us to recruit more inspectors.

Q160 Chris Skidmore: Let us take that risk analysis and place it in the situation of Winterbourne View. I believe that on 6 December Terry Bryan, the whistleblower, contacted CQC directly.

Dame Jo Williams: Yes.

Q161 Chris Skidmore: Obviously, then, you have the local authority taking the safeguarding lead. You mentioned in your own account of events at Winterbourne View, “However, we recognise that had we contacted the whistleblower ourselves directly after we received the email we would have been alerted to the seriousness of the situation and moved swiftly to inspect the hospital.” I want it to be clear on the record, if a whistleblower e-mails the CQC today, what process would be triggered and has that process been changed in light of the Winterbourne View situation?

Dame Jo Williams: The information would go to the inspector, as it did in relation to Winterbourne View. We now know that we need to follow that up and also make sure that their manager has that information as well. We have reviewed what has been happening and tightened up those procedures.

Q162 Chris Skidmore: In the situation with Winterbourne View, the contact was made on 6 December. The safeguarding meeting then did not take place till February 2011.

Dame Jo Williams: Absolutely.

Q163 Chris Skidmore: Once that e-mail had been received by you, you passed it down to the local authority but left the situation as it was, depending on the local authority to have the safeguarding meeting.

Dame Jo Williams: It is fair to say—and I have said this on more than one occasion—that, regrettably, there was an error of judgment. The individual concerned wrongly made an assumption that, because it was resting with the safeguarding board, action was being taken. That should have been chased up. Indeed, she should also have made her own separate assessment of the risk. That did not happen.

Q164 Chris Skidmore: In terms of the culture of allowing people to become whistleblowers, to put that
Dame Jo Williams: It is fundamental to us. This is the critical thing for us. We must always learn from things. It was desperate to see Winterbourne View and know that, potentially, people had experienced some terrible things because we and other people had not taken action. Absolutely, we are very much examining what happened, how we can do better and, as I say, rebuild that confidence so people can come to us and let us know if there are things happening that are putting people at risk. Thank you very much.

Q166 Chris Skidmore: I am very concerned that, in terms of the Winterbourne View situation, real lessons will be learned because that would mean a great deal for the patients and their families. Do you believe that is taking place and that, in terms of what happened at Winterbourne View, you have all learned those lessons?

Q167 Chair: One of the points we took up with the General Medical Council and the Nursing and Midwifery Council when they were here two or three weeks ago was the point you made about the obligation on all health care professionals to be responsible for care being provided around them in addition to their responsibility for the care that they themselves provide. Is that something the CQC engages with? If it finds an example of a health care professional that, in the view of CQC, should have reported what was going on and did not, is that an issue where the CQC engages either with the regulator or in its own right?

Dame Jo Williams: Absolutely.

Q168 Chair: How many professionals have been reported by CQC to their professional regulatory body?

Dame Jo Williams: I do not have that figure.

Amanda Sherlock: We can get them.

Q169 Chair: It would be interesting to know because the question in Winterbourne View, but much more generally, is: how many professionals either knew or should have known what was going on and did not observe their professional responsibility to report it?

Dame Jo Williams: Yes.

Q170 Chair: It is one thing to facilitate whistleblowing. It is another thing to ensure that people understand, if they are professionals, they have an obligation to report.

Dame Jo Williams: I agree with you.

Q171 Chair: Is it something the CQC has followed up as a theme with individual employers or individual providers, that either the culture or individual performance in an individual provider has not reflected that obligation?

Dame Jo Williams: I cannot answer that question with specific examples for you, Chair, but I will certainly look into that.

Q172 David Tredinnick: I want to go back to registration, but, on the whistleblowing, do you think the increase in the number of whistleblowers is because of improved practice or is it in fact that they were ignored in the past and you never picked them up?

Dame Jo Williams: From the point of view of CQC, I have no evidence at all that we previously ignored anyone ringing us with a concern at work.
Q173 David Tredinnick: There is a dramatic increase, isn’t there, in the numbers of whistleblowers who have come to you?

Dame Jo Williams: Yes.

Q174 David Tredinnick: Do you have any idea or thoughts about why?

Dame Jo Williams: Why do whistleblowers come to us?

David Tredinnick: Yes. Why has the number suddenly shot up?

Dame Jo Williams: This is speculative, but I imagine it was because of Winterbourne View and being in the public domain. It is true to say that we are still a relatively new organisation and it may well have been that, for the first time, people understood what the Care Quality Commission was, who we were and how to get hold of us.

Q175 David Tredinnick: Thank you very much. I have a couple of questions on registration. The British Dental Association described the process as “shambolic”. Do you think that is fair?

Dame Jo Williams: We had a lot of conversations and did a lot of planning with the British Dental Association. They helped us with the processes. It is true to say that we had a single process, which we applied both to health, adult social care, and dentistry. We have recognised it is a cumbersome process—the regulations are cumbersome—and that there is some learning there for us. I know it has been painful.

Q176 David Tredinnick: As to this cumbersome process, presumably you are hoping it will be, perhaps, the key issue raised in the Government’s review—is that right—of the registration system? What changes do you think should be made, please?

Dame Jo Williams: Internally, we are reviewing that as well. We obviously need to work with the regulations and we are constrained by the regulations, but if there are things we can do to make that process of application simplified, we are aiming to do that. For instance, it strikes me that, when we fill in a tax application, we are used to saying, “This is not applicable”—one of the things dentists were saying was that particular areas weren’t applicable—making it easier to process in that way.

Q177 David Tredinnick: It is not suitable for small practice registrations at the moment, is it, say, for one or two? It is a very cumbersome system for that, isn’t it?

Dame Jo Williams: The regulations, which contain the essential standards, are applied universally to health, social care, dentists and, in the future, primary care. With those regulations, obviously, we need to be proportionate. Some of those regulations will apply less to someone operating as a dentist as opposed to an NHS hospital. Nevertheless, we have had to work within the regulations.

Q178 David Tredinnick: I put it to you the situation is, in fact, so bad that it is the reason the registration of doctors is going to be delayed until 2014. What exactly are you going to do with the breathing space that you will be given because of the delay in this other important registration of doctors?

Dame Jo Williams: At the beginning of this year—and again it was a very considered decision, recognising that we did have a backlog of work and were still a relatively new organisation that needed to mature—I went to the Secretary of State and said that I thought it was important we had more time to review our processes before registering general practice, primary care. That has been agreed. We have been working with the Royal College for some considerable time—and we will continue to do so—to ensure that process is more streamlined and appropriate. Next year we will be looking at out-of-hours medical services, so we will be doing that on time.

David Tredinnick: Thank you very much.

Q179 Dr Wollaston: Can I return, briefly, to Winterbourne View? How confident can the public be, if you received another e-mail such as the one you received on 6 December, that an inspection would take place and it would be followed up in a timely manner? Also, what do you consider to be the time frame for that?

Dame Jo Williams: I want to reassure you we are now sighted on making sure not only that the individual inspector receives the information by e-mail and by phone call but also that their manager has it too. That is putting in an extra, if you like, assurance in the system. Each inspector will make a judgment about the information they have received alongside the rest of the information they have in relation to a particular service or activity. We are now at the point where, with almost all our reviews of that nature or if we receive a series of concerns or complaints from the public about a service, we would go out and do an unannounced inspection.

Q180 Dr Wollaston: Had you had an e-mail such as the one on 6 December, within what sort of time frame would you aim for that inspection to take place?

Dame Jo Williams: I don’t think we would set a—

Dr Wollaston: You wouldn’t.

Dame Jo Williams: We do not have a target of 24 or 48 hours, but we would expect it to be proportionate to the seriousness of the information we are receiving. An inspector would also want to talk to others that may be involved, for instance commissioners of services, so that the picture is drawn. If it was felt that individuals were at risk, my expectation would be that we went out immediately.

Q181 Dr Wollaston: We would not be waiting eight weeks for that kind of thing.

Dame Jo Williams: No, absolutely not.

Q182 Dr Wollaston: That is very important. One of the other issues that brings me on to is your budget. Your budget is £60 million less than your predecessor’s. That is very important. One of the other issues that brings me on to is your budget. Your budget is £60 million less than your predecessor’s. That is very important. One of the other issues that brings me on to is your budget. Your budget is £60 million less than your predecessor’s. That is very important. One of the other issues that brings me on to is your budget. Your budget is £60 million less than your predecessor’s. That is very important.
is difficult in the world within which we are working at the moment, where money is very difficult and the expectation is that we are a light-touch, proportionate regulator. However, it does seem to me that there is considerable appetite among the public, and indeed those who are providers of service, for us to be more visible and to be carrying out more inspections. Unless we had a complete array of inspectors, of course, or other people were working with us, those who experience services and their families as well as providers—fundamentally, providers—we would not be able to say to the public that services were meeting those essential standards. It is about pulling that information together.

Q183 Dr Wollaston: Following on from that, of course, is the information available to commissioners?

Dame Jo Williams: Absolutely.

Q184 Dr Wollaston: Are you currently contacted regularly by commissioners in helping them to make decisions about care?

Dame Jo Williams: We have a flow of information. In relation to the Health Service, we have something called a Quality and Risk Profile where we draw down well over 250 pieces of information about an individual service. It is analysed. That is the hard data. In addition to that, we receive information from patients’ groups—LINks—which we are evaluating. That information goes to our staff, but also to commissioners. We are working with local government in relation to adult social care, looking at how we can exchange information. At the moment, we are working with 16 local authorities on pilot sites to ensure that flow of information. It is absolutely crucial that we do that and, frankly, with the Health Bill going through with those new changes, it will be crucial that our information is made available to commissioners and the NHS Commissioning Board.

Q185 Dr Wollaston: I know that other colleagues want to touch on Quality and Risk Profiles and the adequacy of that, but, before I finish, do you anticipate yourself having any role in regulating the quality of commissioners themselves, or merely in providing them information?

Dame Jo Williams: As things are at the moment, we no longer have a responsibility for looking at commissioning and regulating commissioning. However, first of all, it is vital we get that information to them, but it is also true to say we are about to embark on—following on from Winterbourne View—a significant series of inspections looking at health services for people with a learning disability. One of the things, almost inevitably, that will emerge from that is a commentary on what is happening in terms of commissioning. We will put that into the public domain. Although we are not regulating it, I know, through those inspections, that information flow will happen.

Q186 Chris Skidmore: Specifically on those inspections, there is a real issue of confidence in the system at the moment, as I mentioned in my earlier section.

Dame Jo Williams: Indeed.

Q187 Chris Skidmore: Those people who want to provide information need the confidence that it is going to be followed up. Obviously, you have now put in place systems and you will take those measures so that the situation of Terry Bryan never occurs again. First, to be clear, constituents contact me and are now copying me into e-mails to CQC, so I follow them through as well.

Dame Jo Williams: Good.

Q188 Chris Skidmore: But I do not know yet, for instance, if the CQC receives that contact by e-mail, whether contact will be made by e-mail or by phone or there will be an active way of chasing up that complaint. I know you cannot give a time frame, but is there a guarantee that that will be done?

Dame Jo Williams: If one of your constituents is sending information to us, absolutely, we are following that up, yes.

Q189 Chris Skidmore: Secondly, in terms of inspections for homes dealing with people with learning disabilities, will those inspections be post registration and being brought into the regulatory system.

Dame Jo Williams: They will indeed, yes.

Q190 Rosie Cooper: I want to address another comment you made this morning. As to your workforce, how do you see the percentage of the work being done with regard to registrations and inspections currently—a short answer to that? Would you see them as both part of the same thing?

Dame Jo Williams: Registration is a process. It is managed.

Q191 Rosie Cooper: I understand the process. What I am asking you is this. How much time does your organisation spend currently on registration and inspection? I know you will say that inspection is part of the registration process, but I am talking about a revisit, a recheck. What is the balance?

Amanda Sherlock: Might I add some information here? Now that we are into a “business as usual” way of working—the bringing of these huge changes and services into registration is by and large completed—approximately 20% of our time is spent on registration and 80% on compliance, enforcement and follow-up, post registration and being brought into the regulatory system.

Q192 Rosie Cooper: How many vacancies do you have in your organisation currently?

Amanda Sherlock: For frontline inspectors?

Rosie Cooper: Throughout the organisation.

Amanda Sherlock: It is approximately 350 across the organisation.

Q193 Rosie Cooper: You have 350 vacancies. How many of those are inspectors?

Amanda Sherlock: 121.

Q194 Rosie Cooper: You are now telling us that you are getting more complaints through the system than
ever. You have all these vacancies. I know you have given evidence to various inquiries, and the Mid Staffordshire inquiry for one. Did you disclose the number of vacancies you had? What are you doing about getting them filled? Dame Jo has talked about conversations with Government about resources—and somebody like me would say you were absolutely stretched and under-resourced—but if you have 350 vacancies and 121 inspector vacancies, there is a problem here, isn’t there?

**Dame Jo Williams:** Can I pick up a couple of points? In relation to the inspectors, we have recruited and offered jobs to 70 people.

**Amanda Sherlock:** That is in the last few weeks.

**Dame Jo Williams:** Recruitment is going ahead now.

Q195 **Rosie Cooper:** How long have these 121 vacancies existed? This is not short term.

**Dame Jo Williams:** No.

Q196 **Rosie Cooper:** Why have you not interviewed and appointed before now? I am told that this is a long-term vacancy problem. If it is, why is it?

**Dame Jo Williams:** We have had to work within guidance to ensure that, when we were changing our systems internally, people being displaced from one job had to be given the opportunity to come into other jobs. It has been a constant changing round.

Q197 **Rosie Cooper:** The public have been put at risk because you have not had enough inspectors while you were busy internally reorganising yourselves. Is that what we are saying?

**Dame Jo Williams:** No. It is absolutely not true to say that. We have worked entirely within the guidance we were given to make sure that we recruited people appropriately—people with the right skills to do the job.

Q198 **Rosie Cooper:** Would you perhaps send to the Committee a chart of how many vacancies in inspection you have had, for example, say, since your inception—the bigger numbers? I am not talking about a clerical thing, but somebody who is going to make a difference to your process. If you had a problem with this, did you disclose it when you were giving evidence at Mid Staffordshire, for example?

**Amanda Sherlock:** Yes, we did.

Q199 **Rosie Cooper:** With the Chair’s permission, I would like to look at some of your indicators about the effectiveness of the model you work on to get your proper risk analysis—sorry, that was the phrase you used before. I am talking about Quality and Risk Profiles. It does not rely on sophisticated number crunching, but rather the quality of the numbers in the first place—in other words, the information you get. As a former chair of a hospital, I am concerned. I know there are 250 different bits to it—and I will come to other bits of this in a second—but, for example, you rely on PEAT scores quite a lot, yet they are tick-box by the hospital themselves. How can that be okay?

**Dame Jo Williams:** The work that has been developed in relation to the NHS and Quality and Risk Profiles has been developed over a number of years. We are now in a much stronger position with analysing that information, but it is supplemented by the information we receive relating to people’s experiences. You will know that that is a rich source of information.

Q200 **Rosie Cooper:** PEAT scores left Stafford with 20 out of 25 for privacy and dignity and the NHS Litigation Authority gave Stafford 9 out of 10 for governance. I am hardly enthused and reassured by all that.

**Dame Jo Williams:** Of course, we have learnt a great deal from what happened at Mid Staffordshire. I will ask Amanda to come in in a moment, but we are absolutely clear that it is very important for us to share information, work with commissioners and work alongside Monitor—and also a range of other organisations, including, as I say, NHS Choices and patients’ groups—to ensure there is a proper flow of information.

Q201 **Rosie Cooper:** Surely the very people you are trying to reach are the very people who will not fill in those forms—the elderly, the confused. For example, my father would never fill in one of those. He would think somebody was going to pick on him. He wouldn’t tell you the truth about what was happening to his care. Those are the very people who, by virtue of their illness, age, infirmity or whatever, would feel vulnerable. They would not be the people who would sit and fill up those forms. If you do not have the ability to reach down and get those numbers in, you cannot rely on the numbers that you tell us you are relying on.

**Amanda Sherlock:** The Quality and Risk Profiles are an excellent repository for data and information, enabling people who are very skilled in analytics to identify the probability of risk in a service. That is heavily supplemented by an inspector using their professional judgment.

Q202 **Rosie Cooper:** Shall I read you the Mid Staffordshire numbers again?

**Amanda Sherlock:** The Quality and Risk Profiles are a tool to support inspectors in making a judgment. It does not in any way make a judgment about the outcomes for people using services. One of the lessons in the dignity and nutrition inspection programme has been that using tools that have been used in adult social care inspection over the years, such as the SOFI tool—Short Observational Framework for Inspection—is as powerful as any set of statistics.

Q203 **Rosie Cooper:** Is that one that you decided to do or the Secretary of State asked you to do?

**Amanda Sherlock:** We were asked to pull together a programme that would look at dignity and nutrition. The method by which we undertook that inspection programme was CQC’s design.

Q204 **Rosie Cooper:** When information is not available for a particular organisation—when some of these categories are missing—is it presumed to be okay or is it presumed that you will need to investigate? The evidence you gave at Mid...
Staffordshire would suggest that you do not investigate that very much further.  
Amanda Sherlock: It is never presumed to be okay because there is a lack of information. In fact, it would be the opposite assumption, that we would need to go and check.

Q205 Rosie Cooper: I will not read you the whole paragraph: “... where the QRP contains insufficient information for a risk to be analysed for a specific outcome, CQC is nonetheless treating the institution as being compliant unless information is received—A. That’s correct. Q.—to the contrary? A. Yes.”

Can I ask you what the actual position is when you get information which is conflicting? Do you go out and inspect when you do not have either the information or the resources—the score is not good enough? Do you go and look at it? What I am trying to get to is: are you confident that you are not missing poor standards? The CQC is in a difficult position because most of the country will see you as the badge that says “This is good”. Yet, so much of the time, from what I have read and can see, you have large numbers of vacancies, you are stretched and you are getting ever more jobs, and we have not even begun to look at HealthWatch, which I am terrified you are going to get as well, because you do not have the resources to deal with it. I hear that you are in discussions, but you are the mechanism by which this country is supposed to be assured that the elderly, the ill and people at risk are being looked after. I can go on.

Safeguarding is dominated by issues to do with children and older patients without capacity. I don’t know what the word is. How do you evaluate that? Who puts that together? For example, the safeguarding one for children asks if there is a visiting room for children that is nicely furnished with toys and uses the national inpatient survey of adults. The “global rating scale” focuses on endoscopy units. It is used in a number of outcomes but not the one relating to medical equipment. There are some really obvious things. I want to be sure children are safe. I believe that they should have toys to play with, but that is a lot lower down on my list for being assured about children and safeguarding than things that are here. I am worried. I am seriously worried about your capacity to deliver.

Dame Jo Williams: Can I pick up one point, if I might? The public are absolutely right to be focusing on the fact that we are the regulator for health and social care, dentists and, in the future, primary care. The centre of our work is focused on that role of protection. However, we cannot do it alone. It is dependent not only on analysis of data but information flowing into our organisation from a variety of different sources, whether it is individual experiences, families or people working in the service. It is also important that we share and gather information from other organisations that I have already mentioned this morning. It is a collective.

Our job is to ensure that if we receive information that raises questions about those 16 essential standards—whether or not there has been a breach—we investigate and find out if there has been a breach. There are judgments to be made about that every time, analysing what we have learnt and what we know already, but that is absolutely central to the work that we do. We are refocusing all our energies to make sure that we do that well and that we get people out there looking at, talking to and listening to those who receive services. One of the things I would say is that providers need to be saying to themselves, “What is happening during the early hours of the morning and 24 hours a day? What am I doing as a provider of a service to ensure that those essential standards are not being breached throughout the day?”

Q206 Rosie Cooper: I absolutely agree that the providers have that responsibility, but I want to put it to you that the great British public are looking to you to make sure they do.

Dame Jo Williams: Indeed.

Q207 Rosie Cooper: Therefore, you must be fully staffed and have the capacity to do it. Genuinely, from the things I have read out, Mid Staffordshire could pass all these tests. You are reliant on information which may or may not be there or be accurate. I hear what you are saying about improvement, but it is going to have to be a huge step change—light years’ improvement—and a much quicker reaction. When you find a breach, what do you do?

Dame Jo Williams: I will ask Amanda to answer that question, but can I also reiterate where I started, that I do think we have made those step changes in the last six months. We are not there yet—and I cannot pretend that we are—and we do need additional resources to be able—

Q208 Rosie Cooper: What have you asked the Secretary of State for?

Dame Jo Williams: We need an additional 10% because we need more inspectors; we need to be able to draw in more experts by experience to go in with us; we need more people who can go in specifically with a background; and, of course, if we have additional frontline staff, we need support systems as well.

Q209 Rosie Cooper: What does an additional 10% mean?

Dame Jo Williams: It is about £15 million.

Q210 Chair: You are saying that, without that, you cannot do your job.

Dame Jo Williams: I am not saying that. We will continue to look at ourselves and say, “What efficiencies can we make?”; because we know that we can improve effectiveness and efficiency internally. What I am saying is, looking at what is happening in the sector, when things are going wrong—when there is a breach—that is resource intense. We need to follow it up, go and ask questions and ensure that progress is being made. If it is not, we need to take action.

Q211 Rosie Cooper: I would like to know the detail. When you identify a breach, what happens, please?
Amanda Sherlock: In very broad terms, if a breach is identified of the essential standards whilst we are on an inspection, that evidence would be brought back, it would be discussed with a clinical expert if it was in an NHS organisation—additional expertise if we wanted to triangulate and ensure that the evidence of the breach was going to stand up to tribunal or stand up, potentially, to prosecution—and we would then make a decision as to the impact on quality and safety against the essential standards. We would then map that against our available enforcement tariff and determine what action was going to be appropriate, if indeed it was going to be escalated into enforcement action. It might be a warning notice; it might be that we would trigger a fuller investigation, if there was evidence of serious or systemic failings that were whole organisational, rather than specific to one of the essential standards; or it could potentially be that we would go down the criminal route and move to prosecution or a fixed-penalty notice. However, in a constrained financial environment, placing a fine on a provider is not usually the best way to lever essential standards compliance.

Q212 Rosie Cooper: How would the public know?
Amanda Sherlock: We would publish. Once we are—and this is a difficulty with regulations—through the appeals period we would publish that information and activity.

Q213 Rosie Cooper: Is your website up to date? It was dreadfully not up to date last year?
Amanda Sherlock: It is being updated next Tuesday. What we have introduced, where we have any concerns, is that it says “under investigation” on our website or “under review”.

Q214 Rosie Cooper: Your website is still not up to date.
Amanda Sherlock: It will say where we are undertaking any inspection review activity. The website will say that we are undertaking that investigation.

Q215 Andrew George: Coming back to the risk-based method that you very much depend upon, I assume you accept that if your budget were quadrupled, that you would never have enough inspectors to drop the risk-based system you primarily depend upon to keep an overview of what is going on around the country. Is that a reasonable comment?
Dame Jo Williams: It is, indeed.

Q216 Andrew George: In that regard also, you depend very much upon whistleblowers, whether they be the patients, their family or staff in the system. Are you reasonably confident that your doors are sufficiently open to that happening, that the message is out there, that people are beating a path to your door and that you are comfortable people are aware of your existence in that respect?
Dame Jo Williams: I have indicated we are seeing a rise in the number of people who are working in an organisation and are concerned. We are probably also getting about 150 calls a week from members of the public expressing their concerns. In fact, that is rather a small number. Our ambition is that people would not only want to contact our central number but that our inspectors on the ground are visible, people know who they are and can make contact with them if they have concerns.

Q217 Andrew George: Through the risk-based assessment—through the QRPs as well—you are monitoring the outputs, as it were, what care is provided. However, within the 250 indicators, presumably a large number of those indicators are an assessment of the inputs. Are you assessing staffing ratios? Taking nursing care homes or even those which involve learning disability, do you have a notional view of what an appropriate staffing level would be?
Dame Jo Williams: I would ask Amanda to pick up that particular point, but the regulation themselves are focused on outcomes for people rather than the inputs, as you describe. One example that springs to mind where we did focus absolutely on the staffing level was in relation to Milton Keynes Hospital maternity services. We felt that, in order to be able to say the service was safe, they needed one-to-one services for women, midwife to mother. In a sense, we stepped outside our parameters, if you like, in doing that, but we believed that, in order to offer a safe service, it was appropriate for us at that time to comment on that and to demand that that happened in order for the service to continue. What I am saying is that if we discovered there was a breach of regulations that related to the number of staff on duty, the ability to give people a good quality experience, then we would be saying to those providers, “We think you need to look at your staffing levels.” Staffing levels, use of agency staff and turnover of staff are often very good indicators of a culture that is not focused on the people they are serving.

Q218 Andrew George: They are part of your QRP.
Dame Jo Williams: I am not sure that they are part of our QRP.
Amanda Sherlock: For the NHS we would have that information available.

Q219 Andrew George: You would have it for the NHS but not in the private sector.
Amanda Sherlock: No.

Q220 Andrew George: May I put this to you, and I will take a moment to say it if you are saying you are stepping outside what you would normally do. Having shadowed nurses in the NHS context, but also talking to nurses and care workers in the private sector, one of the themes which clearly crops up time and time again is this sense that the staff ratio is very much on the edge of what is actually, frankly, viable to run an adequate service. That seems to be across the board, even among the best providers. They are teetering on the edge of viability. I say to the staff, “Do you complete an incident form? Do you comment on this or report it back?” On every occasion the answer is no, they do not, because, if they did, it would affect their future career prospects. They would be asked the
question by senior management, “If you can’t manage, why is it that all the others on the shift can?”, and so on. You have a culture in which staff are under pressure not to complain about the fact that the staffing ratios are on the edge of what is safe for patient care. Therefore, I put it to you that this is surely an input that you should be looking at as an indicator of services which are on the edge of being, if you like, compliant with the kind of quality that I believe we all want to see. Is that not a fair point?

Dame Jo Williams: It is a fair point and I think Amanda said that in the NHS we have that. Reflecting on your comments, this is a critical area. We are currently undertaking a very intensive review of a hospital—and we will be pursuing another hospital probably tomorrow. Quite clearly, in that piece of work, we are looking very much at the whole service, and the way in which they deploy their workforce and the turnover of the workforce would be very important indicators.

Q221 Andrew George: In some sectors, of course, there are professional guidelines as to what the staffing levels should be, and maternity is certainly one of them, but not all sectors have them as you know. It is one of those areas where there is a possibility that there may well be a pattern emerging, both within the acute sector but also in, say, nursing care, and indeed residential care, where staffing levels are not adequate. That is possibly a point which not only needs to be taken up with the individual providers but also fed back to the Department so that it can inform policy, or possibly to the clinical colleges so that they can advise the services themselves as to what the appropriate staffing levels should be. Is that not a fair point?

Dame Jo Williams: It is a very fair point. As part of our review or inspection of a service, we would be looking at the extent to which individuals had a care plan and were central to what was happening in that organisation. Quite clearly, that will reflect on the investment in the workforce. I don’t know whether there is anything you wish to add, Amanda.

Amanda Sherlock: In adult social care, at transition to the new registration and framework, we were very mindful of the shortage of registered managers. One of the key indicators of good quality social care is the capability and availability of good registered managers. Therefore, we took a policy position of placing conditions on the registration of those adult social care providers where there had been a history of a lack of a registered manager and where there were no credible plans in place that the provider could demonstrate to recruit good, high-quality registered managers. Whilst we have nothing in our regulatory framework that allows us to set any minimum staffing levels or staffing ratios, we do link it back to outcomes for service users where we can. That is then, where possible, triangulated back to our regulatory framework to enforce.

Q222 Andrew George: It is, I think, well worth having a view from a managerial perspective but, given that you have indicated today that your QRP indicators do not take account of staff-to-patient ratios across sectors—I quite appreciate that, on the one hand, we are talking about active cruelty and neglect, but as far as the pressures in services across the board are concerned—do you not agree that it would be perhaps time for the CQC to include in its indicators, dependent upon the nature of the service being provided, some kind of indicator as to the staffing level you believe should be in place in order for that service to be a safe service?

Dame Jo Williams: It is true to say that if we thought individuals were at risk we would most certainly be saying there was a need for additional staffing, not only at managerial level, but actually on the ground. Our assessment will be very much based on the impact on those individuals, which gives us some degree of flexibility. However, there is no doubt that, if we felt there was a shortfall and people were being put at risk, we would ask that organisation to improve their staffing.

Q223 Andrew George: I will take as an example helping older patients with dementia and disability to bed at the end of the day. I have complaints from constituents saying that often they are taken to bed too early—3 or 4 o’clock in the afternoon. Of course, the reason for that is because of the staffing levels and that each one takes half an hour for the care worker to get them to bed. If you work it out, given the number of patients which they need to take to bed, they need to start at 3.30 in the afternoon. Thus, you have this absurdity of a care system which is inevitably going to provide poor quality care because the staffing levels simply do not ensure that the patients have an adequate, if you like, time of day to spend out in their property or in the garden.

Dame Jo Williams: I absolutely agree with you, and I will ask Amanda to comment. It seems to me that they are not delivering appropriate care to those people they are looking after.

Q224 Andrew George: The staffing levels will not allow it, though.

Dame Jo Williams: We would be talking to that organisation about breach of compliance, because they certainly won’t be enabling people to have choice and a quality of life that we would regard as appropriate in terms of quality of care.

Q225 Rosie Cooper: How would you know?

Chair: That is exactly the question I wanted to ask. You said that you don’t have a status for looking at staffing ratios, and yet you would express a view if you felt the staffing ratios were inadequate. It cannot, surely, be right that you have no status in looking at staffing ratios.

Andrew George: You are looking at outputs not inputs.

Amanda Sherlock: You would find that out through whistleblowing, through inspections, when you would look at staffing ratios and when you would speak to staff and to residents to get their experiences of care. Then you would go back and track that with the provider and say, “This is what I am being told. Can you demonstrate evidence that this is not true?” and take that approach. However, we are not in every
location 24 hours a day. We are very much dependent on that information being fed through to us.

Q226 Rosie Cooper: When this is televised, you will find so many families throughout the length and breadth of the United Kingdom screaming at the TV that they know their elderly relatives are being put to bed in the afternoon or very early evening. This is going on. It is almost standard practice. Everybody can give you a tale of it. You are saying here it is unacceptable, but how is it going on if it is unacceptable? Is it Mid Staffordshire on a smaller scale? This doesn’t make sense.

Amanda Sherlock: The public have to tell us.

Q227 Dr Wollaston: How can they make the judgment? It is easy for you to make a statement about safe staffing levels for different types of residential care.

Dame Jo Williams: I take the point.

Q228 Chris Skidmore: You are not communicating effectively enough to the public the message of saying what is acceptable and what is not acceptable. You do not have the public guidelines in place. You do not have a consistency of approach. One inspection can turn up one thing and another a different thing. Where is the consistency in quality? That is probably what we are trying to get at here.

Dame Jo Williams: We clearly need to take this away. We need to explore and challenge the evidence that you have put forward that this is happening right across the country, but—

Q229 Rosie Cooper: I am sure newspaper readers and TV viewers will inundate you now. Everybody who deals with elderly people knows this is going on. I have had a number of relatives in the last six months who have either been in nursing homes or been very ill and have since died. I have had conversations with your regional directors and the truth is everybody does know it is going on. Perhaps you are the only people who do not get that this is going on in as big a way as it is out there, but it is.

Dame Jo Williams: That is a good challenge. That is a challenge we have to take away.

Q230 David Tredinnick: What is being asked for is a clear standard—

Dame Jo Williams: I take the point.

David Tredinnick:—something that you aspire to, and perhaps this has been helpful.

Dame Jo Williams: We need to take that away.

Q231 Chair: You have undertaken to take it away. We would be interested to hear how you respond when you have had a chance to look at it. If I may claim the Chair’s prerogative of the last word, as to the proposition from Amanda Sherlock that “the public must tell us,” the public would say that is what they pay inspectors for. Of course, the CQC should respond to public information but, in the first instance, the responsibility surely rests with the CQC.

Dame Jo Williams: Chair, I take that point, but, as we have explored already, it is very important that people tell us. We have a core of information, but we need additional information in order for us to see, further, what is happening.

Chair: May I bring in Yvonne, who has been very quiet? This is information to the public, I think—information the other way round.

Q232 Yvonne Fovargue: It is. Obviously there is a lot of concern after Winterbourne View about the social care system, and yet there will be people who need to use that system and need to go into it all the time. The star system has finished and there is not another system in place at the moment. How are the public to judge even the most basic quality of a home at the moment? The excellence is not coming in. I have more questions on that.

Dame Jo Williams: Did you say “the excellence”?

Q233 Yvonne Fovargue: The excellence award is not coming in. At the moment, how are the public supposed to judge the quality of a home, even on the most basic information?

Dame Jo Williams: Our 16 essential standards mean that, on organisational activity, if there is compliance then the essential standards are being met. As Amanda has said, if there are following up an investigation because there has been a breach, it is very important that that information is available. In terms of decisions relating to people’s future care, it does seem to me that looking at information from ourselves is one part of the picture. It is very important that—these are critical decisions to people’s lives—people talk to others in their community and look, themselves, at what is available. They know the individual that they are concerned for, so there will be something about making sure there is the right service for that particular person.

Q234 Yvonne Fovargue: You have already said it is difficult for the inspectors to go in and look at this. It is even more difficult for a lay person, particularly when it is for their own. There was the star system, at least, I don’t just want compliance for my 83 year-old mum. I want a standard of excellence. I am a bit concerned about the excellence award because it is a voluntary system that not everyone is going to go into. How is the public going to recognise the excellence standard? There might be another home that has not agreed to go into that but is just as good.

Dame Jo Williams: If that scheme comes in, it will be in the public domain. I want to go back to your initial reflection that the public don’t know how to find out what is going on. From the people that I talk to, it is the way in which they are greeted when they visit a home, the way in which they look around and see what is going on, whether there are activities and how are people spoken to. People can make a judgment about cleanliness and the way in which food is presented. There is a great deal that people can do by looking and seeing for themselves. Our work is to ensure that those essential standards are met and that that information is in the public domain. Over and above that, as I say, there is a lot about making a personal judgment yourself by looking and asking questions.
Q235 Yvonne Fovargue: What information will appear on the provider profiles? You have already said that for social care you do not look at issues like staffing levels. What information is going to be there? Will it be enough?
Dame Jo Williams: That is a very good challenge. What we will be saying to the public is: these are the essential standards. If there has been a breach and we are following up, that will be available to the public too. As to the question you raise about the excellence scheme, it is still out for consultation. I am not convinced yet that we have identified how it would work well and how it would address the question that you raise in terms of making sure a particular additional kind of service someone is looking for is available.

Q236 Yvonne Fovargue: What is happening in the meantime? Are the provider profiles up yet? When will they be going up?
Dame Jo Williams: They will be going up in the autumn, but there is already information on the website about individual establishments.

Q237 Yvonne Fovargue: Why is there delay?
Dame Jo Williams: It is partly to do with the volume of activity that we have had to undertake to make sure that the data is accurate—the numbers are very significant. Also, we have to make sure we are not misleading the public in any way in the information that we put out.

Q238 Yvonne Fovargue: It has slipped again now, hasn’t it? It was going to be January, then the summer and now it is autumn.
Dame Jo Williams: Next week our website will put up the information, but we will go further than that in the autumn to enable people to find out even more information. That is what I am saying.

Q239 Chair: Dame Jo, before bringing in Rosie on HealthWatch, can you not understand that people might think this is a more urgent priority than the processing of the registration of dentists and that there is a problem here about priorities within the CQC?
Dame Jo Williams: I understand what you are saying, Chair, but we will be at the point next week of making sure that information is up to date and available to the public. Of course, it is really important that it is accurate. That has been our driving force in making sure that, before we put it out, it is accurate, and we are continuing to work very hard to make sure that, by the autumn, we have something that doesn’t mislead, is easy to access and is understandable by members of the public.

Q240 Rosie Cooper: I must admit it sounds like a bureaucratic nightmare, to which we are about to add HealthWatch. Can you tell me how you see HealthWatch operating under your auspices? How are you not going to let it just become part of this bureaucratic nightmare? What do you see it achieving? Should it be under your auspices or would it be better off somewhere else?
Dame Jo Williams: I want to challenge you about the bureaucratic nightmare, but I will leave that on one side. HealthWatch is an opportunity for us to have a very effective way to gather further information from the public. That relies on the development of local HealthWatch organisations, which will, I hope, be able to hold organisations to account, be gathering information and listening to people in their communities. I would not want it to be exclusive. We get a lot of information from other organisations in communities and so we do not want that to stop. It will enable us, we believe, to do our job even better.

Q241 Rosie Cooper: I hope that is true, but, let me tell you, hope is not a strategy. You need to find a mechanism to make sure those things really do happen. Frankly, for me, Health and Well-being Boards, which all of this will play into, will become talking shops. What we need to know is that somebody is listening. To go back to Chris’ point about whistleblowing, it is not just about HealthWatch, local HealthWatch, it is about how individuals make their way through your system. I can’t go away from, “I do believe it is overly bureaucratic.” Your chief executive talked about being reactive. I don’t think there is anything wrong with being reactive as long as you react quickly enough. Sadly, I do not think, so far, perhaps you have been. It comes to the priorities bit, which is where I started out.
Dame Jo Williams: Yes, quite.
Rosie Cooper: How much time do you spend on registration? People are depending on you.
Dame Jo Williams: Indeed.

Q242 Rosie Cooper: You cannot fail, and you have.
Dame Jo Williams: I absolutely agree with what you are saying about people depending on us. It has not been an easy journey to get to where we are, but where I started was to say that we have made significant progress. We are in a much stronger position than we were at the beginning of the year. We are getting people out, visiting, seeing services, making judgments on a regular basis now and putting that information into the public domain. We are developing different methods of operating, pulling in people who we are calling “experts by experience.” We need, if we are able, to demonstrate that we are and give the evidence for additional resources. I would like to see us recruiting people who would work over weekends—to some extent we are doing that now—and specifically recruiting people who would work different hours, doing the early hours of the morning. We need to have a round-the-clock workforce. Our inspections do happen outside office hours, but not enough.
Q243 Rosie Cooper: As chair of a hospital, I wasn’t paid to go and visit the wards at 3 am, but I did.
Dame Jo Williams: Exactly my point.

Q244 Rosie Cooper: This is the final one from me and then I will stop. You mentioned before that you wanted another £15 million. Did that include the money for HealthWatch or is that excluding HealthWatch?
Dame Jo Williams: No, it does not include HealthWatch.

Q245 Rosie Cooper: How much do you think you ought to get upfront now—on the record, if you can? How much do you think it would take to make HealthWatch work properly?
Dame Jo Williams: The figure we have been talking to the Department of Health about is in the region of £3 million.

Q246 Chris Skidmore: I have a quick question about complaints data. You mentioned you are receiving 150 calls a week currently as a result of Winterbourne View and Southern Cross. Is that not the tip of the iceberg in that what you have is a co-dependency on local authorities as safeguarders? Certainly my own experience is that people will often go to the local authority first to complain. Are you receiving data from local authorities about the number of complaints they are receiving?
Dame Jo Williams: No, we are not.

Q247 Chris Skidmore: Do you not think you should?
Dame Jo Williams: Indeed. As I said earlier, we are working with 16 local authorities, looking at the flow of information between the two organisations. Quite clearly, understanding where there are areas of concern and complaint is crucial information.

Q248 Chris Skidmore: You will find you will get the 150 calls but, nationally, what local authorities are receiving and whether they are effectively following them up is tip-of-the-iceberg stuff.
Dame Jo Williams: It is also fair to say that if a local authority now is concerned in any way about provision, the relationships are such that they would contact us. I am clear about that.

Q249 Rosie Cooper: What about if it is a local authority’s provision of domiciliary care—care in the home? How does that relationship work? They are not going to tell you about when they are going wrong. Lancashire County Council, I am sure, wouldn’t be telling you, in my patch. I tell you.
Dame Jo Williams: Yes. We rely on other people too, absolutely, but the point—

Q250 Rosie Cooper: Let us drill down there. That is really important. How do you deal with local authorities who, for example, would be the paymasters in local HealthWatch? How do you deal with making sure that you inspect them with rigour as well?
Amanda Sherlock: In exactly the same way as we do with any other sector that we regulate. The proportion of directly-provided local authority care is now relatively small. It has been an interesting journey over the years, from when it was a much bigger proportion and registration inspection units were part of local authorities, to the setting up of an independent regulator and working through the challenges that they posed for some local authorities in bringing their directly-provided services up to an appropriate level under the Care Standards Act—now under the Health and Social Care Act. We would not take any kind of lesser approach with our local authority or with an NHS trust than we would with an independent adult social carer or independent healthcare provider.

Q251 Rosie Cooper: I may not know what I am talking about now. Do you regulate care companies that provide care in people’s homes?
Dame Jo Williams: Yes.

Q252 Rosie Cooper: Those organisations are famed for—we have seen it in the press—the 15-minute call where the patient or the resident gets only five minutes because five minutes is spent arriving, making the call to tell people they are there, people then get almost a choice of what they want doing and then the carer has to register the fact that they are about to leave, and they are gone. They are invariably late. Even though you have a rough idea when they are coming, they can be an hour or two either side. The elderly and those people that are sitting in their own homes are expected to take it. If they complain, it gets very, very difficult—and I know because I have had absolute experience of this—so they are not likely to complain.
How would you regulate those companies providing care at home? You only have their documentation to deal with it, unless you go and visit individuals in their home. Do you do that?
Amanda Sherlock: It is a very difficult area that the chair and the board have asked us to look at.

Q253 Rosie Cooper: But that is why they are getting away with it.
Amanda Sherlock: When care is provided in an individual’s own home, that is an interesting dilemma for a regulator, to go and knock on the door and cross the threshold into someone’s own home. We have done it when we have been following up on specific complaints, but, as a matter of—

Q254 Rosie Cooper: I would very much appreciate it—and I presume the Committee would—if you perhaps wrote to us on that basis because we are now saying to the great British public, “You don’t want to be in care homes. You don’t want to be in residential accommodation. You want to be in your own home, but in your own home we can afford you less regulation because we don’t come in and see what is being provided to you or your family and we have to rely on what these companies who are making money tell us.” That does not seem to be the way of the future to me.
Dame Jo Williams: Could I intervene? I endorse what you are saying about those kinds of visits in which people are being rushed and hurried. It is
extraordinarily difficult. I spoke at the Directors of Social Services conference earlier this year saying to them that, as a system delivering services to people, it did not seem to me to be appropriate. That was a challenge to them. I visited an authority last week—Sunderland—where they had a total system of telecarers. There were four vans covering the city throughout 24 hours of the day. If people were in need of some service in addition to the routines that were going on, they could make contact. It was inspirational to see the way in which people were put at the centre of the service. If I might say, one of the other roles that I am fulfilling is working with Andrew Dilnot, looking at the funding and how we pay for long-term care. Undoubtedly, and we have said it publicly, there is a shortfall in the funding. One of the consequences, I think, is that those who commission services are commissioning for minutes rather than thinking around the service for the individual. It is a matter of major concern, and I agree with that.

Q255 Rosie Cooper: We need to protect the people who we are encouraging to receive services in their own home.

Dame Jo Williams: Certainly, indeed.
Rosie Cooper: From the comments made today, they do not have much protection.

Q256 Chair: Thank you very much. Could I conclude with one final question of fact? Earlier in the conversation you said that there has been a long-standing issue of unfilled vacancies in CQC and its predecessor organisations. Are those unfilled vacancies unfilled because of lack of resources or for other reasons? Is it a budget issue?
Dame Jo Williams: No, it is not a budget issue.

Q257 Chair: It is not a budget issue.
Dame Jo Williams: No.

Q258 Chair: Thank you very much. You have given us plenty of food for thought and I think you have said, once or twice in the conversation, that we have given you some food for thought as well.
Dame Jo Williams: Indeed you have.
Chair: Thank you very much.
Written evidence

Written evidence from the Department of Health (CQC 01)

1. This memorandum has been prepared for the Health Committee by the Department of Health in response to the Health Committee’s invitation to provide evidence to assist it in its first annual review meeting with the Care Quality Commission (CQC). The Department is grateful for the opportunity to contribute to this process. This submission is based on CQC’s current legislative role and describes:
   (a) Background:
      — CQC’s establishment,
      — accountability and oversight, and
      — the new regulatory framework;
   (b) Progress with implementing the new regulatory framework under the Health and Social Care Act 2008;
   (c) Issues CQC is dealing with; and
   (d) Future developments.

Background

Establishment

2. CQC is the independent regulator of health and adult social care in England and has a key responsibility in the overall assurance of essential levels of safety and quality of health and adult social care services. Under the Health and Social Care Act 2008 (the 2008 Act) all providers of regulated activities, including NHS and independent providers, have to register with CQC and meet a set of essential requirements of safety and quality.

3. On 1 April 2009, CQC took over from the Commission for Social Care Inspection, the Healthcare Commission and the Mental Health Act Commission.

4. CQC forms part of the wider quality framework, having responsibility for:
   (a) providing independent assurance and publishing information on the safety and quality of services;
   (b) registering providers of regulated activities (including NHS, adult social care and independent sector healthcare providers);
   (c) monitoring compliance with a set of registration requirements;
   (d) using enforcement powers (where necessary) to ensure service providers meet requirements;
   (e) undertaking special reviews and investigations of particular services, looking across providers and commissioners of health and adult social care;
   (f) monitoring the use of the Mental Health Act; and
   (g) helping manage the impact of regulation on service providers and commissioners.

5. The Government is committed to reviewing the regulations that underpin the CQC registration system within three years of operation. As a first step, an initial review we have carried out an initial review to consider the opportunities for streamlining requirements and consider issues that have been identified as the registration system has been implemented. We will shortly be publishing a consultation document setting out proposals for changes and seeking views on any other issues that we should be looking to address with the existing registration system.

6. We will also commence a more comprehensive review of the registration regulations later this year and will subsequently consult on any further changes. We will also, in line with best practice, carry out a review of the whole regulatory framework five years after its implementation.

DH oversight and accountability

7. CQC is an executive non-departmental public body with an annual budget of about £165 million. This represents a very significant saving on the three predecessor bodies. CQC employs about 2,100 staff—the majority of whom are a “field force” of inspectors looking at over 20,000 organisations.

8. CQC has a budget settlement for 2011–12 that has been agreed with the Department of Health. CQC’s financial position is kept under constant review during the financial year.

9. CQC is accountable to the Secretary of State for discharging its functions, duties and powers efficiently and effectively. The Department monitors CQC’s financial and operational performance and risks at a general and strategic level through regular formal accountability meetings. It does not assess CQC’s inspection or monitoring of specific providers. Regular meetings are also held between both Ministers and the Permanent Secretary and Chief Executive of the NHS and the Chair and Chief Executive of CQC, as well as meetings at officials’ level.
10. CQC is responsible for assessing and ensuring the quality of its inspection and monitoring of specific providers on a day to day basis. CQC’s annual accounts and annual report are laid before Parliament and it is publicly accountable through Parliamentary Scrutiny, including Select Committees.

New regulatory framework

11. From April 2010, CQC began to operate a new registration system introduced under the 2008 Act, which initially covered NHS providers. This was extended to include independent sector health care and adult social care providers from October 2010 and primary dental care providers and independent ambulance service providers from 1 April 2011.

12. The new framework is based on regulated activities (eg personal care, surgery) rather than establishments and agencies (hospital, care home). The Department of Health consulted on which activities should require registration (the scope of registration) and the registration requirements providers need to meet in order to register and remain registered (the registration requirements). Failure to comply with these requirements is an offence and they are enforceable by CQC.

13. CQC published its Guidance about Compliance, which explains in more detail how providers can comply with the registration requirements, in March 2010. This guidance is not itself enforceable, but providers must have regard to it in complying with the registration requirements, and it must be taken into account by CQC when any decision about registration is taken.

14. Where a registered provider fails to meet any of the registration requirements, CQC is able to take the following independent enforcement action:
   (a) issuing a warning notice;
   (b) imposing, varying and removing conditions of registration;
   (c) issuing a monetary penalty notice for prescribed offences;
   (d) prosecuting for offences;
   (e) suspending registration; and
   (f) cancelling registration.

15. Initial registration is the start of a more responsive system that enables CQC to check continuously and monitor whether services are meeting the essential requirements. The system CQC has developed brings together a wide range of information including information from: people who use the services and staff; inspection reports; complaints and whistleblowing concerns; hard data sets (eg mortality and infection rates); statutory notifications; and information from partner bodies and service commissioners, into a Quality and Risk Profile (QRP) for every provider. The QRP is updated whenever CQC receives new information about a provider (including, for example, concerns raised by people who use services, or reports by other bodies). The information contained in the QRP is available to the inspector, and acts as a prompt for action.

Quality and Risk Profiles

16. QRPs are one of CQC’s key tools for ensuring its regulation is proportionate and based on up to date evidence.

17. CQC uses the QRP to gather all it knows about a provider in one place. It enables CQC to assess where risks lie and prompt more targeted enquiries and inspection and more proportionate regulatory action.

18. It does this by:
   (a) bringing together all of CQC’s knowledge about an individual provider automatically, so it doesn’t have to manually bring all the information together;
   (b) providing a consistent method for estimating the risk of essential requirements not being met: this means that operations teams will be consistently prompted to ask targeted questions about a provider’s risk; and
   (c) identifying potential issues more quickly: because new information is added regularly. CQC is able to see a fuller picture for each organisation and will be able to spot patterns that may demand attention that may have been missed if only looking at one piece of information.

Whistleblowing and complaints

19. CQC invites people to pass on concerns and feedback on its website. Any concerns raised with CQC by a member of the public or a whistleblower are added to the providers QRP. This allows CQC to:
   — spot problems or concerns in local services that it may need to act upon;
   — make decisions about whether a service should be registered;
   — monitor on an ongoing basis whether care services continue to meet the essential standards of quality and safety;
— look at how commissioners of services (like primary care trusts) find out what services people need, and if money is being spent wisely to provide services in the local area; and
— check what providers tell CQC about their own performance.

20. The inspector responsible for oversight of the provider decides whether or not the issue requires an immediate response.

Registration fees

21. CQC operates within a capped budget. This means that any additional fees income it generates will result in a reduction in its grant-in-aid from the Department of Health.

22. Under the 2008 Act, CQC is responsible for developing, consulting on and setting its registration fees. CQC’s 2011–12 fees schedule was published on 29 March 2011. CQC has streamlined the way it charges fees so that there is no longer a separate cost for making a variation to registration, so the fees in the schedule are not directly comparable with the fees charged under the old system. However, it is worth noting that registration fees for social care providers had not increased during the previous five years. CQC is intending to consult on its fees schedule for 2012–13 later this year.

23. It is an established principle that those individuals and organisations that are subject to regulation should meet the cost of that regulation through fees. HM Treasury guidance on the setting of fees is that the norm is to charge at full cost. Where a fee is charged at less than full cost there should be a plan to achieve full cost recovery within a reasonable period.

Progress with Implementing the New Regulatory Framework under the Health and Social Care Act 2008

24. During 2009–10, CQC registered NHS providers against a registration requirement relating to healthcare associated infection.

25. Since 1 April 2010, NHS providers have been registered against the full set of registration requirements under the 2008 Act. Initially 22 NHS bodies were registered with improvement conditions. By April 2011, all but two of them had made the improvements needed and the conditions on their registrations were lifted.

26. Since October 2010, CQC has registered private and voluntary healthcare and adult social care providers under the 2008 Act, replacing the existing registration of these providers under the Care Standards Act 2000.

27. On April 2011, primary dental care and private ambulance services were brought into the new registration system. CQC is currently in the process of making decisions on registration. The registration of all of these providers was not completed by 1 April. CQC estimates that it will have registered 75% of these providers by the end of June.

Primary medical care

28. Under the current legislation, primary medical care providers will come into the scope of registration with CQC on 1 April 2012. The Department has launched a consultation on deferring the registration of most providers of primary medical services for the NHS until 1 April 2013. The consultation proposes that the registration of dedicated out of hours services and NHS walk-in centres should still go ahead on 1 April 2012. This proposal would give CQC the space to modernise and streamline its regulatory methods resulting in an improved experience for providers of primary medical services when they are registered and a more responsive service for those providers that are already registered with CQC.

Issues CQC is Dealing with

Second Opinion Appointed Doctors

29. The Mental Health Act 1983 (the 1983 Act) sets out a number of circumstances in which a person may not be given medicine or other treatment for their mental disorder without the approval of a second opinion appointed doctor (SOAD). SOADs give their approval in the form of a “SOAD certificate” on a statutory form prescribed in regulations.

30. In England, CQC is responsible for appointing SOADs. They are all consultant psychiatrists (though the 1983 Act itself only requires that they be doctors). In early 2009, the SOAD service—then run by the Mental Health Act Commission—was experiencing problems. In particular it faced a much greater than forecast demand for SOAD visits to patients on supervised community treatment (SCT). Arranging and completing visits to SCT patients has also turned out to be more difficult and time consuming than the equivalent for detained patients. Consequently, long delays built up, which have still not been fully resolved.

31. We are using the Health & Social Care Bill to amend the 1983 Act so that SOAD approval is no longer required for medication and (for adults) for ECT for SCT patients who consent to it (and have the capacity to do so). That will put SCT patients on a similar footing to detained patients, and will make a sizeable reduction in demand for SOAD opinions.
32. CQC has also been seeking to appoint an increased number of SOADs and is looking at ways in which it (and the healthcare system) can be more creative in recruiting SOADs.

**Review of CQC operations following the incidents reported at Winterbourne View**

33. The Department has asked for an investigation of the roles of all of the agencies involved in this case and will be drawing together the key lessons from the reviews being undertaken by CQC, the NHS and safeguarding boards. The Department will be assisted in that task by Mark Goldring, the Chief Executive of Mencap, who will not only bring an independent perspective but also a depth and breadth of knowledge of the needs of people with learning disabilities. Ministers will then report further to Parliament. CQC, for its part, is committed to learning lessons from this case and to making sure that where there are signs of poor care, CQC acts quickly to protect vulnerable people.

34. To ensure the social care system of the future is fit for purpose, the forthcoming social care white paper will explore the place of regulation alongside other mechanisms in driving quality improvement in social care. As was the case with the NHS white paper, this will include a discussion of the opportunities presented to refine and strengthen CQC’s role as a quality inspectorate in this new system.

**Dignity and nutrition**

35. The Secretary of State asked the CQC to undertake a programme of nurse-led inspections to look at the care of elderly patients in NHS hospitals.

36. The inspections have been carried out through CQC’s registration function enabling CQC to use its enforcement powers where it finds non compliance. The inspections have focused on the two registration requirements that are particularly relevant to the care of older people. These are:

   — Outcome 1: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run; and
   — Outcome 5: Food and drink should meet people’s individual dietary needs.

37. Following a registration inspection, CQC is required to publish a report on the matters inspected (referred to as a compliance report). Where CQC has identified substandard care that does not meet the registration requirements, it is taking action requiring the provider to make necessary improvements to achieve compliance.

**Future Developments**

38. The White Paper, *Equity and excellence, Liberating the NHS* proposed strengthening CQC as an effective quality inspectorate, and establishing HealthWatch England as a statutory part of CQC, to champion service users and carers across health and social care.

39. The *Report of the arm’s-length bodies review*, published on 26 July set out the Government’s intentions to reform the Department’s arms length bodies sector in light of the changes to the wider health and social care system announced in the White Paper. The arms length bodies review proposes that, subject to parliamentary approval, CQC would, over time, assume responsibility for some of the essential functions of the Human Fertilisation and Embryology Authority and the Human Tissue Authority.

40. On 14 October 2010; the Government also announced as part of the Advisory Non-Departmental Public Bodies review that statutory functions of the National Information Governance Board would transfer to CQC. The transfer of functions relating to the processing of information by registered persons is being effected through the Health and Social Care Bill currently in Parliament.

**Health and Social Care Bill—provisions affecting CQC**

41. Subject to passing through Parliament, the Health and Social Care Bill will make the following changes to CQC’s functions:

   (a) CQC will gain responsibility for the monitoring of, and seeking to drive improvements in, information governance practice by registered care providers in England;
   (b) HealthWatch England will be established as a statutory committee of CQC to act as the independent national champion for health and social care consumers;
   (c) It will be placed under a duty to operate a joint licensing system with Monitor;
   (d) CQC will no longer have a duty to conduct periodic reviews of Primary Care Trusts and English NHS providers (ie NHS Trusts and Foundation Trusts)—CQC’s focus will be on providing assurance that registered providers are meeting essential levels of quality and safety;
   (e) CQC will be placed under a duty to co-operate with other arms length bodies in the exercise of their functions;
   (f) CQC will be required to gain Secretary of State approval for its policy on pay (remuneration, pensions, allowances and gratuities) for all of its staff;
   (g) CQC will also be required to gain Secretary of State approval before conducting a review, study or
investigation to ensure these are conducted into priority areas, where CQC and Secretary of State consider that they will have the most impact in helping to improve the health and social care system.

HealthWatch England

42. HealthWatch England will be established as a committee of the Care Quality Commission. Basing HealthWatch England in CQC will place the views of patients and service users at the heart of the health and adult social care regulator and will provide a clear route for the concerns service users to be considered by CQC.

43. It is envisaged that the functions of HealthWatch England will be:

(a) to provide general leadership, advice and support to local HealthWatch (although local HealthWatch will be directly accountable to the relevant local authority);

(b) to make recommendations and provide advice to the NHS Commissioning Board, Secretary of State, Monitor and CQC itself, based on information (including feedback) received from local HealthWatch, about issues that, in HealthWatch England’s view, require action to be taken by persons/bodies responsible for commissioning, providing, managing or scrutinising health and social services;

(c) to provide advice and make available its expertise to the NHS Commissioning Board in relation to how to fulfill its duties in relation only to patient/public engagement;

(d) to publish a report on its views on standards and provision of care services; and

(e) to provide advice to the Health and Social Care Information Centre in relation to the information which, in HealthWatch England’s view, would be of most use to users of health and social care services to enable them to make choices in relation to their care.

44. HealthWatch England will also be able to propose that CQC investigates services. Its role will be limited to advising that CQC carry out an investigation into service provision in particular cases. Although HealthWatch England will provide vital information to support CQC’s monitoring role, CQC will retain the power to decide whether or not to conduct an investigation when a recommendation is made.

Joint licensing

45. The Bill places duties on both Monitor and CQC to co-operate in carrying out their respective functions. In particular, it requires the bodies to operate a joint licensing and registration process with a single application form and a single licence document and to ensure that any conditions imposed upon registered providers and licence holders are not inconsistent or contradictory to each other. The aim is to ensure that the regulators operate the joint licensing regime in a streamlined way which would create a single integrated process and interface for providers, minimising bureaucracy and administrative burdens. Other than the joint administration of the licence issuing process, CQC and Monitor would retain separate responsibilities for their parts of the regime—the two organisations would have separate responsibilities regarding enforcement and would levy separate fees.

Making information publicly available

46. CQC makes information on the safety and quality of services available to service users and the general public through its website.

47. CQC is currently developing an online profile of every registered provider, setting out reports on reviews and other up to date information on the provider, including whether or not the provider is meeting the registration requirements. Where a provider is not meeting the requirements, the profile will set out what improvements are required.

Excellence scheme

48. The Commission for Social Care Inspection introduced quality ratings in 2008 to provide an assessment of the quality of each adult social care service registered under the Care Standards Act 2000. CQC continued awarding these ratings until 30 June 2010 when it stopped carrying out key inspections under the Care Standards Act and focused its resources on registering providers under the new registration system, which came into force on 1 October 2010.

49. Under the new registration system, CQC assures compliance with the safety and quality requirements at explained above. The registration system does not provide any information about quality above compliance with the essential levels of safety and quality.

50. The Department of Health has asked CQC to develop an excellence scheme for adult social care providers. We are looking at what regulations are needed to give CQC this additional function.

51. The scheme will provide an independent assessment of quality over and above the information made available through registration and compliance monitoring. Whilst CQC will own the excellence scheme, it is looking to deliver the scheme through third party organisations and has had expressions of interest from a number of bodies.
52. The scheme will be voluntary so providers will be able to choose whether to apply for an excellence award or not and providers will be required to pay a fee when they apply for the excellence award. This will be set at a proportionate level.

53. Providers will undergo an assessment, which CQC proposes should include a site visit to assess whether the provider meets the definition of excellence. An excellence award will not be automatically given to providers that have paid the fee.

54. The Social Care Institute for Excellence (SCIE) has developed a definition of an excellent service. CQC launched a 12-week public consultation on the definition of excellence and their proposals on Monday 9 May. Alongside its consultation, CQC is inviting third party organisations to tender to provide the excellence scheme and has had a number of initial expressions of interest.

June 2011

Written evidence from the Care Quality Commission (CQC 02)

HEALTH SELECT COMMITTEE APPEARANCE

Thank you for the invitation to provide written evidence to the Health Select Committee for our session on 28 June.

I thought that it would be helpful to provide some context to CQC’s approach to its work. What regulation can and should do is to minimise the risk of poor quality care being delivered. We do this by undertaking extensive risk assessment backed by a rigorous programme of inspections. This, in turn, underpins another key element, namely the shaping and nurturing of a culture that won’t tolerate poor quality care, neglect and/or active cruelty to those in care and reports it when it sees it.

Amongst the key players in helping to minimise risk are patients themselves, because they are the only ones who know for certain what care they have been given and how good they feel it is. Second are their carers, who may actually be the ones to speak for the patient in some cases. The organisations that provide and commission the care have a critical role to play. The degree to which we are informed is partly dependent on what we have been told by the other groups mentioned above.

Harnessing the potential information resource offered by the patients, carers, commissioners, providers and the body corporate is a major challenge for us but we have designed a system with their full participation in mind.

It is crucial that we have a realistic view of the potential and the limitations of quality regulation in the NHS and care sector. In particular, it is dangerous to burden our system with unrealistic expectations of what can be achieved, where these are unlikely to be fulfilled, irrespective of the system in use.

This does not mean that we do not take every transgression that impairs a patient’s experience of the NHS and care services extremely seriously. We do. Indeed, we have gone to considerable lengths to ensure that we have systems that are fit for purpose and that involve people who use services as far as possible and we have more work in train to improve this further.

However, no amount of regulation—however well resourced—can guarantee that events such as Mid Staffordshire and the recent case at Winterbourne View never happen again. There are millions of daily interactions in NHS and care provision, the overwhelming majority providing good experiences for patients and users, and only a minute percentage of which will give rise to serious concerns. The resourcing level that would be required fully to monitor every transaction is unaffordable and couldn’t provide a foolproof system. Not only can we not be everywhere at the same time, but the people who perpetrate consistently poor quality care or the type of cruelty that we saw at Winterbourne View are often very skilful at hiding it.

We are very aware of the danger of individual errors being made by those receiving the information. We are undertaking a hearts and minds exercise to ensure that our analysts and inspectors rigorously challenge provider organisations if we receive any negative or concerning information.

I appreciate the Committee will have a wide range of questions. I attach for your information an annex setting out the key events of the last 15 months.

I look forward to meeting your Committee and discussing our work with it.

Dame Jo Williams
Chair
Care Quality Commission
June 2011
1 April 2010
— New regulatory framework comes into effect.
— For the first time 409 NHS trusts registered, licensing them to provide services—22 trusts have conditions imposed.
— Application window opens for 1,500 independent healthcare and 12,500 adult social care provider organisations to apply for registration with effect from 1 October 2010.

April–September 2010
— Begin compliance reviews at NHS trusts.
— Independent health care and adult social care providers continue to apply for registration.
— Resource constraints identified as high risk of non-delivery of registration. Staff from headquarters seconded to process registration transition applications.
— NHS quality and risk profiles shared with trusts online.
— Development work begins on new care quality directory to provide information to the public on each care provider.

May 2010
— Public sector recruitment freeze announced.
— Mid Staffs Public Inquiry announced. Internal resources found to support Inquiry work.

July 2010
— Mid Staffs Public Inquiry begins.

October 2010
— Existing independent health care and adult social care providers registered under the Health and Social Care Act 2008.
— Compliance inspections for independent health care and adult social care begin under new Act.
— ALB review published, outlines proposals for merger of CQC, Human Fertilisation and Embryology Authority and Human Tissue Authority.

November 2010
— Window for applications for registration for 8,000 dental and 200 private ambulance providers opened.

December 2010
— Operational implementation review launched—13 workstreams to improve and streamline processes.

January 2011
— Health and Social Care Bill published.

February 2011
— Recruitment freeze relaxed, allowing recruitment to begin externally from the NHS, ALB and government redeployment pool.

March 2011
— Programme of Dignity and Nutrition inspections begins.

May 2011
— CQC evidence given at Mid Staffs Inquiry.
— Adult Social Care Excellence consultation launched.
— Panorama programme on Winterbourne View.
— First Dignity and Nutrition inspection reports published.
— Proposal to Department of Health on deferment of primary medical care registration.
Second phase of Operational implementation review launched—five priority programmes identified from 13 workstreams.

JUNE 2011
— Announcement of programme of inspections of learning disability services.

Written evidence from Mr Alan Stinchcombe (CQC 03)

Summary
— Possible contributory reasons for the Commission’s recent failure to safeguard vulnerable adults in Winterbourne View are overload, limited focus of inspection and insufficiently frequent inspections.
— Difficulty experienced by a user of the Commission’s Care Directory knowing precisely which services a service provider offers and the Commission’s judgment as to how well those services are being provided.

Text
1. The recent failure of the Care Quality Commission (CQC) to safeguard vulnerable adults in Winterbourne View may come as little surprise to anyone, for the following reasons.
   (a) The Commission has a massive remit and probably too small an establishment of staff. Furthermore, on 1 June 2011, BBC News reported a CQC inspector as saying that too many posts in the Commission are currently vacant. The Committee may wish to ask the Commission for statistics.
   (b) The Commission appears to have abandoned conducting inspections in favour of reviews of compliance with “essential quality and safety standards”. BBC News also reported the aforementioned CQC inspector as saying that a compliance review is limited to specific areas of concern and does not amount to a thorough inspection of the care home’s compliance with all the essential quality and safety standards.
   (c) The Commission’s publication How we monitor compliance\(^1\) states “we will have a programme of planned reviews in which every location is reviewed at least once every two years.” It is unclear whether this is a statutory requirement, but in any case it appears that the Commission is reporting far too infrequently on care homes.

I have examined a sample consisting of all 42 records found by searching for care homes with nursing in Bristol in the Commission’s Care Directory.\(^2\) I found the most recent date of reporting by Review of Compliance or Inspection Report. As does the Commission’s website, I ignored any later Service Reviews, as these were purely paperwork exercises based on self-assessment.

The limited size and geographic extent of this sample limits the conclusions that may be drawn from my analysis, but I discovered the following:

(i) The percentages of the total of 42 records reported on since various dates are as follows:

<table>
<thead>
<tr>
<th>Date</th>
<th>Percentage of homes reported on since date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr 07</td>
<td>100</td>
</tr>
<tr>
<td>Oct 07</td>
<td>98</td>
</tr>
<tr>
<td>Apr 08</td>
<td>81</td>
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<td>Apr 10</td>
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<tr>
<td>Oct 10</td>
<td>17</td>
</tr>
<tr>
<td>Apr 11</td>
<td>0</td>
</tr>
</tbody>
</table>

(ii) It is notable that:
   1. No reports produced since April 2011 are yet available.
   2. Of the seven reports produced since October 2010, only four (57% of the total) were conducted purely as part of a routine schedule of planned reviews. The remaining three (43%) of the total were conducted at least in part because of previously identified concerns, that is, as “fire-fighting” measures.
   3. Since the inception of the Commission in April 2009, just over two years ago, only 55% of the sample has been reported on. Correspondingly, 45% of the sample has not been reported on with the Commission’s intended frequency of at least once every two years.

\(^2\) http://caredirectory.cqc.org.uk/caredirectory/searchthecaredirectory.cfm
4. Since April 2008, just over three years ago, only 81% of the sample has been reported on.

5. One home, representing just 2.4% of the sample, has not been reported on since April 2007, just over four years ago.

The Committee may wish to ask the Commission for more comprehensive statistics and an explanation for the apparent mismatch between intention and outcome.

2. Even where up-to-date reports exist, it is unclear to me as a user of the Commission’s Care Directory precisely which services a service provider offers and the Commission’s judgment as to how well those services are being provided.

The Commission registers an adult social care provider not also as offering certain specialisms, which are specified in the service provider’s record on the Commission’s website, but also as providing other services stated in the service provider’s Statement of Purpose, but this information is not provided on the Commission’s website.

Since the abolition of the old rating system in 2010, according to the Commission’s website, it is “designing a new system to assess the quality of services”, including “a new measure of excellence currently being developed with key partners and after consultation with providers and people who use services.” Consultation is only now occurring for implementation of the new system from April 2012.

RESEARCH DATA

RECORDS OF CARE HOMES WITH NURSING IN BRISTOL FROM THE COMMISSION’S CARE DIRECTORY

<table>
<thead>
<tr>
<th>Name</th>
<th>Last report</th>
<th>Review of Compliance</th>
<th>Reason for Review of Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Bridge Project</td>
<td>Oct-09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hillside</td>
<td>Dec-08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>St Joseph’s Home, Bristol</td>
<td>Apr-08</td>
<td></td>
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<td>Claro Homes</td>
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<tr>
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<td>Name</td>
<td>Last report</td>
<td>Review of Compliance</td>
<td>Reason for Review of Compliance</td>
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June 2011

**Written evidence from Healthcare Audit Consultants Ltd (CQC 04)**

**SUMMARY**

We recommend:
- a more active stance is taken to regulation and management in comparison with the light-touch approach adopted previously;
- the creation of one regulator ie combining CQC and Monitor, covering both economic and quality issues, thus helping to ensure sufficient resources are available and a blinkered approach is not taken focussed on one particular aspect or sector of healthcare;
- more focus on adverse outcomes and full investigation of these to help focus on essential improvements;
- a more focused drive to identify blockages to progress and improvement in conjunction with the other health regulators, the Department of Health and Government;
- more attention is paid to warning signals and these are highlighted rather than be induced into providing a higher level of reassurance than may be warranted;
- more encouragement and protection of whistleblowers and complainants rather than be content to consider overall satisfaction levels which can be prone to manipulation;
- less reliance should be placed on self-certification in the future;
- a review of the number of healthcare regulators and their budgets with a view to combining resources and establishing an adequate resource base for regulation to be most effective;
- the regulator should identify in an annual risk assessment the consequences of inadequate resources and
- a duty of co-operation be mandated and a positive climate fostered between the regulators.

1. **INTRODUCTION**

1. Our perspective is as independent advisors on healthcare issues experienced in a wide range of healthcare matters. As far as this consultation is concerned we consider CQC’s existing role and working methods. Detailed recommendations are provided throughout this paper.

2. **THE ROLE OF CQC**

2. The duties and powers of the CQC are to:
- register providers of healthcare and social care ensuring they meet essential standards of quality and safety;
- monitor how providers comply with the standards by gathering information and visiting them as needed;
- use enforcement powers such as fines and public warnings, if services drop below the essential standards;
- act to protect patients whose rights are restricted under the Mental Health Act;
- promoting improvement in services by conducting regular reviews of how well those who arrange and provide services locally are performing;
- carry out special reviews of particular types of services and pathways of care, or undertake investigations of areas where there are concerns about quality;
- seek the views of people who use services; and
- inform people about the quality of their local care services.

3. The CQC regulates:
- providers of medical and clinical treatment and care given to people of all ages, including treatment given in hospitals, ambulance services, and mental health services. We will eventually include primary care such as GP and dental practices;
— providers of care services for adults in residential homes, in the community and in people’s own homes. We focus on people who find themselves in vulnerable circumstances, including those with mental health problems, learning disabilities, physical disabilities or long-term health conditions and older people; and
— providers of services for people whose rights are restricted under the Mental Health Act.

3. **Systems versus Outcomes**

4. We believe there is a tendency in the work of the Commission to examine systems rather than give due regard to adverse outcomes. This produces the anomaly of “adequate” systems generating poor outcomes. Although expressed in different words, this is the message conveyed by the conclusions of the Francis report on Mid Staffs:³

“A common response to concerns has been to refer to generic data or benchmarks such as star ratings, rather than the experiences of actual patients. While benchmarks and data-based assessments are important tools, these should not be allowed to detract attention from the needs and experiences of patients. Benchmarks, ratings and status may not always bring to light serious systemic failings.”

(Francis report Executive Summary Conclusions page 24)

5. Although system audits are an essential tool, we recommend more focus on adverse outcomes and full investigation of these to help focus on essential improvements.

4. **A positive Bias can Induce Complacency**

6. We detect a tendency to see the glass half full rather than half empty. The declared focus on achieving improvement is that it fails to focus on the unacceptable. For example; there is ample evidence to suggest levels of clinical supervision are inadequate;⁴ clinical audit less than satisfactory;⁵ mortality issues under-investigated and standards of nursing care leading to bedsores, infections and dehydration common. Again Robert Francis reported on a lack of urgency when addressing such issues.

7. We detect this attitude still in the reporting style, investigative zeal and performance of the CQC. It values good relations with its corporate clients and its ability to demonstrate improvement more than stamping out the unacceptable.

8. **We recommend** less light-touch regulation and a more challenging style.

5. **The Elephants in the Room**

9. We detect an unwillingness to tackle big issues. For example there have been problems in achieving progress in developing clinical networks that would consolidate specialist work in specialist centres and hence provide higher quality services for patients at less cost. Commissioning has tended to protect NHS providers from competition rather than fostering change and hence progress in implementing changes in long-term condition management has been woefully slow. We would expect a regulator to be investigating areas of poor performance and driving improvement.

10. **We recommend** a more focused drive to identify blockages to progress and improvement in conjunction with the other health regulators, the Department of Health and the Government.

6. **Providing “False Reassurance”**

11. There is a danger that the Commission is actually by its actions providing false reassurance. The general effect is to lull people into believing standards of care are better than they really are. Lessons need to be learnt from recent scandals as it is clear that standards are unacceptably low in many settings and this is not being captured or addressed quickly enough. Problems are likely to get worse as financial problems escalate.

12. **We recommend** that the regulator pays more attention to warning signals and highlights these rather than be induced into providing a higher level of reassurance than may be warranted.

7. **The Regulator should not Pay too much heed to Issues Around the Image of Providers**

13. There is in our view a tendency for the regulator when examining issues to be overly concerned with management anxieties about the perception of their hospital or organisation. The regulator is not a public relations consultant. The role of the regulator is to draw out dissident voices and not be satisfied that the weight of client and/or staff voices appears satisfied.

14. **We recommend** the Regulator does more to encourage and protect whistleblowers and complaints rather than be content to reflect overall satisfaction levels which can be prone to manipulation.

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³ The Mid Staffordshire NHS Foundation Trust Inquiry chaired by Robert Francis Feb 2010
⁴ Foundation for Excellence by John Collins- Medical Education England October 2010
⁵ Francis Report op cit p19
8. **An Overreliance on Self-certification**

15. Self-certification has played a large role in the process of assessing performance. As in financial services there are risks in following this route. Although this may be a cheaper way of regulating it has clearly not been successful and has put patients at risk.

16. **We recommend** that less reliance is placed on self-certification in the future.

9. **A Failure to Identify the Risks Associated with an Inadequate Budget for the CQC**

17. We realise that the work of the CQC has been constrained by budget but we believe it should do more to justify an expanded role in conjunction with the other regulators. If the NHS Commissioning Board is disavowing a strategic role and placing more responsibility on regulators, then the regulators must work together and ensure there are sufficient resources available for the tasks demanded.

18. **We recommend** a review of the number of healthcare regulators and their budgets with a view to combining resources and establishing an adequate resource base for regulation to be most effective. At very least we believe that there should be a pooling of the resources of the CQC and Monitor.

19. **We recommend** the regulator should identify in a risk assessment the consequences of inadequate resources.

10. **Need for Co-operation between Regulators and Auditors**

20. There have been many reports of lack of co-operation between regulators and rivalry over future roles. It is not clear therefore what active steps have been taken to share information, identify matters of concern, and to avoid duplication of tasks and resources.

21. **We recommend** that a duty of co-operation be mandated and a positive climate fostered between the regulators.

*June 2011*

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**Written evidence from the English Community Care Association (CQC 05)**

1. **Summary**
   
   — We believe CQC is failing in its duty to protect some vulnerable people.
   
   — CQC processes are administratively complex and time consuming and are also not always properly delivered.
   
   — CQC has discarded its role for quality improvement in Adult Social Care (ASC) in favour of assessing for essential standards only. Removing the star rating system with its assessments of “good” and “excellent” as a core service of the regulator and moving instead to a voluntary and extra charged for service for “excellence” only, has not been subject to proper consultation and national debate.
   
   — Fees for the majority of ASC providers increased for 2011–12 for which only a few days notice was given yet CQC itself is providing a poorer and lesser service than previously.
   
   — CQC does not provide value for money and does not apply fees to different types of providers on a fair basis.
   
   — CQC no longer has a significant role in assessing the adequacy of commissioning by PCTs and councils which is to the detriment of a full understanding of the whole health and social care system.
   
   — CQC lack of leadership with respect to quality monitoring and commissioning has encouraged councils and PCTs to take on similar and duplicative roles to that of CQC resulting in increased costs and administrative burden for providers.
   
   — Confidence in the regulator is very low.
   
   — CQC needs to engage all stakeholders and set out benchmarks against which its own performance should be judged. It is currently judging providers against standards of timeliness of delivery for example which it itself cannot meet for a service that providers pay for.
   
   — The inspection/assessment model is not deemed to be credible based as it is on provider self assessment and a reduced number of face to face inspections.
   
   — Providers do not see a clear vision for proactive regulation and instead see a largely reactive approach.
   
   — Consistency of approach still remains an issue with providers.
   
   — CQC follow up action once poor practice has been identified is not always clear to the sector particularly when that action relates to NHS services.
   
   — The sector is not always listened to.
2. General Comments

2.1 The recent Panorama programme into Winterbourne View follows on from CQC’s investigation into poor nutrition on hospital wards, the Health Ombudsman report into care of older people, and the NCEPOD (Nov 2010) report. The number of inspections has fallen whilst the cumbersome and lengthy re registration process took place and this is not yet back to pre registration activity.

2.2 There is somewhat of a downward spiral as confidence in CQC ebbs away across commissioners and providers and most importantly the public in the CQC’s ability to proactively deal with poor care, which after all, tarnishes all providers, the vast majority of whom do a good job and aim to achieve the best care and support for individuals.

2.3 CQC has put in extra resources, and not before time, to address the delays and lengthy time it takes to register a manager, new service and/or a service variation—up to 120 days at one point in time. Delays such as this are unacceptable and we have evidence of people waiting for admission to homes and being unable to be cared for in their chosen setting because services have not been registered.

2.4 Providers meanwhile have invested in new buildings and staff but are deprived from earning any income until CQC has completed the registration processes. Managers in Scotland are registered in an average of 4 weeks whereas the average time in England has at one stage been 16 weeks and has never been anywhere near the Scottish system.

2.5 Providers have reported CQC losing their documents and payments, taking so long to process an application that the original CRBs for managers expire and the process has to start again. CQC are to look at online systems which will be a huge improvement but we hope that this can be done speedily and with the necessary resources to ensure a streamlined and straight forward means of undertaking these processes.

2.6 ECCA believes that CQC has moved from a commitment to monitor improvement over and above the essential to regulate only against a single benchmark of meeting essential standards, without any real public debate. Providers having previously received a star rating within their registration fee will now pay a higher fee but receive no assessment of quality above essential unless they are prepared to pay extra for it.

2.7 Again there has been no debate on this with the sector and this has been presented as a fait accompli. In the current financial climate where frontline services should be protected CQC should not be charging more for less and instead holding fees as currently or reducing them to reflect the reduced service being given to adult social care. Provider fees are also being cut by commissioners so it is unrealistic of CQC to impose cost increases onto frontline services in this way. We question how CQC can call itself the Care Quality Commission; yet the focus in current pronouncements is “essential standards”.

2.8 Indeed the CQC’s proposals to launch an “excellence” scheme in the future are uncertain because:

— Providers are unaware of how exactly it will operate and who will run it for CQC.
— The consultation on it is still underway and the reaction of the sector to date has been negative.
— The scheme will carry an additional charge for providers to that for regulation which takes more money from frontline services and puts it into systems and processes.
— The scheme will be voluntary and so it is difficult to know if the scheme(s) will be viable and how much they will actually cost.

2.9 CQC should be subject to time requirements agreed with government and the sector on:

— Time taken to register a new provider.
— Time taken to register a manager.
— Time taken to register a variation (eg an increase in care home bed numbers).
— Time taken to publish a written report following a service inspection.

3. CQC Fees

3.1 We have many concerns regarding the recent consultation regarding fees set by CQC for 2011–12 not least that the fees announcement was made to providers with only a few days notice. We list below, however, some particular points regarding the lack of fairness, as we see it, in terms of different types of providers being treated differently and less favourably than other providers.

3.2 We did a comprehensive response to the consultation but our concerns were largely ignored and this has caused considerable frustration as to why we take the time and effort to respond to such consultations.

— CQC states that its model (as applied to all sectors) for setting the fees across the bandings used the assumption that smaller providers pay a higher unit charge than larger providers, though larger providers pay a higher absolute fee. Based on our own calculations we believe that this does not hold true for Adult Social Care (Accommodation Provided) where larger providers are being asked to pay a higher unit charge than small providers, and we therefore believe that there is either a flaw in CQC’s model or a flaw in the assumptions that have been applied to the model.
— Adult Social Care (Accommodation Provided) is the only sector where CQC has made no allowance for the economies of scale in regulating providers that operate from multiple sites. It is irrational for CQC to treat this sector differently to all other sectors.

— The late change that CQC applied to the fees for the Adult Social Care (Accommodation Provided) bandings resulted in the total charge for small care homes (ie those with three beds or fewer) being reduced by £416k, with this sum then being added to the total charge for larger care homes. The effect of this decision on one ECCA member for example is to add an extra £46k to the annual registration fee (given that the charge was already set to increase by nearly £700k p.a.). It is especially worrying that this decision was taken on the basis of just five consultation responses from Adult Social Care providers (Accommodation Provided) which claimed that small providers paid proportionately more than large providers.

— CQC has stated that inspector ability is generic to the ability to regulate any sector and not specific to each sector. Does this mean that inspectors do not have specialist knowledge for the areas they are inspecting eg acute hospitals.

— The misleading text within CQC’s original consultation that suggested that the cost recovery from Adult Social Care was lower than other sectors, was incorrect when in fact the opposite was true.

— The sum of £3.5 million that CQC will seek to recover from one ECCA member compared to a maximum of £115k chargeable to even the largest and most complex NHS Trust warrants a full explanation from CQC.

— CQC’s reluctance to provide full details of its actual and budget costs and its reluctance to fully explain how it expects to take £9 million off the cost of regulating NHS services is of concern. In view of the recent adverse publicity surrounding the very poor standards of nutritional care in some NHS hospitals, this requires a full explanation from CQC.

Caps also apply to the fees of other healthcare providers:
— Hospital related health care activities—cap of £150k p.a. set at 16 or more locations.
— Independent ambulance services—cap of £48k p.a. set at 16 or more locations.
— Dental services—cap of £48k p.a. set at 101 or more locations.
— A cap applies to the fees of domiciliary care providers of £32k p.a. set at 26 or more locations.
— Social care activities involving the provision of accommodation (ie care homes) is the only sector where a fee cap has not been set on the number of locations operated by any single provider.

4. Duplication

4.1 The issue of duplicate monitoring of independent care services by councils and PCTs has concerned providers for a number of years. This is where councils and PCTs set up their own local quality assessment schemes which replicate elements of CQC basic assessment of essential standards and of the previous star ratings system. The result is a waste of public resources and confusion for people wishing to use services. Importantly, such local schemes represent a huge conflict of interest where the Council and/or PCT is both paymaster and judge of quality, linking fees to the quality rating on which it alone has made the judgement.

4.2 The problem is twofold. Firstly, legal guidance for councils was set out in 2006 under section 7(1) of the Local Authority Social Services Act 1970 regarding oversight of adult care. Alongside this legal framework sits best practice guidance with a responsibility for Directors of Adult Social Care to ensure the quality of adult social care services across the local authority area in all sectors, irrespective of whether or not services are provided directly by the Council.

4.3 Whilst some councils took a pragmatic approach and used the independent CQC star ratings to guide them in this role and to help them in setting fees, other councils believed this meant they should set up their own quality schemes in addition to any contract monitoring already undertaken. Secondly, a profound loss of trust by Council and PCTs in the ability of CQC to monitor quality, (a view often based on the reduced numbers of inspections brought in by CSCI) meant Councils and PCTs wanted to take on the role of quality judge themselves.

4.4 The premature ending of star ratings has only exacerbated this situation with commissioners now no longer having any independent national assessment of quality available to them and will not have until such time as a replacement for the star ratings is in place. This is planned for April 2012 but the consultation has only just started and there can be no guarantee that what is proposed will be either acceptable to the sector or be able to be delivered by the April date.

4.5 Attempts to draw up a non duplication protocol between ADASS and CQC have resulted after two years of work in an agreement to draw up an information sharing agreement. None of this is finalised and does not meet the original aim for this work set. The work started on this process in 2008 and the original vision was agreed with ADASS as:

“ADASS and CSCI have agreed to work together to clarify roles and responsibilities for promoting improvement in the quality of registered services for adults. Work will be taken forward to develop a
protocol that will clarify the interface between regulatory and contracting activity, promote efficiency in the use of public resources, minimise the administrative impact on providers and add value in promoting better outcomes for people using services. Other stakeholders, including PCTs and providers will be asked to contribute their views over coming months."

4.6 CQC has not been able to assert any leadership in telling Councils to modify their behaviour and ensure commissioning for quality means, we would argue, ensuring individual needs are properly met by the provider through individual review as opposed to the wholesale monitoring and inspection of services which replicates the role of the regulator.

4.7 Anything councils and PCTs do over and above what CQC has already done should be; justified in terms of cost and benefit with a proper impact assessment that incorporates the time and investment needed by providers to meet Council requirements; explained how it will be communicated to local people and benefit individuals; and should be done in consultation with providers, as genuine partners.

4.8 The focus of the work is now very much on ensuring a better means of exchanging information between CQC and ADASS and trying to stop duplication of effort or requests of providers for information. However no council will sign up to it until there is a technical solution in place to allow for that exchange of information. As a result the protocol will probably be no more than a statement of intent which will mean councils will carry on as normal.

4.9 The reality is that the protocol will simply not go far enough to ensure with respect to council and/or PCT quality schemes that:
- new quality schemes are appropriate in the first place;
- new quality schemes are good value for money and efficiently run;
- encourage partnership with providers;
- tackle the conflict of interest between quality judgement and funding; and
- are clear what quality schemes mean for the public.

4.10 Finally the question is whether we want numerous council schemes, plus PCT schemes which are each different to the other and which will impose a huge amount of time and effort on an underfunded provider sector. For providers caring for people from a number of councils and/or PCTs the demands will be even greater and possibly contradictory.

4.11 The issue of duplication is causing members extreme concern. It is also, we would argue, in the current financial climate, a priority to ensure duplication, and therefore the waste of public money spent in this way, is eliminated as far as possible.

4.12 It is also a priority to decide whether we want local or a national means of assessing quality with a proper assessment of the costs and benefits of the various options. This needs to be led nationally as opposed to allowing a variety, oversupply and duplicate options to develop. We had hoped CQC might take on this role but we have seen no evidence that this is likely to happen.

5. Quality Assessment or Essential Standards

5.1 CQC has taken two decisions that call into question its genuine desire to engage with views that are at variance with the official line and/or its own interests:
1. First, making the entire operational infrastructure of the new quality scheme—including the landmark plan to introduce application charges for the excellence award—non-negotiable is indicative of a reluctance to accept the principle that no one has a monopoly of wisdom, that ideas should be contested. By doing so, CQC has treated providers with contempt.
2. In addition, the adoption of a lone, free-standing award of excellence, providing recognition of quality over and above essential standards has been taken in flagrant disregard for the clear preference of responses to the original consultation (February 2010), for more gradations of scale over fewer.

5.2 It was a mistake to abolish the star rating system which empowered and informed the public, even with its many shortcomings, before a replacement was ready to be implemented. The proposed replacement of one rating system instead of a series of ratings as before, will not be as helpful for the public.

5.3 Even if it really was impossible, as an interim measure, to adapt the star rating scheme to accommodate essential standards, there can be no excuse for the singular lack of urgency demonstrated by CQC, especially when the award of “excellence” in the chosen model is not directly linked to standards (as star ratings were to national minimum standards).

6. Application Charges

6.1 Quality assessments should not be funded from additional fees levied on services. The regulator has a statutory duty to encourage improvement in services, for which it is resourced: “The Commission is to perform its functions for the general purpose of encouraging—(a) the improvement of health and social care services” [s.3(2) Health & Social Care Act, 2008]
6.2 We do not believe this responsibility can be met by monitoring essential standards, as CQC officials have claimed. In fact, CQC has itself made the connection between its “improvement” responsibility and the provision of information about quality above essential standards, insofar as, in the regulator’s view, the scheme will “motivate providers to improve the quality of care”.

6.3 Indeed, the Commission has recognised that “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...” [Guidance about compliance with essential standards of quality and safety, p6]

6.4 That point was reiterated in the statement (on the CQC website), dated 28 February 2011, announcing the excellence scheme: “An excellence award can recognise best practice, be a spur to improvement for providers who already meet CQC’s essential standards...”

6.5 The DH has been at pains to distinguish between essential standards and quality standards, with the link to service improvement being made exclusively with the latter. “Quality Standards are not the same as the regulatory standards which service providers need to achieve for registration purposes. These ‘essential standards’ capture the minimum acceptable requirements for quality and safety, whilst the Quality Standard is intended to reflect best practice in striving for excellence, and support the achievement of the best outcomes.” [Transparency in outcomes: a framework for adult social care, p.12]

6.6 Again: “These basic standards for quality and safety act as a bedrock from which improvement can be made towards the higher levels of practice and outcomes identified in the NICE Quality Standards for social care. To establish which providers are successfully going beyond those essential standards, and striving for excellence, a further assessment mechanism will be needed.” [Ibid, p.29]

6.7 Given CQC’s decision to outsource the delivery of the excellence award, then that part of their funding which has been allotted for “improvement” purposes should be used to fund the activities of the delivery body(ies). There is no justification for charging a separate fee.

6.8 Though CQC has noted that “recognition of the scheme by commissioners in commissioning decisions will be important” [Progress update to CQC Board, September 2010], it should reflect on its failure—and that of its predecessor body—to use its leverage with council commissioners to broker a scale of quality premiums linked to ratings while it had the power to do so.

6.9 We will be giving detailed comments on the proposed “Excellence” scheme in response to the official consultation.

June 2011

Written evidence from the British Dental Association (CQC 06)

EXECUTIVE SUMMARY AND GENERAL POINTS

1. The British Dental Association (BDA) is the professional association and trade union for dentists practising in the UK. Its 23,000-strong membership is engaged in all aspects of dentistry including general practice, salaried services, the armed forces, hospitals, academia and research, and includes students.

2. The Department of Health set the Care Quality Commission (CQC) an almost impossible task to perform in registering over 9,000 dental practices within a very short timescale. Poor communication, with conflicting information, combined with an unrealistic deadline for registration put unnecessary stress on the profession at a time when BDA surveys show that dentists with NHS contracts are already suffering from extremely low morale. The uproar in the profession once the process began was unprecedented. We suggest that the Committee asks CQC to account for the problems that occurred during the registration process.

3. While not objecting to regulation per se, the profession has made it clear that the way regulation by CQC is turning out is both unwelcome and unnecessary. Dentists are already regulated by the General Dental Council as individuals and as providers with NHS contracts (which are the vast majority) are subject to inspection and monitoring by Primary Care Trusts.

4. CQC regulation represents a further bureaucratic layer in the practice of dentistry. It is also a significant additional cost for these small businesses to meet, with no clear benefit to the profession or public. In a time of austerity and where government is seeking to make as many efficiency savings as possible, including imposing pay cuts for dentists, this additional cost is unjustifiable.

5. The BDA recommends that the Health Select Committee questions the appropriateness of CQC registration for dentistry and takes into account the lessons that have been learned from the extreme problems that occurred during the registration of dental practices. Failing the removal of dentistry from the remit of CQC, which is the option we would favour, we recommend that the Committee secures guarantees from CQC that continuing compliance is properly and proportionately managed and that the profession is fully consulted.
RESPONSE

6. The BDA welcomes the Health Select Committee’s inquiry into the Care Quality Commission. In our response to the 2008 DH consultation on the framework for registration of health and adult social care services, we stressed the importance of a regime that would be proportionate and cost-effective, integrated, tailored to the individual service, and would not be duplicative and wasteful of resources. We do not believe that this has been the case.

7. We regard the approach of CQC to the registration of dental practices to have been extremely poor. Essential general information on the process was last-minute; further information was also late, with unrealistic timelines. There appeared to be a distinct lack of knowledge about the particular issues affecting dentistry in CQC and advice from the helpline was often contradictory with CQC advisers interpreting requirements differently. We believe that the reason for this was the unrealistic timetable set by the Department of Health and the lack of resources available to the Commission, but the Association made approaches to the Healthcare Commission at a very early stage asking to be involved in order the ensure a smooth implementation, and these were later repeated to CQC. We urge the Committee to question CQC on the lessons learned.

8. Dental practitioners’ primary aim is the delivery of dental care. Any regulatory burden must be justified as demonstrating improvements in patient care, protection and safety or reducing unnecessary waste. Registration with CQC appears to achieve none of these aims for dentistry. The main purpose of CQC is to regulate the services of the provider. In our case, dentists themselves are subject to regulation by the General Dental Council. For a profession such as dentistry, where individual professionals are responsible to a governing body and, for the most part, to the NHS through Performers List requirements, NHS contracts and PCT inspections, we remain uncertain as to why the previous government felt, and the current government agreed, that dentistry required this extra level of regulation with no removal of another layer such as PCT requirements.

9. Correspondence between the BDA and CQC is available if the Committee requests it.

10. The BDA has written to CQC on numerous occasions making it clear that the registration process has been poorly managed and that more care was needed to understand the particular issues affecting dentists. This did not, however, have the effect of altering the registration process. Information continued to be provided in disconnected stages. In September 2010 CQC outlined a three-stage registration process. This required dentists to “enrol” with CQC within two weeks as a precursor to registration. The shortness of the timescale and lack of information was a cause of great concern to the profession and resulted in CQC responding to a letter from the BDA admitting that “information provision had been a problem”. The specification of timelines. There appeared to be a distinct lack of knowledge about the particular issues affecting dentistry in CQC and advice from the helpline was often contradictory with CQC advisers interpreting requirements differently. We believe that the reason for this was the unrealistic timetable set by the Department of Health and the lack of resources available to the Commission, but the Association made approaches to the Healthcare Commission at a very early stage asking to be involved in order the ensure a smooth implementation, and these were later repeated to CQC. We urge the Committee to question CQC on the lessons learned.

11. The BDA has written to CQC on numerous occasions making it clear that the registration process has been poorly managed and that more care was needed to understand the particular issues affecting dentists. This did not, however, have the effect of altering the registration process. Information continued to be provided in disconnected stages. In September 2010 CQC outlined a three-stage registration process. This required dentists to “enrol” with CQC within two weeks as a precursor to registration. The shortness of the timescale and lack of information was a cause of great concern to the profession and resulted in CQC responding to a letter from the BDA admitting that “information provision had been a problem”. The specific registration guidance for dentistry was published in September 2010. This did not make any sense without the context set out in the 278-page generic Essential Standards of Quality and Safety which was not sent to dentists until November 2010. It was left to the BDA to translate this document into requirements that would make sense in dental practice. The registration process itself was also beset with apparently minor, but in the circumstances significant, problems, such as e-mails containing the passwords required for registration being sent late and in many cases being classified as “junk” by e-mail servers. This resulted in unnecessary stress for dentists as the 28-day window for registration approached with the threat of legal penalties if it was missed.

12. The profession also faced considerable difficulties with enhanced CRB checks. Where dentists did not already have PCT-countersigned CRB checks, CQC required them to be countersigned at post offices. Initially, the CQC had allocated only 27 post offices in England for countersigning applications for CRB checks resulting in some dentists having to close surgeries for a day to attend their nearest post office. Following pressure from the BDA, the number of post offices permitted to countersign CRB checks was increased to 100. It is disappointing that the CQC had not considered the impact of having such few post offices in the initial stages.

13. There were many instances where PCTs failed to comply with CQC’s request for verification of the existence of a PCT-countersigned CRB disclosure. Where dentists had their PCT-countersigned CRB disclosure available, CQC refused to accept this as evidence. CQC insisted that only the PCT could verify that it had countersigned the disclosure. Ultimately this resulted in CQC contacting dentists advising them that a further CRB check countersigned by the CQC was necessary to progress their application for registration.

6 Correspondence between the BDA and CQC is available if the Committee requests it.
14. CQC also e-mailed all dentists informing them that they needed a registered manager. This caused a great deal of concern among many dentists until it emerged that many had been sent this e-mail in error. CQC has also requested that dentists pass on information regarding fees to their “finance manager”. This lack of understanding from the regulator about how a small dental practice is run is frustrating and disturbing.

15. On behalf of our medical colleagues, we welcome the Department of Health’s decision to delay registration of general medical practices until April 2013 so that CQC’s systems, tools and processes can be refined.

**Practice Transfers**

16. Now that the profession has struggled through the registration process, we are finding that very serious obstacles are arising in the sale and purchase of practices and in giving effect to simple changes in practice ownership, in partner changes for example. Such problems include the need for new CRB checks and the length of time both this and the CQC process takes inhibits sale and results in lenders holding back the finance for the sale to be completed until registration is finalised.

**Continuing Compliance**

17. The BDA wants to avoid problems arising in continuing compliance and ensure that inspections are proportionate, effective and in the interests of both patients and practitioners when they do occur. We have not yet, however, seen the terms of reference that the practice inspectors will adhere to and can, at this stage, only hope that they are proportionate and relevant. We would also like to have much firmer assurances about the training that inspectors of dental practices will receive and have concerns that inspectors will have generic requirements that completely disregard the nature of a dental practice.

18. In the interests of patient care, we would welcome the opportunity to work with CQC to ensure that continued compliance is based on reasonable and practical requirements and define the role of the practice inspectors. We hope that we are involved in a timely way.

*June 2011*

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**Written evidence from Alzheimer’s Society (CQC 07)**

Alzheimer’s Society is pleased to submit evidence to the Health Committee’s scrutiny of the Care Quality Commission.

**Alzheimer’s Society**

Alzheimer’s Society is the leading care and research charity for people with Alzheimer’s disease and other forms of dementia, their families and carers. The Society has expertise in providing information and education for people with dementia, carers and professionals. It provides a helpline and support for people with dementia and carers, runs quality day and home care, as well as funding medical and scientific research. It campaigns for improved health and social services and greater public understanding of all aspects of dementia.

**Summary**

— Alzheimer’s Society welcomed the launch of the new Care Quality Commission (CQC) in May 2009. A single organisation to regulate the quality of health and social care services is vital if we are to see improvement in quality of care for people with dementia and their carers.

— The Society also welcome CQC’s stated commitment on dementia. In signing up to the Dementia Action Alliance,7 CQC identified three key areas for improvement:

1. Ensuring that the care of people with dementia becomes more people-centred, including a focus on person-centred care plans.
2. Ensuring that people with dementia receive care that meets the essential standards of safety and quality.
3. Improving the commissioning of services for people with dementia.

— However, Alzheimer’s Society does not have confidence that CQC is in a position to effectively regulate for quality. There remains a widespread failure by health and social care to provide high quality dementia care. This is despite the fact that raising the quality of care for people with dementia and their carers is a major priority in health and social care, with the Government committed to accelerating the pace of improvement. The regulatory system is a vital component of the whole systems approach that is needed to drive up dementia care and CQC must be provided with the resources and powers necessary to allow it to carry out its role effectively.

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*The Alliance is a coalition of over 50 organisations, who are committed to improving quality of life for people with dementia and their carers in England.*
In particular, CQC must be supported to drive up the quality of dementia care in care homes. This is vital given that two thirds of care home residents have dementia, yet poor quality dementia care is widespread. Regulation in a care home setting is very different to the NHS, and inspection is essential for ensuring that good quality dementia care is being provided, which focuses on the outcomes that matter to people with dementia and enables them to live their lives well. Yet CQC is working in a context where inspection rates are reported to have fallen by 70% and where cases such as Winterbourne View residential hospital are raising questions about the effectiveness of regulation in its current form.

In addition, CQC is working within a context where the Dilnot Commission on funding of care and support is due to report its conclusions in July. The Commission is looking at how to secure the highest quality care outcomes and any new system of care must therefore have a robust way of ensuring better quality care. Now is the time to ensure that there is a robust regulation and inspection system in place that works with services to ensure consistent safety and quality. People using health and social care services will look to CQC to ensure standards are being met and to take action where they are not.

This submission will highlight background information on dementia and the challenge it presents to health and social care services. This is to help the Committee understand the scale of the challenge. The submission then outlines the range of activity that CQC must carry out to improve dementia care, to highlight the scope of powers and resources needed.

Alzheimer’s Society thinks it is vital that CQC must set the bar high for dementia care. It seems that poor quality care is tolerated and providers must understand that they could do much better in terms of the quality of dementia care that they provide. Levers must be introduced to support improvements. In particular CQC should:

1. Prioritise the driving up of quality in care homes.
2. Implement a robust inspection system, including unannounced inspections and inspectors with an understanding of dementia care.
3. Assess how well health and social care services are working together.
4. Ensure that there is an adequate system in place to give people buying care a way of judging quality.
5. Use its power to enforce good care, particularly early intervention in care homes to prevent situations reaching crisis point.
6. Involve people with dementia and carers in its work.

1. Dementia and health and social care services

1.1 There are 750,000 people with dementia in the UK. This is forecast to increase to over one million by 2025 and 1,735,087 by 2051. One in three people over 65 will end their lives with a form of dementia.

1.2 Dementia is a complex condition and people will require a broad package of care from a range of agencies across health and social care. Dementia is progressive, which means people with dementia and their carers are coping with a changing pattern of abilities over time. As the disease progresses, people with dementia will need more support. Eventually, they will need help with all their daily activities.

1.3 People with dementia are core users of health and social care services:
   — Two thirds of people with dementia live in the community.
   — One third of people with dementia live in care homes. Two thirds of care home residents will have a form of dementia.
   — Up to one quarter of hospital beds are occupied by people with dementia aged over 65 years at any one time.

1.4 Dementia currently costs the United Kingdom £20 billion each year. By 2018 dementia will cost the UK £27 billion per annum. Yet this is not being spent effectively. The National Audit Office’s report in 2007 found that health and social care spending on dementia was late in the condition and was often not contributing to good outcomes for people with dementia.

2. The current state of dementia care

2.1 Dementia is a key example of where urgent action is needed to improve quality. For example:
   — Home from Home (2008) found that huge variations exist in the quality of care between care homes; half of all respondents reported that their relative did not have enough to do and one in 4 said that they weren’t involved in the decisions made about their relatives care.
— In the Commission for Social Care Inspection’s (CSCI) report *See me, not just the dementia* (2008)\(^{10}\) 100 thematic inspections of care homes were completed, which examined the experiences of people with dementia using an observational process (the Short Observational Framework for Inspection—SOFI). The majority of homes had previously been rated as adequate or good through inspection, with a few rated as excellent. Despite this, the dementia care provided in these homes was not found to be adequate.

— The All Party Parliamentary Group on Dementia found in their report *Always a last resort* (2008)\(^{16}\) that over 100,000 people with dementia in care homes were being inappropriately given antipsychotic drugs. Inappropriate use can cause significant harm to people with dementia.

— Counting the cost (Alzheimer’s Society, 2009)\(^{18}\) found that people with dementia are staying in hospital longer than those without dementia, in part due to the poor quality dementia care provided. The longer people with dementia are in hospital, the worse the effect on their symptoms of the dementia and the individual’s physical health; discharge to a care home becomes more likely, and antipsychotic drugs are more likely to be used.

3. The dementia policy context

3.1 *Living well with dementia: a National Dementia Strategy for England*\(^{4}\) (NDSE) published in February 2009, sets out 17 objectives designed to support people to live well with dementia. In September 2010, the Department of Health published its revised, outcomes focused implementation plan for the Strategy.\(^{8}\) It states that:

— Raising the quality of care for people with dementia and their carers is a major priority under the new Coalition Government.

— The Government is committed to ensuring there is greater focus on accelerating the pace of improvement in dementia care.

— Local organisations are expected to publish how they are delivering quality outcomes so that local people can hold them to account.

3.2 Following the publication of the NDSE, A Department of Health report into the use of antipsychotics for people with dementia (2010)\(^{10}\) found that 180,000 people with dementia are being treated with these drugs, yet of these, only 36,000 are appropriate. In response, the Government committed to reducing the use of these drugs by two thirds by November 2011.

3.3 The revised Operating Framework for the NHS\(^{11}\) included dementia as one of only two items added as requiring increased emphasis. The revised plan states that NHS organisations should be working with partners on implementing the NDSE.

4. The role of CQC in improving dementia care

4.1 CQC must not tolerate inferior standards of dementia care. The growing number of people with dementia, the seriousness of the condition, the cost it imposes and the widespread poor standards of care has led Government to state that it is a priority area. CQC must recognise this and be supported to work to improve quality of care across the board. Providers must also understand that they could do much better in terms of the quality of dementia care they provide. CQC must prioritise the following:

(a) Work to drive up the quality of dementia care in care homes

4.2 In the last 20 years there has been a significant shift in the profile of people in care homes, which means that now over two thirds of people in care homes have a form of dementia. The role of care homes has now become the provision of late stage dementia care and the primary task of the care home sector is providing good quality care to people living with dementia.

4.3 Yet despite dementia being the core work of care homes, the provision of dementia care continues to be of poor quality. Currently, CQC is not providing an adequate response to the state of dementia care in care homes, and does not have the resource or powers to work effectively. The need to urgently drive up the quality of dementia care requires a specific approach to inspection and regulation. In particular, regulation in care homes must focus on enabling people with dementia to live their lives well and achieve outcomes that matter to them.

4.4 CQC must be supported to ensure that there is:

— A system of frequent inspection by trained inspectors, including unannounced inspection—see paragraphs 4.4 to 4.8.

— A focus on the outcomes that matter to people with dementia during the inspection process. Care homes are about living ones life, and there should be an emphasis on activities and social interaction. The services that CQC register should do all they can to support people to live rewarding lives as well as maintain abilities and independence.
4.6 Inspection is a vital part of understanding the care provided to people with dementia, particularly in a care home setting. In the south of the UK, where two thirds of residents will have dementia and reports have shown the quality of care to be particularly poor. The NSDE places an emphasis on understanding the real-life experience of people with dementia, particularly through the use of the SOFI observational process, and on care home inspections that must include an assessment of the quality of care that people with dementia experience.

4.7 Inspection therefore must be an integral part of any review system if we are to drive forward improvements in dementia care. At this time, as the number of inspections drops, Alzheimer’s Society does not have confidence that CQC can effectively understand, monitor and improve the dementia care being provided in care homes. CQC must be enabled to carry out this vital part of its work through the provision of adequate resource to allow for frequent inspections, including the use of unannounced inspections.

4.8 In addition, if inspection is to understand outcomes that are important to people with dementia, training for inspectors in best practice in dementia care is vital. Previously Alzheimer’s Society has had concerns about the consistency of knowledge about dementia care amongst inspectors. CQC inspectors must be kept up to date on best practice in dementia care so they can provide the right support to services to ensure the best outcomes for people with dementia.

(c) Assess how well health and social care are working together

4.9 CQC is well placed to monitor how well health and social care services are working together. This is particularly important for people with dementia, as they will often be receiving a range of services from both sectors. Currently, few people receive the seamless service that health and social care services should be aiming for.

4.10 In cases where an inspection of one service reveals problems with another, Alzheimer’s Society believes that it is important that CQC use their ability to inspect across health and social care. For example, an inspection of a care home may reveal that the local NHS services for people with dementia are not providing adequate support to the care home. This information should be used by CQC to support the NHS to improve its services.

4.11 Given the current priority attached to joint working, within the context of dementia and within the wider health and social care context, it is vital that CQC place an emphasis on this area.

(d) Provide a robust system for assessing and reporting the standard of social care

4.12 We know the current quality of services for people with dementia varies considerably. Alzheimer’s Society has serious concerns with the replacement of the quality ratings system with a simple description of the essential standards of quality and safety and whether a provider has met them. This system will not allow a service user to understand the differences between the quality of care provided by different services. It therefore does not support effective choice. Whilst the Society acknowledges that the recognising excellence in adult social care award is in development, there are concerns that the current proposals will not provide a standardised excellence rating and is not an adequate replacement for the ratings.

4.13 In addition, the Society has concerns that any rating system will not allow people with dementia and carers to assess the quality of the dementia care being provided. This is particularly important in care homes, where two thirds of residents have dementia and the quality of care overall is not representative of the quality of dementia care (for example, as shown by the findings of the CSCI report See me, not just the dementia).

It is vital that this is addressed to support effective choice and control. Alzheimer’s Society would like to see a system where service users can clearly understand the quality of care each service provides, and for care homes, the quality of dementia care that is provided.

8 For example, in May 2011 Community Care reported that the number of on-site inspections of adult care services being conducted by the Care Quality Commission fell 70% in the first six months of the new regulatory regime (www.communitycare.co.uk/blogs/adult-care-blog/201105/).

9 For example, the Government’s response to the Future Forum’s recommendations notes that integration of care means seamless care for all, and that there is the need to get all parts of the system working towards that goal.
(c) Use enforcement powers, with a particular focus on early intervention in care homes

4.14 Alzheimer’s Society strongly supported the expanded powers at CQC’s disposal (in Alzheimer’s Society’s response to the consultation on CQC enforcement policy). There remains unacceptable variation in the quality of services available to people with dementia and a robust enforcement policy is vital to improving quality and outcomes for people with dementia.

4.15 It was a widely held view that CQC’s predecessor social care regulator, CSCI, did not have sufficient powers needed to drive up standards and quality. The Society reiterates its view that earlier intervention, through the use of penalty notices and suspension of registration, can be effective in driving up the quality of dementia services and avoiding crisis situations, such as emergency admissions to hospital or into long term care. CQC must have the capacity and resources to intervene earlier. The Society also reiterates the need for CQC to report to the public information on enforcement, which is integral to building faith in the regulatory system.

(f) Involve people with dementia and carers in the work of CQC

4.16 The Society was very pleased to see the Care Quality Commission’s development of a Statement of Involvement. The Society’s response to the consultation on the statement of involvement highlighted that it must provide for people with dementia, or it will fail a significant group of service users. People with dementia are significant users of health and social care services and yet the care offered is frequently of unacceptably poor quality. If quality is to be improved, and care is to truly focus on the outcomes that matter to people with dementia, they must be involved in CQC’s work.

4.17 CQC must actively support people with dementia to have a voice. The Society expects CQC to enable people with dementia to offer their opinions and share their experiences. Simply including people with dementia in studies and surveys will not be enough—people with impaired capacity require extra support to be involved and CQC must provide this.

References


June 2011
Written evidence from Action on Hearing Loss—RNID (CQC 08)

SUMMARY
— Action on Hearing Loss—RNID recognises that safety and the management of risk in care settings must remain central to the Care Quality Commission’s role.
— A large proportion of people in care homes will have some hearing loss, for instance, 82% of people aged over 80 have or would benefit from a hearing aid.
— Ineffective communication in care settings carries high risks.
— Ineffective communication within care settings makes it more difficult to for providers to achieve the Care Quality Commission’s essential standards.
— Action on Hearing Loss—RNID is calling for a separate point around communication to be included in the Essential Standards and outcomes to ensure that service-providers recognise its importance.
— It is important that the CQC facilitates the integration of health and social services by capturing patients’ experiences across the whole care pathway.

1. We’re Action on Hearing Loss—RNID, the charity working to create a world where deafness or hearing loss do not limit or determine opportunity and where people value their hearing. We work to ensure that people who are deaf or hard of hearing have the same rights and opportunities to lead a full and enriching life. We strive to break down stigma and create acceptance of deafness and hearing loss. We aim to promote hearing health, prevent hearing loss and cure deafness.

2. We welcome the opportunity to submit evidence to the Health Committee.

3. Action on Hearing Loss—RNID recognises that safety and the management of risk in care settings must remain central to the Care Quality Commission’s role. We also appreciate the emphasis in the essential standards on service-users’ quality of life. However, we would like to see a separate point around communication to be included in the Essential Standards and outcomes to encourage the recognition of the importance of communication in care settings.

4. A substantial number of people living in care homes will have some level of hearing loss. For instance 47% of people aged over 65 and 82% of people aged over 80 have or would benefit from a hearing aid. Older people use healthcare services more than other groups; therefore a high proportion of people in healthcare settings will have a hearing loss. As a result, communication is more challenging in such settings; at the same time ineffective communication carries high risks, for instance, it may lead to mistakes around the administration of medication. Similarly, ineffective communication within care settings makes it more difficult for organisations to achieve the Care Quality Commission’s existing standards.

5. The challenges presented by sensory loss, and its implication are widely recognised. For instance, My Home Life,[10] a report prepared by Help the Aged (now Age UK) highlights the importance of relationships to people in care homes, stating that these are the most important factor in determining the quality of life of residents. It also recognises that sensory impairment can make relationships with other residents difficult and that staff can help residents in this respect.

6. Moreover, people in care homes do not live in isolation, if steps are taken to help one person to communicate more effectively this can be beneficial for other residents and staff.

7. Therefore, Action on Hearing Loss—RNID would like to see a separate point around communication to encourage the recognition of the importance of communication in care settings. This should include the following:
   — Effective systems are in place to alert staff that a patient or service-user has a hearing loss or is experiencing other difficulties around communication.
   — Staff understand what they should do if residents’ behaviour suggests that they may have a hearing loss.
   — Staff will take steps to help residents to communicate effectively with themselves, other residents and any other contacts.
   — Staff will check regularly that hearing aids are working and that residents are wearing them correctly.
   — The environment is maintained and adapted to help people to hear better (eg installation and maintenance of induction loops, minimisation of background noise).
   — Information is provided in accessible formats.
   — Communication support is available to people who would benefit from this.

8. As the regulator of both health and care services CQC is well-placed to assist integration between health and social care services. Therefore, it is important that the CQC facilitates the integration of health and social services by capturing patients’ experiences across the whole care pathway.

9. Action on Hearing Loss is currently conducting research around the diagnosis and management of hearing loss in mainstream care homes. We will circulate the final report, expected in autumn 2011, and would welcome the opportunity to share early findings with the Health Select Committee.

June 2011

Written evidence from National Care Association (CQC 09)

1. INTRODUCTION

1.1 National Care Association represents the interest of independent sector registered providers of social care. The membership comprises primarily SME’s.

1.2 The provision of services by members covers a wide spectrum of the categories of care including care of older people, people with dementia, people with learning disabilities, people with physical disabilities, both in care homes and having the care delivered in their own homes.

1.3 National Care Association is committed to:

— The raising of standards for the benefit of those in receipt of care.
— A trained and skilled workforce.
— The recognition of Social Care as a profession alongside Healthcare and Social Work.
— Delivering a flexible service tailored to the needs of individual service users rather than delivering the services that have always been delivered.

1.4 All members of National Care Association are subject to registration by the Care Quality Commission.

2. CARE QUALITY COMMISSION

2.1 When the Care Quality Commission became operational National Care Association welcomed their approach particularly that the monitoring process would focus on outcomes for service users.

2.2 We welcomed the monitoring of outcomes because we believe that the regulator should monitor what is important and not that which can be easily measured. The focus on outcomes is a methodology that we have been promoting for several years.

2.3 The actual “outcome” of the work of the Care Quality Commission has therefore been a disappointment to members of National Care Association:

— The registration of Care Providers in 2010 did not go well for providers.
— Interviews have been given to the press by officials of the Care Quality Commission which have undermined the social care sector.
— The insistence on pressing ahead with the introduction of the Excellence Award in April 2012 despite the reservations of the social care sector and more lately the concern about the additional cost of an Excellence Award at a time of stringent public spending cut backs.
— The Panorama programme about Winterbourne View.
— The belief of the Social Care sector that the Care Quality Commission is now a health led organisation.
— The imposition of increases and changes to the regulatory fees payable to the Care Quality Commission with three days notice.

2.4 We will deal with each of the above items in turn below.

3. RE-REGISTRATION OF SOCIAL CARE PROVIDERS IN 2010

3.1 From a provider point of view the Re-registration process did not go well. There were real problems of language (between the public sector and the private sector) for providers. The impact of this could have been ameliorated if the representative bodies had been consulted about the paperwork in the early stages of development. As it was we first saw the documentation three days before the Re-registration process began.

3.2 Many care home owners when filling out the documentation faced with tick boxes one of which said care home and another of which said personal care ticked both boxes. Hardly surprising as that is what they do. To everyone’s surprise personal care applied to domiciliary care only. Care home providers who had ticked both boxes had their application returned.

3.4 After the Re-registration process had started both care homes with nursing and care homes were told that they should consider also registering as:

— Treatment Centres.
— Diagnostic Centres.
— This may have been appropriate guidance for some care homes with nursing but many care homes were put under huge pressure to register for these two categories. This pressure demonstrated a failure to understand social care.
— The guidance has now been withdrawn.

3.5 We could go into much more detail about this unhappy period. We would be pleased to supply more information if required.

4. PRESS INTERVIEWS
4.1 An interview given to the Independent newspaper by the Chairman of the Care Quality Commission caused a great deal of upset amongst Care Providers. The interview can be accessed at:

5. EXCELLENCE AWARD
5.1 The Care Quality Commission (CQC) has issued a Consultation Document about the design of their new Excellence Award.

They have also invited Expressions of Interest from interested parties to administer a CQC-licensed excellence award for adult social care providers. CQC said that “successful applicants will need a track record of delivering audit or inspection programmes as well as knowledge of the social care.”

5.2 Care Providers pay a substantial annual fee to the Care Quality Commission to be registered and regulated. If this scheme is implemented they are going to have to pay an additional fee to another organisation if they want to apply for the Excellence Award.

5.3 Members of National Care Association want to know what they are paying CQC for if they are now going to have to pay thousands of pounds more for a second inspection process. Surely when inspecting providers of care CQC is best placed to identify which provider is delivering an excellent service.

5.4 The Care Quality Commission has said that providers of care can decide whether or not they wish to apply to be considered for the Excellence Award (a service would have to be fully compliant to apply).

5.5 In an article in The Independent on 28 February Ministers were quoted as saying:
"Nursing homes are to be told to submit to new ‘excellence tests’ or risk losing public funding,” under plans to be announced today.
"Ministers have warned that only those institutions which meet the new standards are likely to be funded in future by local councils."

5.6 This hardly suggests that this will be a voluntary scheme and are our members are therefore alarmed because any such scheme will not be cheap. Independent accreditation can cost small business thousands of pounds something the sector can ill afford at this time of financial restraint.

5.7 Local Authorities are responsible for the funding of approximately 60% of all placements in care homes in England. Most members of National Care Association are therefore facing very tight financial arrangements with Local Authorities and in many instances fees are being reduced. Quality care providers will want to concentrate expenditure on quality of care and quality of life. This proposed Excellence award will be another financial burden on providers of care and National Care Association believes that providers who seek to achieve the award will be required to comply with yet another paper chase.

5.8 It is time to stop this relentless imposition of bureaucracy on Social Care providers.

6. WINTERBOURNE VIEW
6.1 Winterbourne View is a private long stay hospital but the confidence of SMEs in the independent sector has been shaken by the failure of the Care Quality Commission to react to the most serious allegations made by the whistle blower.

6.2 Members of National Care Association are customers of the Care Quality Commission. Our members pay large amounts of money to be regulated and expect in return to be the subject of robust inspection and a critical friend relationship.

6.3 The reality is that now more than ever there is very limited inspection, just a paper chase.

6.4 More than anything the social care sector expects the outcome of the work of the Care Quality Commission to be a reassurance to the public of the quality social care.

6.5 There is a serious issue developing of a complete loss of confidence in the regulator throughout the sector.
7. IS THE CARE QUALITY COMMISSION A HEALTH-LED ORGANISATION?

7.1 Of the Members of the Board of Directors of the Care Quality Commission only the Chair is a Social care professional and it would be most unfair to expect the Chair of such a large organisation to concentrate on social care when she is responsible for the entire Commission.

7.2 Of the Executive Directors although there are a number with a health background the closest I can see to social care is someone who was an OT before they joined the Inspectorate.

8. RECOMMENDATIONS

8.1 The expertise within the representative bodies should be recognised by the Care Quality Commission and particularly when consultations are taking place their voice should be heard. (At the moment in a consultation a response from National Care Association is treated as one voice and not as the representative of 2,000 providers).

8.2 The Excellence Award should be deferred immediately and discussions with sector representatives should begin to arrive at a proposal acceptable to all.

8.3 The role of the Care Quality Commission should be clearly spelt out:
   — Are they an Inspectorate?
   — Do they listen to serious complaints?
   — Do they have a procedure to make decisions about how to handle complaints?

8.4 At least one Director with a background in social care should be appointed to the Board of Directors without delay.

8.5 There should be an Executive Director appointed with a social care background who is responsible for Care Quality Commission work in social care.

8.6 The Care Quality Commission needs to be able to demonstrate that it is able to and wishes to work with SMEs in the same way that it works with NHS providers.

8.7 The Care Quality Commission should not be operating in isolation but should work with sector representatives as stakeholders and partners. It is not in the interest of the responsible care sector to lurch from crisis to crisis.

We want a regulator that is proactive and who is able to reassure the public that a regulated service meets an acceptable standard. To do this they need to inspect the service and not the paperwork.

June 2011

Written evidence from the Royal College of Nursing (CQC 10)

1.0 INTRODUCTION

With a membership of more than 410,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

The RCN welcomes the Health Select Committee’s decision to hold annual review meetings with the Care Quality Commission (CQC) and Monitor and is pleased to have the opportunity to submit written evidence in advance of the sessions on 28 June 2011.

2.0 CARE QUALITY COMMISSION (CQC)

2.1 Executive summary

— The CQC is the regulator to assess compliance by legally binding standards of safety and quality. The CQC has a unique role because it has a number of enforcement powers, including in the extreme, closing a provider down, if they fail to comply with the essential standards of quality and safety. It brings to bear strong incentives for providers to ensure that they deliver safe, high quality care. Given the financial pressures faced by the NHS and adult social care providers, there is now an even greater case for an effective regulator who is sufficiently resourced, skilled and proactive to prevent harm. We want to see the CQC fully supported to continue to mature and develop as an organisation.
— The RCN calls for the CQC to undertake more announced and unannounced inspections, and for staffing metrics to be explicitly included within their approach. This is even more important if there are to be more providers involved in delivering NHS services under the phasing in of the Any Qualified Provider (AQP) policy outlined in the Government’s recent response to the NHS Future Forum report. The RCN would also like to see the CQC become more proactive in preventing problems occurring, alongside focusing on providers when concerns have been raised.

— The RCN has consistently called for “intelligent” regulation, with sufficient levels of monitoring, investigation, inspections and use of metrics. This should also include timely intervention by the CQC where quality of care is found to be poor.

— The RCN believes that the CQC should include standards and targets on staff health and wellbeing in assessment processes and standards for best employer practice, including staffing levels and staff engagement. We also believe that there is a need to recognise the long term link between quality staff and quality services, and the need for the regulator and providers to take a long term view on investment in training and payment to staff working in both health and social care providers. This is evidenced in previous work from the Healthcare Commission and the Boorman Review on Health and Wellbeing.

— The RCN would like to see the CQC provide more investment in leadership. This includes continuing training and support for assessors and inspectors, and allowing standards to be measured through a mix of questions and indicators.

— The CQC has a significant workload and is taking on more responsibilities, such as the registration of GP practices. The RCN appreciates that like other public sector organisations, the CQC has to strive to do more with less money and to work with fewer resources in the current economic climate. However, we urge the CQC to review the balance of their work between using information to assess providers, and inspections to see what is happening “on the ground”. We also note that the CQC is still going through transition and has staff vacancies which need to be urgently filled.

— The RCN believes that the resource allocation to the CQC, including staffing levels at the regulator, should be reviewed by both the CQC itself and Government to take into account the considerable increase in workload for the regulator. It is important that the CQC has the sufficient means to fulfil their obligations effectively to ensure public confidence in the regulator.

3.0 Increased Number of Inspections

3.1 Effective regulation needs to consider the likelihood of poor performance being detected. In a predominantly self-assessment approach to regulation, it is important to include announced and unannounced inspections to cross check the information supplied to the regulator and to ensure the strong possibility of poor performance being detected.

3.2 Events since the establishment of the CQC in April 2009 have shown that evidence being routinely provided to the regulator, is not accurately reflecting what is happening in reality. For example, the case highlighted by the BBC’s Panorama programme in May 2011 at Winterbourne Hospital (where concerns were raised with the CQC but subsequently not acted upon), as well as other instances of substandard care being highlighted by the BBC’s Panorama programme in May 2011 at Winterbourne Hospital (where concerns were raised with the CQC but subsequently not acted upon), as well as other instances of substandard care being provided to the regulator, is not accurately reflecting what is happening in reality. For example, the case highlighted by the BBC’s Panorama programme in May 2011 at Winterbourne Hospital (where concerns were raised with the CQC but subsequently not acted upon), as well as other instances of substandard care being delivered in the NHS.

3.3 The RCN therefore calls for the CQC to undertake more announced and unannounced inspections, and for staffing metrics, including staffing levels and skill mix, to be explicitly included within the regulatory approach. This is even more important if there are to be more providers involved in delivering NHS services under AQP as outlined in the Government’s response to the NHS Future Forum report.

3.4 The CQC has approximately 200 members employed in frontline and national roles across the CQC, representing over 10% of the total workforce. RCN members, who are employed by the CQC, feel that the organisation wrongly places stronger emphasis on its role in registration than it does on ongoing compliance and inspection. Whilst this is a function of timing (because registration has been and continues to be a very big task), it should have been recognised at the outset that as well as continuing the “day job” of proactively monitoring providers, there was a need to also deliver a new regulatory approach. RCN members have reported that they would prefer more inspections to take place, as they are concerned about preventing poor care using the “light touch” regulatory approach designed by the CQC management and the Department of Health.

3.5 RCN members do, however, recognise that the volume of case work does impact on how proactive the organisation can be with regards to inspection. In light of the recent CQC staff survey,\(^\text{11}\) which showed that morale within the CQC workforce was poor and that concerns around caseload and workload were significant, the RCN calls upon the CQC to urgently review the caseload and workload of its Compliance and Registration Inspectors. We would also like the regulator to identify safe and manageable caseloads for its fieldforce staff. The RCN urges the Government to ensure that the correct funding resources are available to, and utilised by, the CQC in ensuring sufficient staffing levels within CQC. We note that the CQC is still going through transition and has staff vacancies, which need to be urgently filled.

\(^{11}\) CQC Staff Survey to be published shortly.
3.6 The RCN would also like to see the CQC become more proactive in preventing problems occurring, alongside focusing on providers when concerns have been raised. For example, the recent reports by the CQC on dignity and nutrition in NHS hospitals were a direct request from the Secretary of State, Rt Hon Andrew Lansley MP, rather than a CQC initiative. Following the recent Panorama programme, it is the Minister for Care Services, Paul Burstow MP, who has ordered inspections of similar providers.

4.0 “INTELLIGENT” REGULATION

4.1 The RCN has consistently called for “intelligent” regulation. This means sufficient levels of monitoring, investigation, and inspections, correct metrics and timely intervention by the regulator where quality of care is found to be poor. This should avoid a “tick box” culture and allow CQC staff to use their professional judgement, as inspectors and assessors. It is important that these individuals feel that their expertise is utilised most effectively.

4.2 The RCN would also like to see the CQC provide more investment in leadership at the organisation. This includes continuing training and support for assessors and inspectors, and allowing standards to be measured through a mix of questions and indicators.

5.0 ENSURING HIGH QUALITY CARE

5.1 The regulator needs to understand the essence of high quality care and the difference this makes to the experience felt by patients and the outcomes of their care and treatment. They need to see beneath the data and fully understand the organisation that they are reviewing.

5.2 It is incumbent on NHS service providers to demonstrate that they have nurse staffing levels and the mix of skills needed to deliver services safely. We believe that systems and staffing metrics must be in place to allow the public and the CQC, to see that this duty is fulfilled. In December 2010, the RCN published guidance on safe staffing levels, examined staffing levels and skill mix in hospitals, care homes and the community and highlighted evidence proving a link between staffing levels and patient outcomes. The research showed that NHS wards where care is compromised daily due to short staffing have twice as many patients per registered nurse as those where care is not compromised.12

5.3 The RCN believes that the CQC must also recognise the long term link between quality staff and quality services and the need for the regulator and providers to take a long term view on investment in training and sufficient payment to staff working in both health and social care providers. The CQC should also include standards and targets on staff health and wellbeing in assessment processes and standards for best employer practice, including staff engagement. This is evidenced in previous work from the Healthcare Commission and the Boorman Review on Health and Wellbeing.13

6.0 ABILITY TO DELIVER AND VALUE FOR MONEY

6.1 The RCN is mindful of significant challenges for the CQC in carrying out its regulatory functions. We appreciate that like other public sector organisations, it has to strive to do more with less money and to work with fewer resources. This is also happening at a time when the organisation is taking on more responsibilities. For example, CQC is currently due to register all GP practices by next April, although the organisation has now asked the Department of Health to extend that deadline.

6.2 In addition, the RCN has been engaging with Government on the Public Bodies Bill regarding its proposals for the future of the Human Fertilisation and Embryology Authority (HFEA). We understand the Government is now minded to keep most of the functions of the HFEA together but move them to the CQC with subsequent abolition of the HFEA. We, alongside a number of other organisations, have concerns about how this would work in practice should this go ahead and whether the CQC would be able to cope with this further extension of its remit into this specialised area.

6.3 The RCN therefore has concerns about the CQC’s capacity to cope with increased demands placed upon it by its new, enhanced responsibilities, as well as potential future responsibilities, such as the HFEA. We were interested to see reports in the Health Service Journal (26 May 2011) that the CQC Board has established a working group to examine whether the regulatory model is “sufficiently sustainable to deal with foreseeable changes in the policy environment”. The working group is due to report in September and the RCN would welcome the opportunity to contribute to this review.

6.4 As a result of the current budget restraints and during this time of reforms in the NHS, the CQC needs to look at how they can work differently and in a more streamlined way to make efficiency savings, which do not impact on their role as a regulator. It should also be incumbent on the CQC to make it clear if the leadership do not believe that they have sufficient resources to be an effective regulator.

6.5 However, the RCN also believes that the resource allocation to the CQC, including staffing levels at the regulator, should be reviewed by both the CQC itself and the Government to take into account the considerable

increase in workload for the regulator. It is important that the CQC has sufficient means to fulfil its duties and improve public confidence in its ability to undertake its responsibilities.

7.0 MONITOR

7.1 Executive Summary

— The RCN continues to support the introduction of Foundation Trusts on a case by case basis. Despite ongoing discussion about the proposed role of Monitor, the RCN believes that it is important to remember that the regulator will continue to retain its core duty of authorising and regulating Foundation Trusts.

— We welcome the Government’s decision to remove the blanket deadline in the Health and Social Care Bill for abolishing NHS Trusts as legal entities, although we recognise that the Government expects that the majority will be authorised as Foundation Trusts by April 2014. The RCN would like assurances that the bar set by the regulator will not, in reality, be lowered in order to achieve this timetable.

— Given the size and influence of Foundation Trusts, the RCN believes that there is a need for Monitor to ensure the integrity of democratic representation within these organisations.

— The RCN believes that the proposed changes to the NHS necessitate a very clear set of standards and credible checks and balances in the system. If the number and type of providers increases, it is important to ensure that they operate in ways that deliver high quality, safe care.

— The RCN is pleased that the Government listened to concerns that the RCN and others have raised about the role of Monitor as set out in the Health and Social Care Bill. We welcome the news that it will no longer have a duty to promote competition as an end in itself. We have consistently argued since the publication of the NHS White Paper in July 2010 that competition over price must not override quality.

8.0 CORE DUTIES

8.1 The future role of Monitor has come under much discussion in light of the Government’s Health and Social Care Bill. However, despite any additional duties placed on Monitor in the future, it will continue to undertake its current remit as the regulator of NHS Foundation Trusts.

8.2 The RCN continues to support the introduction of Foundation Trusts on a case by case basis. However, there are considerable risks in moving all remaining Acute Trusts to Foundation Trusts status within a short timeframe, which could result in a lower level of quality. We welcome the Government’s recent decision to remove the blanket deadline in the Health and Social Care Bill for abolishing NHS Trusts as legal entities, although we recognise that the Government expects that the majority will be authorised as Foundation Trusts by April 2014. The RCN will seek assurances that the bar set by Monitor will not, in reality, be lowered in order to achieve this timetable.

8.3 Given the size and influence of Foundation Trusts, the RCN believes that there is an increasing need for Monitor to ensure the integrity of democratic representation within these organisations. In a survey of RCN members in February 2010, the majority viewed local control of a Foundation Trust, with the full engagement of community and staff constituencies in their governance, as one of the greatest benefits.

8.4 However, RCN members expressed concern that too much emphasis on a “big business ethos” could squeeze out patient, public and professional engagement. As Foundation Trusts reach critical mass, we believe Monitor should look to strengthen governance arrangements, promote best practice public patient involvement and encourage partnership working.

8.5 RCN members argue that too many Foundation Trusts do not effectively communicate their service plans to nurses, patients and members. In addition, members believe there is a lack of practitioner engagement in the development process of Cost Improvement Plans and the organisational levels at which crucial decisions are being made in Foundation Trusts. This creates a potential for “top-down” management in achieving cost savings and efficiency targets with little or no ownership at clinical team level.

8.6 The RCN has concerns regarding transparency, as RCN members feel that Foundation Trust Boards conduct their business in private. We accept that there may be some need for parts of Board meetings to take place in private. However, the majority of business could and should be discussed in an environment in which staff are not excluded. We would also like to see Monitor call for more information to be publicly available following Board meetings.

8.7 The potential for successful Foundation Trusts to merge with and take over failing NHS Trusts holds the prospect for creating provider organisations whose size and revenue will far exceed anything that we have previously seen in the NHS. For this reason, along with the increase in numbers of Foundation Trusts, there is

a need for Monitor to be sufficiently resourced to continue to regulate and manage the risks of failure of
Foundation Trusts. The system of regulation as a whole needs to be made to work well, including clear
accountabilities as well as robust checks and balances. We also believe that it is important that Monitor and
CQC work closely together, particularly in the areas of inspection and delivery of frontline care.

9.0 HEALTH AND SOCIAL CARE BILL

9.1 The RCN is pleased that the Government listened to concerns that the RCN and others have raised about
the role of Monitor and welcomed the news that it will no longer have a duty to promote competition as an
end in itself.

9.2 We consistently argued since the publication of the NHS White Paper in July 2010 that competition over
price must not override quality. We were concerned that the issue of promoting and regulating competition
may hinder Monitor from the most important issue of regulating a national health service, which delivers
integrated, collaborative and comprehensive care.

9.3 The RCN was unsettled by comments made by the Chair of Monitor, David Bennett, which compared
the role of Monitor to those bodies that regulate the utilities and telecommunications sectors. However, we
were pleased to see that the Government has since distanced itself from these comments.

9.4 Under the Government’s proposals to amend sections of the Health and Social Care Bill, Monitor’s core
duty will now be to “protect and promote patients’ interests”. The RCN is awaiting further detail on how
Monitor will support the delivery of integrated services for patients, where this would improve quality of care
or increase efficiency.

June 2011

Written evidence from Action on Elder Abuse (CQC II)

SUMMARY

A national regulator of care services was established because of concerns by national and regional care
providers, and others, that regulation and inspection by Local Authorities resulted in inconsistent approaches.
This problem has not been solved. Confidence of the commissioners of services in CQC appears so low that
they now carry out their own inspections of services—called contract monitoring visits—resulting in multiple
inspections of providers. That is wasteful of resources and does little to improve the experiences of service
users.

Key points:

— The new inspection model was not tested within social care prior to implementation. Social care
does not have the established data sources necessary to make it work. It has proved insufficient
within the NHS too.
— There is a “one size fits all” approach to care provision that fails to recognise varying levels of risk.
— The re-registration process was time consuming, inefficient and confusing. It diverted inspectors,
resulting in a 65% drop in inspections.
— There needs to be a minimum inspection frequency and a guarantee of “face to face” inspections.
— CQC has defined its role narrowly, focusing exclusively on registration compliance. It let the
Quality Rating Scheme fall into disuse, with no immediate replacement, and proposes a new
system which cannot provide a comparison overview, and which could force out good providers.
— It has cut those staff with policy expertise in social care, and thereby appears to have compromised
its capacity to achieve broader improvements.
— There has been an inability to retain leadership at the head of CQC, affecting its ability to deliver
a consistent level of strategic direction, with decisions revised and changed frequently.
— It has withdrawn from Adult Safeguarding interaction. There is no central monitoring of CQC
attendance at safeguarding boards. Safeguarding staff report difficulties in getting attendance at
strategy and case conference meetings.
— CQC gives a confusing message on investigating complaints, and are inconsistent in their actions.
They cannot indicate how many unannounced inspections were triggered by a public complaint.
Context is missing from their process, which relies on who is making the complaint and not what
the complaint is about.
— They do not centrally monitor the effectiveness of compliance actions and cannot therefore
confirm effectiveness.
— CQC have been inaccurate in public statements, creating a confusing message for the public about
care quality.
— The approach and methodology used in the nutrition and dignity hospital inspection process are of concern. Inspections appear subjective, with questions over consistency of decisions. There is no evidence that nutritional content of meals is being scientifically assessed. Despite highlighting incidents across multiple reports no safeguarding referrals were made.

REGULATORY MODEL

1. The CQC regulatory model relies upon receiving intelligence from various sources which is fed into a quality and risk profile (QRP). Inspection activity may then be triggered by this information.

2. Responsive reviews of compliance, which may be triggered by a safeguarding alert, can additionally occur but only focus on the area of concern. Instead, reviews are planned to occur every two years to look at full compliance, but will not necessarily involve “face to face” inspection ie a desktop exercise relying upon information obtained from provider completed assessments and other documentation that may have been obtained. There is no statutory minimum inspection frequency.

3. The inspection model was not tested within social care prior to implementation.

4. Adult social care does not have the established data sources that exist in the NHS. Consequently, the many QRPs contain little more than statutory notifications and the last inspection report. As many inspection reports are now outdated, (some providers have not been inspected since 2008 or earlier) this gives little assurance of compliance (particularly where there have been changes in service management). Inspectors are most concerned about services that also fail to provide statutory notifications and therefore do not get identified by this process.

5. Even within the NHS this system does not necessarily give assurance about quality. One report from the recent nutrition and dignity inspections within the NHS (http://www.cqc.org.uk/_db/_documents/RAL_Royal_Free_Hampstead_NHS_Trust_RAL27_RoyalFreeHampstead_DANI_15032011.pdf) showed that findings from an internal survey were at odds with observations about privacy at inspection:

   “It was reported in the NHS Inpatient survey (2009) that the Royal Free hospital is better than other hospitals at privacy for examination and patients did not have any concerns about their privacy being upheld. However we saw incidents of care being carried out with open curtains,... We observed contradictory evidence as staff discussed patients’ care in front of them without their involvement and staff discussed patients’ in an environment that did not allow for privacy.” (page 7/8)

6. This demonstrates that reliance upon self assessment as a primary means of establishing regulatory compliance is unreliable.

7. There appears to be an assumption that all services are of equal risk. However, services providing accommodation and care, 24 hour care, or high levels of domiciliary care may require a different level of scrutiny to those that provide short episodes of care, because they have much more control over a person’s life and thus require “face to face” inspection to a greater degree than, for example, dental practices.

8. The failure to differentiate between social care types means that there is no coherent approach to standard setting and inspection of domiciliary care, with concerns that the proposed Excellence system will not work within that sector.

9. The new system of registering social care providers was time consuming and inefficient for CQC, and did not test compliance other than by self declaration. The process therefore gave a false sense of reassurance as it could only confirm a provider’s assertion of compliance. A targeted approach would have focussed on services known to be performing poorly.

10. CQC have confirmed there were 10,856 inspections of care homes between 1 April 2009 and 31 March 2010, while in the following year there were only 3,805. Inspectors were diverted to the registration process, away from their primary function, in a manner that lacked transparency.

11. There needs to be a minimum inspection frequency and a guarantee of “face to face” inspections for social care provision and certain healthcare provision, including hospital provision for people with learning disabilities.

ROLE IN IMPROVEMENT: QUALITY RATINGS ETC

12. Under the Health and Social Care Act 2008 CQC has a role to promote improvement (section 3 of Health and Social Care Act 2008):

   “The Commission is to perform its functions for the general purpose of encouraging (a) the improvement of health and social care services...”

13. CQC has defined this narrowly, focussing exclusively on registration compliance. However CSCI believed that regulation could play a significant role in leveraging improvement and applied a full range of functions, in addition to registration compliance. This is a major difference in approach between the two organisations.
14. When CQC was established there was an expectation that it would maintain a quality ratings system: “... it is the Government's intention to use this power to require the Commission to review and assess all residential premises providing adult social care, whether run privately or by a local authority, as the CSCI has done through its ‘Quality Ratings’ scheme.”

15. CQC allowed the Quality Rating system to fall into disuse without immediate replacement and only recently launched consultation on an alternative. While there were limitations with the “Star Rating” system, it was understood by the public and care providers. Its loss without replacement resulted in a lack of up to date information to assist people in choosing a service.

16. CQC proposes delegating the new “Excellence” service to an external body, and levelling an additional charge for providers to be assessed and participate. This makes it likely that some providers will be financially excluded. It will therefore not provide a comparison overview, and if it used to control the market, could force out good providers who are unable to buy into the new system and therefore do not get reflected on “preferred” lists.

**Influencing the Market/Informing the Public**

17. Unlike predecessor bodies who produced regular reports on themes and aspects of social care provision CQC has failed to do so.

18. It has not delivered on its announced programme of special reviews and now proposes to link this function to registration compliance.

19. It has cut those staff with policy expertise in social care, and thereby appears to have compromised its capacity (in terms of staffing numbers and expertise) to use its functions for external influence to achieve broader improvements.

**Leadership and Decision Making**

20. There has been an inability to retain leadership at the head of CQC. The most high profile departure was Barbara Young as chair, but the Executive Team has also lost Gary Needle, Jamie Rentoul, Linda Hutchinson, Kylie Kendrick, and David Johnstone. Of those in post in 2009 only Cynthia Bower, Jill Finney, Richard Hamblin and John Lappin remain.

21. This calls into question whether it can deliver a consistent level of strategic direction, particularly as decisions are revised and changed frequently. It is not surprising that staff surveys indicate a lack of confidence in the leadership (Community Care reported that only 14% had confidence in the decisions of the Executive Team: [http://www.communitycare.co.uk/Articles/2010/07/08/114865/CQC-slammed-by-own-staff-as-survey-exposes-low-morale.htm](http://www.communitycare.co.uk/Articles/2010/07/08/114865/CQC-slammed-by-own-staff-as-survey-exposes-low-morale.htm)).

22. In October 2010 CQC published an agreed Board position paper and action plan in relation to older people and people with dementia. One priority for the first 12 months was:

   “Establishing a new older people’s advisory board and smaller dementia reference group to actively engage with stakeholders and people who use services so that they can inform and influence our work”.

23. Five months later the position papers were reframed “into a single plan containing a small number of actions with clear governance and reporting structure into the Board via the Executive Team.” Notwithstanding the time wasted in producing discarded strategic plans, this is a potential loss of focus on key issues.

24. The older people’s advisory board was never established, and the May 2011 Board meeting agreed a new recommendation that the existing advisory groups and remaining improvement boards be disbanded in favour of members being listed on a stakeholder register, with one overarching stakeholder reference group.

**Interaction with Safeguarding**

25. The CQC Adult Safeguarding protocol is not as robust as the former CSCI one. In particular, the previously agreed information sharing protocol forms that were submitted to strategy and case conference meetings have been deleted, weakening the overall process.

26. CQC have described relationships between them and local safeguarding boards as “useful to ensure that the local safeguarding arrangements are working effectively and raise area-wide issues where necessary”. Regional representatives should attend safeguarding boards, not routinely but at least once per year, and Compliance Managers are responsible for establishing local information sharing arrangements, which may include safeguarding issues. However, this activity is not monitored centrally and they cannot confirm frequency or scope of attendance, or whether this is happening at all.

27. Adult Safeguarding staff suggest that in practice, there has been an almost total withdrawal from interaction with local authorities regarding safeguarding, unless issues cannot be ignored or demand a response, with increasing difficulties in getting attendance at strategy and case conference meetings. As a primary safeguarding agency this should be considered a serious failing.
COMPLAINTS, CONCERNS AND SPY SOFTWARE

28. CQC indicate that their “role does not extend to investigating individual complaints.” However, they like to “hear about people’s individual experiences... because we believe involving people who use services in everything we do will help improve them for everyone. We therefore encourage people to share information with us.” They also indicate that they are “responsive in the way we regulate and use information as we get it, to make real-time decisions and to take action quickly where we need to. If we judge that services are not meeting essential standards we use our powers to require improvements.”

29. This is a confusing message for the public, and for CQC itself. Jo Williams seemed unclear on this earlier this month (http://www.guardian.co.uk/society/2011/jun/07/disability-abuse-winterbourne-view-care-regulator-review).

“Asked to explain the difference between a complaint and whistleblowing, which the CQC says it does take up, Williams struggles. She accepts there may be a need to look again at the distinction and how it is explained to the public and media. But she stresses that if the system is working properly, an inspector will be told that an individual has contacted the CQC to complain about a care service on their patch, even though the CQC will not itself pursue the complaint, in order to inform the inspector’s general view of the service.”

30. CQC cannot indicate how many unannounced inspections were triggered by a public complaint, which means they do not know if the system is “working properly”.

31. The Health and Social Care Act 2008 does not bar the Commission from investigating complaints but it has not placed a duty on it to do so.

32. If a relative complains about care quality to an inspector during an inspection, it may be investigated within that process. If it is raised on another date, outside of the inspection, they will not do so. But, if they approach a care assistant who then raises the matter with the Commission, it may be investigated as a response to a whistleblower. Context is missing from this process, which relies exclusively on who is making the complaint and not what the complaint is about.

33. The proposal to purchase web crawling software to monitor social networking sites such as Facebook for complaints about providers will complicate this further. (http://www.nursingtimes.net/nursing-practice/clinical-specialisms/management/cqc-to-trawl-online-networks-to-find-complaints/5022713.article). CQC suggest:

“the spur to consider a new system came from the challenge posed by the large number of social care facilities the CQC must regulate. There’s something about the nature of the care you get with social care which also makes it suited to this kind of information-gathering. With social care, we know a lot of the good information is going to be qualitative rather than quantitative because the units [of measurement] are so low.”

34. This would mean that someone could not complain directly to CQC, but could do so through a third party whistleblower or Facebook.

MONITORING OF COMPLIANCE

35. Usually, organisations are expected to ensure that the strategies they employ are effective and achieve expected outcomes. CQC however do not centrally monitor the effectiveness of compliance actions, a major regulatory activity. The responsibility rests with local compliance teams at an individual service level who make a judgment on whether the compliance has been achieved. As a primary safeguarding agency this should be considered another serious failing.

PUBLIC CONFIDENCE

36. On 23 November 2010 the BBC reported that care homes officially closed down had been allowed to continue operating (http://www.bbc.co.uk/news/health-11789475). CQC had claimed that 93 homes and agencies had been shut in the past year due to poor ratings, but this was not accurate. They had announced the closures in September 2010, claiming the figures demonstrated a new determination to “get tougher”, and had asserted that 42 providers had shut because of enforcement action, with the rest closing voluntarily.

37. The BBC found some were:

“actually allowed to remain open despite concerns about standards, while others had never been rated ‘poor’ at all. In some cases the regulator had allowed homes to close and then reopen on the same day, if the home applied to do so.... Dunning reports about their past records were then removed from the CQC’s website, so potential residents and their relatives could no longer read them”.

38. On 27 January 2011, Jo Williams gave an interview to the Independent (http://www.independent.co.uk/life-style/health-and-families/health-news/dire-state-of-care-homes-for-the-elderly-is-only-going-to-get-worse-says-top-inspector-2195530.html). Linking public sector cuts with care quality, she argued that providers would be asking “what can I do to cut corners”. She stated that more needed to be done to train staff in nursing homes, that the workforce was patchy, with many staff on the minimum wage, and that there was a need to repair dilapidated buildings. None of this had been previously identified or raised by CQC.
39. She described a care sector that was poised to “slash costs as a result of the public sector cuts” and that “it is against this background that the Commission is signalling that it will take an increasingly tough line to ensure that ‘essential standards’ are met—even when budgets are cut.” This article caused public concern, and anger within the provider sector as there appeared to be no objective evidence to justify these statements.

40. On 8 June 2011, Jo Williams gave an interview to the Guardian (http://www.guardian.co.uk/society/2011/jun/07/disability-abuse-winterbourne-view-care-regulator-review) which seemed to imply a “hierarchy of vulnerability” in their approach. Panorama had been one of a number of recent major concerns, which included outcomes from the CQC investigation into nutrition in hospitals, the Ombudsman’s report into the hospital care of older people, and the report by the National Confidential Enquiry into Patient Outcome and Death. None of these generated a similar regulatory response.

CURRENT INSPECTION OF HOSPITALS WITH REGARD TO NUTRITION AND DIGNITY

41. One hundred hospitals were inspected, during 9am to 5pm on one day. Evening meal times were not included. In our view the inspections appear subjective, and it is difficult to ascertain how consistency of decision making is being achieved.

42. It appears that nutritional content of meals is not being scientifically assessed, and meals are not checked for temperature or presentation. Conclusions are based upon a “straw poll” of patients rather than an objective measurement (eg a ward with three families bringing in meals due to food quality concerns was deemed an insufficient number to warrant failure).

43. Despite multiple incidents that should trigger multi agency safeguarding processes, no referrals were made. While safeguarding was “on the minds” of inspectors, they were happy with Trust responses and took no further action. This breached the CQC guidance on sharing information (http://www.cqc.org.uk/_db/_documents/Information_sharing_v_2_78–09_200910133519.doc) and the intent of No Secrets.

44. The compliance reports read as a narrative which follows inspectors around the wards. There appears to be a lack of consistency regarding judgements reached; eg Whips Cross is deemed compliant with standards 1 and 5 despite documented evidence of a patient having no food or hydration for 30 hours. There appears a fine line between this and other hospitals deemed non compliant eg Ipswich NHS Trust.

45. The reports use “dignity” to describe what in social care CQC would describe as abuse or a safeguarding issue. It is our impression that lead inspectors seem concerned about the impact of critical terminology on the hospitals, which undermines the focus of protecting patients and the public.

June 2011

Written evidence from NHS Partners Network (CQC 12)

SUMMARY

1. NHS Partners Network (NHSPN) welcomes the opportunity to submit evidence in advance of the Health Committee’s annual review meeting with the chair of the Care Quality Commission. This submission conveys the sectoral view and experience of the NHSPN’s members and as such is complementary to the whole system overview provided by the NHS Confederation.

2. Members’ experiences of working with the CQC have been on occasions challenging, but we welcome the improvements the CQC has made to improve its performance. We believe a partnership model should be developed to improve effectiveness and the efficiency of the clinical regulatory process.

3. NHSPN believes that the purpose of clinical regulation should be to ensure the delivery of safe, effective care. The processes of clinical regulation should be achieved as efficiently as possible to maximise the proportion of resources that can be channelled to delivering high-quality care. This means:
   (a) ensuring the delivery of safe, effective care:
      (i) there is an opportunity to drive continuous improvement in the care quality baseline through the CQC’s responsibility to assure minimum standards, although this needs to be used judiciously to avoid the risks of constantly “moving the goalposts”; and
      (ii) there needs to be a common vision of care quality shared across providers of care, the CQC and other organisations with a regulatory or market development function, including the DH, NHSCB, Monitor and commissioning consortia. This should include an understanding of the impact that an organisation’s financial health can have on care quality;
   (b) efficiently achieving the delivery of safe, effective care:
      (i) it is important to avoid duplication across different regulatory organisations while ensuring care standards are met and patients protected. A high-level credentialing system could reduce the burden of accreditation across numerous regulators and commissioners;
      (ii) there should be a sharper focus on how all the activities carried out by the CQC deliver value measured by the impact on clinical quality delivered by providers; and
a partnership model would help eliminate unnecessary waste, both from the regulator side and the provider side, allowing resources to be focused more on improving and delivering patient care. Features of a partnership approach would include:
— the development of appropriate clinical understanding and expertise by regulators;
— meaningful interpretation of what regulations mean in practice;
— greater transparency about how information will be used;
— rapid feedback between regulator and providers; and
— learning from organisations that excel in customer relations.

Introduction
4. NHS Partners Network (NHSPN) is pleased to submit evidence in advance of the Health Committee’s annual review meeting with the chair of the Care Quality Commission.

5. NHSPN represents the widest range of independent sector providers of care to NHS patients. Our members deliver care ranging from primary to acute elective provision as well as out of hours and home-based services. More than 42,000 clinicians—surgeons, anaesthetists, GPs, nurses and other healthcare professionals—are engaged by NHSPN members. Collectively, this makes up the largest group of clinicians outside traditional NHS organisations and includes in excess of 26,300 doctors, 9,000 nurses and 6,600 other healthcare professionals.

6. This submission is informed by work led by NHSPN’s clinical forum which is comprised of clinical directors from all members and plays a central role in ensuring that the Network’s work programme is guided by sound clinical practice. This work includes a recent meeting between NHSPN members and the CQC’s chief executive, Cynthia Bower.

Experience of NHSPN Members Working with the CQC
7. During spring 2011, NHSPN’s clinical forum conducted a survey of members about the policy and practice of the CQC’s regulatory approach. Members identified numerous challenges including:
   (a) an inconsistent view of quality across regulators;
   (b) duplication across organisations responsible for different aspects of quality;
   (c) concerns about the role and efficacy of self-certification;
   (d) inconsistency in approach by the CQC across the country and within individual providers;
   (e) prioritisation of process over outcomes;
   (f) poor internal processes at the CQC; and
   (g) a mixed approach to working in partnership with regulated organisations.

8. NHSPN would stress that the experiences of members were mixed and several identified that the CQC’s performance has improved. We also welcome the open and frank acknowledgement of some of these challenges given by Cynthia Bower at a recent meeting with NHSPN members.

9. NHSPN welcomes some of the improvements which have recently been put into place by the CQC to address some of these challenges. We strongly believe that significant further improvements could be made by establishing a clear set of guiding strategic principles and pursuing the practical operational implications that follow.

Principles that should Guide Clinical Regulation
10. NHSPN believes that the purpose of clinical regulation should be to ensure the delivery of safe, effective care. The processes of clinical regulation should be achieved as efficiently as possible to maximise the proportion of resources that can be channelled to delivering high-quality care.

11. A number of principles follow:
   (a) ensuring the delivery of safe, effective care:
      (i) there is an opportunity to drive continuous improvement in the care quality baseline through the CQC’s responsibility to assure minimum standards, although this needs to be used judiciously to avoid the risks of constantly “moving the goalposts”; and
      (ii) there needs to be a common vision of care quality shared across regulators, providers and commissioners;
   (b) efficiently achieving the delivery of safe, effective care:
      (i) it is important to avoid duplication across different regulatory organisations while ensuring care standards are met and patients protected;
      (ii) there should be a sharper focus on how all the activities carried out by the CQC deliver value measured by the impact on clinical quality delivered by providers; and
(iii) a partnership model would help eliminate unnecessary waste, both from the regulator side and the provider side, allowing resources to be focused more on improving and delivering patient care.

12. Each of these principles has clear operational implications which are outlined below.

THE PURPOSE OF CLINICAL REGULATION—ASSURING MINIMUM STANDARDS AND IMPLICATIONS FOR QUALITY IMPROVEMENT

13. NHSPN recognises that the CQC has now been given a very clear direction that its role should be to ensure minimum standards, and not to focus on continuous quality improvement beyond those standards. While this clarification of the role of the CQC is sensible, it requires that the relationship that the CQC has with providers that already offer care which exceeds these standards should be re-evaluated to ensure that it is still fit for purpose.

14. While NHSPN recognises the complexity of assuring both minimum standards and striving towards continuous improvement, we believe all organisations should be encouraged to improve quality. While a significant element of this may fall beyond the remit of the CQC, there is still a potential role for the CQC to drive improvement in the baseline of minimum standards over time. For example, minimum standards could be set at a level such that organisations struggling with care quality have to demonstrate tangible improvements over time in order to achieve registration. This would leave commissioners and patient choice to drive improvement elsewhere in organisations that are already exceeding these minimum standards.

A SHARED UNDERSTANDING OF CLINICAL QUALITY

15. We recognise that the responsibility to demonstrate care quality rests with providers, but within that context there needs to be a common vision of care quality shared by the CQC and other organisations with a regulatory or market development function, including the DH, NHSCB, Monitor and commissioning consortia.

16. At present, there are a number of different models of quality identifying various domains. There is a lack of consistency and approach across the English health system, with the CQC and the DH taking different views on the domains of quality. The different models include:

(a) The Institute of Medicine (IOM) identifies six quality domains: care that is safe, timely, effective, patient-centred, efficient and equitable.

(b) During the middle of the past decade the IOM model was, at least in part, incorporated into a seven-domain model adopted by the DH covering: safety; clinical and cost effectiveness; governance; patient focus; accessible and responsive care; care environment and amenities; and public health.

(c) The DH’s Outcomes Framework by contrast focuses on mortality, enhancing quality of life for people with long-term conditions, helping people to recover from episodes of ill-health or following injury, ensuring that people have a positive experience of care and ensuring patient safety. These of course drew heavily (and explicitly) on the three dimensions of quality advocated by Lord Darzi in High Quality Care for All (patient experience, safety and effectiveness) but significantly less on timeliness, efficiency and equity. These first three dimensions of quality remain the basis of Quality Accounts.

(d) By focusing on essential standards, the CQC takes a different approach that outlines expectations of care so that patients are involved (or at least informed); have access to care that meets their needs; is safe; provided by suitably qualified staff and by organisations that constantly check the quality of their services.

17. While NHSPN members recognise there is overlap and value from all the approaches identified above, this diversity of approach can lead to duplication as well as gaps. NHSPN would therefore recommend that:

(a) all organisations with a regulatory function, including commissioners, should work to the same model of quality;

(b) any approach must be high-level—micro-management of quality management systems is set to fail; and

(c) there should be mechanisms that go beyond minimum standards to encourage continuous quality improvement as detailed above.

18. NHSPN is concerned by the potential split between the regulation of providers’ financial and clinical performance. Financially challenged organisations are more likely to be susceptible to pressures to compromise safety. Models of clinical quality should therefore include approaches that incorporate “integrated governance” to assess and manage the potential impact of an organisation’s finances on clinical care.

IMPROVING EFFICIENCY BY AVOIDING DUPLICATION

19. Just as it is important to ensure that there is a common understanding of clinical quality, so duplication of process across different regulatory organisations should be avoided while ensuring care standards are met and patients protected.

20. NHSPN recognises that significant work has already been carried out by several organisations including the NHS Confederation, Independent Healthcare Advisory Service (IHAS) and the CQC’s own Provider
Advisory Group to identify overlaps and duplication in regulation. These overlaps also have crossover into commissioning processes. Despite this considerable volume of work, which includes the Concordat, the 2009 NHS Confederation-IHAS report, What's it all for? and the CQC’s “working in partnership” agreements with other regulators, there remains significant duplication which diverts resources away from delivering care.

21. One relatively straightforward practical solution would be to create a “passport” approach: ie a national high-level credentialing system to cut out the burden of accreditation with numerous separate regulators and commissioners.

22. In practice this would require all providers to complete a standard form which contains information that is pertinent for all organisations involved in the regulatory process. This would need to be updated annually or after a major service change, and would avoid the need for multiple regulatory organisations to make further requests for that information, or permutations of it. This approach would also need to include an explicit statement of indemnity that would reassure risk-averse commissioners who may be tempted to duplicate requests for information in order to safeguard themselves from risk.

23. We are also aware that organisations with a regulatory function may wish to share information about providers between them both to minimise duplication and to ensure that overlaps do not occur between regulators. NHSPN welcomes this approach and sees it as complementary rather than as an alternative to a high-level credentialing system.

**FOCUSING ON VALUE—ACTIONS THAT IMPROVE CLINICAL QUALITY**

24. There should be a sharper focus on how all the activities carried out by the CQC deliver value measured by the impact on clinical quality delivered by providers.

25. There is currently a lack of transparency on fees. In the future, fees should be proportional to and derived from the value which regulation delivers, rather than calculated by dividing the running costs of the current system by providers.

26. We know from providers’ experience that many of the CQC’s processes introduce significant administrative costs yet it can be difficult to understand the impact they have on ensuring or improving care quality. Costs could be reduced significantly if those processes which do not appear to add any value, and possibly detract from the business of delivering high-quality care, could be removed. This could lead to lower fees and also free resource to be invested in areas that would add value such as ensuring inspectors have adequate experience, knowledge and understanding of the organisations for which they are responsible.

27. For example, we know that the caseload for CQC inspectors has increased from an average of 50 to 60 locations per compliance inspector in 2010–11 and that there is also significant regional variation. NHSPN recognises that it is difficult for inspectors with a high caseload to develop a thorough understanding of the organisations for which they have responsibility.

28. NHSPN would advocate a thorough independent review of the CQC’s activities including an assessment of the value of its activities in terms of improvements in patient care. This would help identify areas that could be trimmed and re-focused to increase the CQC’s overall value.

**LEARNING FROM OTHER SECTORS—A PARTNERSHIP MODEL TO IMPROVE EFFICIENCY**

29. We know from best practice regulation in other sectors, eg aviation, that regulators who work in partnership and encourage open dialogue with the organisations they regulate facilitate a culture whereby problems and challenges are discussed early enabling solutions to be agreed and implemented. The first step in achieving a partnership culture would be for the CQC to make significant improvements in its own internal processes and its communications with care providers.

30. A partnership model of clinical regulation could therefore help eliminate unnecessary waste, both from the regulator-side and the provider-side, allowing resources to be focused more on improving and delivering patient care. In practice, this would mean:

(a) appropriate clinical understanding and expertise by regulators;
(b) meaningful interpretation of regulations;
(c) greater transparency;
(d) rapid feedback; and
(e) excellent customer relations.

31. **Appropriate clinical understanding and expertise is required by regulators.** NHSPN strongly rejects the CQC’s approach that it is “enough to be an expert in regulation”. This leads to variation in approach, with more attention on processes than clinically important areas and a lack of understanding of the diversity of modern healthcare.

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16 Hansard 8 Jun 2011, column 348W (http://www.publications.parliament.uk/pa/cm201011/cmhansrd/cm110608/text/110608w0002.htm#1106092004209)
32. There are different nuances to the understanding required to be an expert regulator. As well as appropriate clinical expertise, the CQC needs to respond to increasingly diverse care models. Because the independent sector is a relatively new market entrant in some areas of NHS provision, independent providers have been among the first to encounter the limits of the CQC’s relatively inflexible processes shaped around traditional care models. As increasingly diverse care providers emerge, this will only become a more significant challenge for the CQC. A flexible and clinically-intelligent approach that is sensitive to differences in organisational structures that arise from different ownership and care models is required. This needs to span all tiers of the CQC—from its leadership through to individual inspectors.

33. **Meaningful interpretation.** We understand that responsibility for interpreting regulations ultimately rests with providers, but the CQC should be able to articulate what its regulations mean in practice. If the CQC cannot interpret its regulations into practical care, providers are unlikely to achieve compliance. Moreover, it is difficult to see how the CQC can identify failing practice if it similarly cannot articulate what constitutes good practice.

34. **Transparency.** Providers should be able to understand how information they submit will be used, where they are in any given process and standards for CQC decision-making. This would improve consistency and interpretation and reduce the impression that processes are being made “on the hoof”.

35. **Rapid feedback.** Rapid feedback is valuable both to reinforce positive practice and to address failing areas promptly. Members have noted that where rapid feedback occurs, it is extremely helpful as long as it is evidence-based and consistently applied. There is a real opportunity to systematise this good practice across the CQC.

36. **The CQC could learn much from organisations that excel in customer relations.** This would help improve the CQC’s own operational efficiency and ease of compliance. At the moment, compliance is too focused on responding to the CQC’s challenging administrative processes, rather than on improving care. We welcome improvements such as the introduction of local account managers and this could be developed further to include:
   (a) further rolling-out dedicated local account managers and introducing named call handlers at the CQC’s Newcastle call centre with responsibility and ownership of specific issues;
   (b) a duty to improve the CQC account handlers’ understanding of the care provided by organisations that fall within their account;
   (c) systematic opportunities for providers to give immediate feedback on every provider—CQC interaction—this information should be used by the CQC to improve its internal processes and in staff appraisals;
   (d) guaranteed turnaround times for queries to be resolved with clear processes to escalate problems; and
   (e) greater consistency—both among CQC staff in response to queries and in its approach to all sectors.

**CONCLUSION**

37. NHSPN recognises that the CQC faces a range of operational and policy challenges arising in part from its wide and relatively recently changed responsibilities. We welcome recent operational improvements, the open approach adopted by its leadership and its recent proactive engagement with providers to support innovative models of care in the new system architecture.

38. NHSPN strongly believes that adopting a rigorous focus on the CQC’s core purpose combined with a common vision of quality will help the CQC achieve further improvements assuring the safe delivery of effective care.

*June 2011*

**Written evidence from Mencap (CQC 13)**

Mencap is the UK’s leading learning disability charity, working with people with a learning disability, their families and carers. We want a world where people with a learning disability are valued equally, listened to and included. We want everyone to have the opportunity to achieve the things they want from life.

**Executive Summary**

Mencap is responding to this inquiry both as a campaigning organisation and as a major provider of services. With the changes to the NHS proposed in the Health and Social Care Bill as well as the recent scandal at Winterbourne View, the role of CQC is even more important in ensuring safety and better outcomes for people with a learning disability.

Many of the weaknesses found in the sort of provision highlighted at Winterbourne View have been previously discussed in other reports looking at other abuse cases. Solutions have also been proposed in reports looking at commissioning for people with profound and multiple learning disabilities, as well as reports on
involving carers in developing the social care workforce. In essence, the solutions to improving outcomes and reducing outcomes are known—the key is ensuring that best practice is followed. The CQC is pivotal.

As a provider, Mencap believes that CQC needs to clarify its process. In terms of patient safety, Mencap believes CQC needs to ensure that it also has access to more expert knowledge of learning disability, increases its unannounced inspections and also works more with families and carers to make abuse less likely.

MENCAP’S INVOLVEMENT WITH CQC

Mencap provides high-quality, flexible personal support to people with a learning disability and works to tailor its services to support each person throughout their life. In 2009–10, Mencap provided personal support to 4,868 people.

Ensuring that people with a learning disability, often with very complex needs, are supported to live independent and fulfilling lives is central to Mencap’s work. Mencap is therefore used to engaging with the CQC’s day to day work of review and inspection.

Mencap have also campaigned for many years around improving the health of people with a learning disability—through highlighting the premature, avoidable deaths of people with a learning disability while in the care of the NHS and working to support healthcare professionals to get care right from the start.

The committee may also be aware that Mark Goldring, Mencap’s Chief Executive, is part of the Department of Health's review into Winterbourne View.

LEARNING FROM PREVIOUS SCANDALS AND THE REPORTS THAT FOLLOWED

Over the past few years a number of key reports into abuse scandals involving people with a learning disability have offered insights both into the causes and the practical steps that should be taken to improve the health and care offered to this group. Unfortunately despite this wealth of accepted evidence and policy, practice on the ground, by some, continues to let down people with a learning disability.

In 1993 and 2007, Professor Jim Mansell wrote two reports which outlined appropriate measures that should be taken to safeguard people with a learning disability, when receiving care. These reports are as follows:


Both clearly articulated that a failure to develop appropriate services for people with a learning disability had led to an increase in the use of placements which are expensive, away from the person’s home and not necessarily of good quality. The reports warned that out of area placements carried an increased risk of abuse and bad care practices.

Both also made recommendations regarding the need to develop better services models (local, small, skilled) and better commissioning (not commissioning expensive, large, out of area placements and planning for the development of local based services).

Two audit reports have also previously been published on the issue of specialist inpatient learning disability services:

— Healthcare Commission report: A Life like no other. A national audit of specialist inpatient healthcare services for people with learning disabilities in England (2007). This report followed the Cornwall and the Merton Sutton reports, each identifying unacceptable and failing standards of services, including abusive behaviour towards people with a learning disability and institutional abuse. As a result of the audit the serious concerns in relation to six of the 154 services visited resulted in POVA referrals and the identification of only a very small number of services that were identified as routinely good across all aspects of service delivery.

“There needs to be a shift in the way specialist healthcare services are commissioned and provided so that we can be assured of the safety of people with learning difficulties and the quality of services they receive.”

— Care Quality Commission: Specialist inpatient learning disability services: follow up of audit 2008–09. This noted some progress since the 2007 audit but described the quality of services “at best inconsistent and at worst damaging”.

All of the reports (referred to above) illustrate that many of the issues raised in the Panorama programme are well documented. The recommendations previously made regarding good practice in supporting people with challenging behaviour and mental health needs are not contentious, and yet situations are still arising where inappropriate unsafe care is being provided.
More recently Professor Mansell was commissioned by the DH to write the Raising Our Sights report (March 2010) which highlighted how effective local services can be when provided in community and local settings for people with profound and multiple learning disabilities.

**THE CQC HAS A KEY ROLE TO PLAY IN IMPROVING QUALITY AND SAFETY**

Mencap believes that the CQC needs to sharpen some of its day to day processes to support a smoother working relationship with providers. In addition, Mencap believes that is needs to take a more proactive approach towards tackling abuse.

Mencap sees a number of activities that could make a huge difference both to “day to day” and investigative work:

1. The CQC needs to have clearer administrative processes.
2. The CQC needs to consider again how it could bolster its inspection work.
3. The CQC needs to better the health experience of people with a learning disability.
4. The CQC needs to work more closely with families and carers—who should be able to constructively input into the care received by their loved ones.

**CQC’S ADMINISTRATIVE PROCESSES ARE NOT CLEAR ENOUGH TO PROVIDERS**

With the arrival of the Health and Social Care Act in 2008, the CQC came in to being; bringing together umbrella organisations and a far wider remit for inspection and review. Mencap believe that the changes have had a number of unintended consequences:

1. Nearly two years after the changes, there are still no common CQC processes for activity such as how to register a service, how to deregister a service or how to provide access for inspection. These non-standardised CQC procedures, have also meant a higher burden on providers round training & compliance.
2. To cope with this variance, Mencap appointed a Compliance Manager in 2010. With no comparable post in CQC, Mencap has still had to deal with many different members of CQC staff, reducing the ability to build strong working relationships over a period of time.
3. Finally, Mencap believes the outcomes at inspection are now potentially a disincentive to services pushing for better outcomes. The CQC have now moved away from rankings such as “good” or “excellent” to a service purely being noted as “compliant” or “non compliant.” This may seem like a small change, but could make a huge difference to the way in which services see themselves and inhibit the way in which patients and their families are able to exercise meaningful choice between providers.

Mencap’s perception is that the CQC do not perceive any of these issues to be particularly problematic and as a result the work of providers is being made less straight forward.

**CQC’S INSPECTION REGIME NEEDS TO BE CONSIDERED AGAIN—PARTICULARLY FOR SOCIAL CARE**

While the events at Winterbourne undoubtedly had many contributory factors, it is interesting to look at some of the broader issues this case illustrates:

1. Figures published by Community Care Magazine\(^\text{17}\) showed that no inspections of independent learning disability hospitals, such as Winterbourne View, were conducted between 1 October 2010 and 31 January 2011.
2. Freedom of Information requests (by the charity Action on Elder Abuse) showed that the level of inspections by the CQC fell by 70% in 2010–11. Such unannounced inspections are crucial to assuring the quality of services. What level of inspection the CQC carried out at Winterbourne remains to be seen.
3. The CQC now has a much broader remit, covering many more specialties and services. Yet despite this, the CQC has almost exactly the same amount of resource.
4. Previously there were a small number of key CQC staff with specific expertise around learning disability who could offer input and guidance to other CQC colleagues. As they have now left CQC—there is no such resource for other CQC staff to draw on.

When the above is taken together, it is easy to see how the very specialist needs of those with the most complex health and social care needs may not be being well served by a busier, CQC who do less inspections and who no longer have access to learning disability specialty knowledge.

Mencap believes it is vital that the issues of expertise available and unannounced inspections are considered again by the CQC. While neither will be the whole solution, if done as part of a rigorous and sustained effort, they could help reduce the likelihood of abuse.

\(^{17}\) [http://www.communitycare.co.uk/Articles/2011/06/15/117012/cqc-did-not-check-learning-disability-hospitals-for-months.htm](http://www.communitycare.co.uk/Articles/2011/06/15/117012/cqc-did-not-check-learning-disability-hospitals-for-months.htm)
It is Vital that CQC is More Alive to the Specific Health Issues that Affect People with a Learning Disability

The Winterbourne View centre was interesting as it crossed both health and social care provision. While it is not clear what “assessment” or “treatment” were going on in this facility, the health issues and CQC’s role in assuring health quality need to be looked at, both in this case and more widely.

People with a learning disability continue to die prematurely and avoidably; being 58 times more likely to die before their 50th birthday than the rest of the population. This group is also at disproportionate risk of epilepsy, obesity and many other health problems.

One of the key contributory factors to these deaths (as well as worse health outcomes) is the continuing poor, illegal, discriminatory performance of some individual doctors. Families supported by Mencap have recounted that too many doctors still display prejudiced views about the life chances of people with a learning disability and, as a result, treat patients differently. This, in turn, leads to worse outcomes.

Mencap is also aware that many doctors are not adequately adjusting their practice to cope with the specific health needs of people with a learning disability. This starts with communication. If a patient is non-verbal, how does a doctor ensure that he/she engages with the patient in their best interest, without inadvertently discriminating?

Beyond communication, come questions of capacity and consent—issues which a DH report in 2010 (6 Lives Progress Update) identified were still major problems for doctors and other healthcare professionals.

Finally, when treatment is given—how do doctors ensure that the way in which they deliver treatment and care is reasonably adjusted as demanded by the Equality Act? The key then is also for CQC to understand how to review and inspect services’ ability to make these sorts of adjustments and work collaboratively with others to proactively address areas of concern as they arise.

Over the past few years, Mencap has been particularly concerned as a number of the deaths of people with a learning disability have occurred at the same hospitals and not been picked up the CQC in its role as a health regulator.

Mencap believe that it is a key role for the CQC to understand the health inequalities facing people with a learning disability and the reasonable, legally demanded, steps that healthcare professionals should be taking to address them. Yet with the decline of inspection and no specialist expertise for inspectors to refer to, many of the issues may not be looked at during inspections and are unlikely to be sought during paper based review work by the CQC.

The CQC have also moved to a new set of common health outcomes on which they measure which don’t reflect the health experience of people with a learning disability. As many of those with the most complex needs may also be non-verbal, standard Patient Reported Outcome Measures can also not be relied on to fill this gap.

Involving Families and Carers

In 2011 Mencap was funded by the DH/Valuing People Now team, to pull together the “Good practice in involving families in your workforce development; the what, why and how” report.18

This report contained a section on how involving family carers could help providers achieve CQC outcomes. One of the key areas here was to link CQC outcomes to the values and principles that families told Mencap they value most.

Families and carers provide the best knowledge of an individual and how to help them best. Where providers work closely with the family or carers, outcomes are likely to be better. Mencap believe CQC inspection should consider these again, as they are still relevant, particularly as the next steps following Winterbourne are being looked at.

In Summary

1. As a provider, Mencap would like there to be clarity on the standard CQC processes at the earliest possible moment. Mencap believe there should be no regional variance in these basic processes.

2. The evidence on what works in terms of good quality and safe provision already exists, the key is in implementing the guidance and ensuring that the standards set are lived up to.

3. Mencap believes that the CQC should think again about whether it has the relevant expertise and understanding of how to ensure safe and effective health services for patients with a learning disability or other complex needs.

4. The question of increasing unannounced inspections should also be looked at.

18 www.mencap.org.uk/workforce
5. Finally, families and carers can play a crucial role and could be involved more in assuring the quality and safety of services for people with a learning disability, particularly those with the most complex needs.

June 2011

Written evidence from Joint Trade Unions (CQC 14)

1. This submission has been drafted jointly by the trade unions recognised by the Care Quality Commission (CQC) to represent staff employed by the Commission. Between us our trade unions also represented staff at all of the CQC’s predecessor bodies, so we have long experience of the development of regulatory systems for health and social care services. The unions that make up the staff side may have also made individual submissions to the committee as part of this inquiry.

2. We wrote to the Minister for Care services in July 2010, and to the Health Select Committee in October 2010, outlining a number of concerns. These included staff morale, the very troubling experience of registering adult social care providers under the 2008 Health and Social Care Act (HSCA), training provision and diminishing use of site inspections.

3. Since then our members have been working under the 2008 HSCA methodology and they are raising a number of concerns and issues that we would like the Committee to consider in its current inquiry.

4. The joint trade unions believe that there should be an independent review of how the transition to CQC was handled. The trade unions were consulted about key issues during the transition and in the early days of the Commission including decisions to remove administrative support from regional offices, the establishment of a call and processing centre, and the “field force” staffing model. On each of these key items the unions cautioned against the decisions made and we believe that CQC would be in better shape today had the Commission taken these views on board.

5. We believe a review should look at the decision-making that led to the current staffing shortages and capacity problems, and the flaws in the current methodology and organisation design. It should review which consultants and interims were used during the transition—what they were contracted to do, and how much they cost. It should also examine decisions to have a voluntary redundancy programme for inspectors in December 2009, and compulsory redundancies in 2010. This would provide an opportunity for lessons to be learned which could inform proposals and planning for other mergers of public bodies.

STAFFING ISSUES

Morale

6. CQC’s 2010 staff survey showed that staff morale and confidence in the leadership and management of the organisation was alarmingly low. Staff welcome any signs that the organisation has begun to listen to their concerns—industrial relations within the organisation have begun to improve and there is an implementation review which is looking afresh at how the new system should be implemented. We hope this review will take proper account of staff/trade union concerns and we will continue to feed into it.

7. However in the meanwhile staffing shortages, a training deficit and ongoing uncertainty about aspects of the methodology are taking their toll. The recent revelations from the Panorama programme, and the ongoing Mid-Staffordshire inquiry, have left staff feeling vulnerable and frustrated that the concerns they have been airing since CQC’s inception are only now attracting scrutiny.

Caseloads

8. The average caseload per compliance inspector has increased from around 50 at 1 April 2010 to 62 at 1 April 2011. That is an increase of 24%. The highest regional average caseload is now 70 and the lowest regional average caseload is 56. Staff previously employed by the Commission for Social Care Inspection (CSCI) had typical caseloads of between 30 and 40 services.

9. A “buddying system” means that if an inspector is absent on sick or annual leave, or there are vacancies, a colleague may be responsible for monitoring over 100 services. Our members do not feel this is safe or acceptable.

10. Our members report the very real effects of excessive caseloads:

   (1) watering down of the compliance activity that can be carried out in respect of each service. Staff have been told to complete visits in one day irrespective of the size of the service;
   (2) emphasis on firefighting—an inspector can spend a large amount of time dealing with enquiries, and notifications and making follow-up calls on anything that has come through on one of their services— to the detriment of time which should be spent planning, executing and writing up planned and responsive reviews of services;

19 PQ by John McDonnell MP; Hansard, 9 June 2011: Column 440W
(3) having services on your caseload about which you have no knowledge because you have not had time to look at them. This raises fears about what will happen if something goes wrong in one of these services—staff feel they have the responsibility for the service, but not the power to exercise it; and
(4) a large hospital is given the same weight on an inspector’s caseload as a small care three bedded care home.

Numbers

11. The establishment staffing figure for CQC is around 900 inspectors and assessors. To illustrate just how far front-line staffing levels have dropped we believe that in 2009 around 875 inspectors were employed by CSCI alone covering adult social care only. Now we have the same number but with responsibility for over 400 NHS Trusts and 8,000 dentist practices as well.

Vacancies

12. Since the Government imposed a recruitment freeze on civil service and arms length bodies, the Commission has been carrying around 150 vacancies for inspectors and assessors and another 150 in other roles. We welcome the fact that the freeze has now been partially lifted and CQC is now recruiting to fill the inspector posts. The majority of staff at the national call centre which handles all incoming calls and correspondence are agency staff. Members report poor working conditions and high staff turnover.

13. The trade unions are very concerned about the staffing model and working practices in the call centre operation. This is a vital function as all incoming calls, letters and other communications from patients and service users, members of the public, service providers and staff are routed through the centre. We believe that dealing with these effectively and ensuring that information is accurately summarised, recorded and fed through to inspectors is responsible and skilled work.

14. However, CQC is employing these staff on a very low rate of pay which it says is justified by the local labour market in Newcastle, drawing comparisons with commercial call centres. We believe that these staff need more training and better working conditions. CQC should move swiftly to permanent employment rather than a high proportion of agency staff so that turnover is stabilised and skills and knowledge can be built up.

Expanding remit

15. CQC has just become responsible for 8,000 dentist practices as well as ambulance trusts. We very much welcome the Government’s decision to consult on delaying registration of 8,500 GPs’ practices until 2013. However this does not ease the current pressure and it will require detailed planning and development work, given the uncertainty about the final shape and impact of the government’s NHS reforms. We are also not certain what impact CQC’s forthcoming takeover of the Human Fertilisation and Embryology Authority and the Human Tissue Authority will have.

Training

16. One of the biggest concerns raised with the trade unions recently has been about the quality of training they have received from CQC to equip them for their new roles. They say the roll-out has been chaotic, and often of poor quality. We have examples of staff struggling to carry out their role because they have not been trained on the use of the IT system. We also have members who say they have not had the training they need to competently inspect NHS provision for those who came from a social care background, or vice versa. We welcome the recent effort by CQC to pull together a training plan and address these deficits, but until members see the results they are continuing to struggle.

17. Whilst the Commission believes regulatory skills are generic, our members are clear that knowledge of services and professional practice is vital to establish their credibility and authority with the people they are expected to challenge. One member spoke of how they felt anxious about having to assess issues relating to complex treatment regimes, and fearful of missing something. Members have also raised their concerns that they do not get support from CQC to meet the CPD requirements they would need to maintain their professional registration as social workers or nurses.

“Risk-Based” Methodology

Sources of information to inform risk assessment

18. There has been a considerable drop in the number of statutory notifications received by the Commission. In the case of adult social care, the number received each year fluctuated between 220,000 and 250,000 between 2005 and when Care Standards Act regulation ceased. In the year to April 2011 under the new Act methodology, the number of notifications received halved to 110,000.20

20 PQ by John McDonnell MP, Hansard, 9 June 2011: Column 439W
19. Our members have been raising this because they are concerned that things like medication errors and falls about which they used to be informed, should be vital sources of intelligence for a regulator which relies on a risk-based methodology.

20. Our members have raised real concerns about the paucity of information available to them when seeking to assess risks in adult social care providers. The Commission keeps a “Quality and Risk Profile” (QRP) for each provider, and there is a marked difference in how much data is available to populate this profile in the NHS sector, compared with the social care sector. Information from the main operating IT system is not automatically uploaded to the QRP—it has to be done manually.

21. Our members say that there is great variation in the amount and quality of information received from Local Involvement Networks—some visit providers, some do not. Some provide high quality reports and feedback to CQC, some do not. Most have limited resources and the work they do depends on the commitment and particular interests of volunteers.

22. There is also a growing vacuum left by the fact that many local authorities are cutting jobs in their quality assurance units. We have seen examples of councils cutting staffing in quality assurance by 50%, PCTs are also cutting back on quality monitoring. The potential pitfalls of this interplay between the responsibilities of commissioners and of the regulator came into sharp focus in the Winterbourne case.

Site visits

23. The Care Quality Commission conducted 2,008 site visits between the beginning of October 2010 and the end of March 2011, compared with 6,840 for the same period 12 months earlier—a 70% fall.21

24. This reflects in part a hangover from the diversion of resources to the process of registering social care providers that took place in the run-up to October. However it also reflects reduced staffing resources and an early emphasis on site visits as a last resort which had to be authorised by managers. This position has shifted now, and greater emphasis is placed on site visits and on the inspector’s professional judgement about when and how often visits are needed. But with the increase in caseloads and the staffing shortages the ability to conduct site visits and the amount of time available to spend on them, are constrained.

Enforcement

25. The establishment of CQC was intended to widen the range of enforcement powers the regulator had and ensure that more enforcement action is taken where care standards are breached. The Commission regulates against what are “essential” standards for safe and effective delivery of care. Non-compliance is therefore serious and should not be allowed to persist.

26. We are concerned that far from increasing under the new regulatory regime, enforcement action has decreased for adult social care providers and independent healthcare providers. In adult social care, the number of enforcement actions taken has more than halved from 480 in April 2009–10 to 221 in April 2010–11. Enforcement actions against NHS Trusts have however increased from five in 2009–10 to 13 in 2010–11.22

27. The enforcement process is described by members as bureaucratic and long-winded.

28. Feedback from members suggests that there is still some ambiguity and inconsistency about what constitutes compliance. For example, can you be deemed compliant if there are minor or moderate concerns about how far a particular standard is met? How long are providers afforded to address concerns at this level?

29. We have also detected differing interpretations among members in different parts of the country about the extent to which provider self-assessment declarations routinely need to be independently verified, as opposed to verified and checked out only where a risk or contra-indication has been identified. The self assessment for providers requests qualitative and subjective information.

Short-cuts

30. The pressures on CQC mean that there are inevitably ideas about how to further streamline regulatory processes. Our members are currently concerned about suggestions that planned reviews may routinely only look at a few of the 16 essential standards. We would urge caution about such decisions. The public expects essential to mean essential and that infection control, nutrition and consent to care for example are all vital aspects of what should be checked.

Safeguarding protocols

31. The Winterbourne View case has focused attention on how robust systems are for dealing with safeguarding information, and whether information from whistleblowers is triaged appropriately to the inspector responsible. Information and contacts come in to the call centre. We believe that it is a skilled and sensitive role to deal with such calls. Staff need to be able to extract the necessary information, while reassuring the person making contact and gaining their confidence. As we have stated we are therefore concerned about the

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21. Communitycare.co.uk 3 May 2011
pay, training and agency staffing levels in the call centre. We are also concerned about the use of performance targets for call handling which may mitigate against patient and careful handling of sensitive calls.

Infrastructure

32. Some of the pressure on our members is caused by time wasted on a cumbersome IT system (CRM) which members describe as not user friendly, endless box-filling, duplication of inputting and needing to “feed” the system. Again work is underway as part of the current comprehensive review to address these issues but IT solutions and fixes are slow to be delivered and to some extent it is a losing battle to try and retro-fit a set-up that was designed for a different system.

33. There is also real frustration among staff about the copious guidance documents they are expected to work through and constant changes and updates to guidance which they are expected to digest.

Support and expertise

34. CQC has a small team of national professional advisors who can support inspectors in planning inspections. However members have raised concerns about whether there is adequate cover and access to these to meet their needs.

35. All inspectors and assessors are home-based and there are real issues of loss of peer support and isolation which are difficult to overcome. Many members say their 1:1 sessions with managers are process-orientated and focus on performance targets.

Excellence scheme

36. The loss of the star rating scheme for social care providers has left the public and commissioners with no easy way to assess differences in quality of care between providers. The proposed “excellence” scheme raises a number of concerns for our members. It will be outsourced to be run by competing providers. It is likely they will compete on the cost of fees they charge to providers to apply to their schemes, and we fear there may be incentives to award excellence in order to generate business. While it will be the awarding bodies’ responsibility to assess whether providers meet the excellence standards, there is still a great risk of reputational damage to CQC when a provider badged as excellent is found to be providing sub-standard care. We are worried that awards may be made for a period of say two years, when standards and quality can deteriorate very rapidly within that time period.

Multiple Inquiries

37. Staff went through a difficult and turbulent time in the establishment of CQC. Now more than two years on, there is no end in sight to the turbulence and uncertainty. Staff are having to cope with:

—a the pressure of staff shortages;
—a an ongoing internal implementation review re-examining most aspects of the new HSCA regulatory regime they have been trying to work with for nine months;
—a the potential outcomes of the Mid Staffordshire inquiry;
—a the potential outcomes of the various post-Winterbourne inquiries; and
—a the probing of CQC’s role in relation to Southern Cross.

What the Trade Unions are Calling for

38. The trade unions welcome the Select Committee’s scrutiny of CQC. We wish to see action which will build and strengthen CQC—we do not want to see any further reorganisations or mergers. We have identified a number of actions we wish to see implemented which we believe will lead to a stronger and more effective regulator:

(a) A complete review of current work volume and activity against the staffing model.
(b) A full assessment of the workload impact of dentists, ambulance and GPs coming into regulation.
(c) Expansion of the range of statutory notifications so it more closely mirrors the position under the old Care Standards Act, and can be used to build a fuller picture of a provider.
(d) A regulatory model which builds in minimum frequencies for site inspections, with more frequent visits made where inspectors judge this necessary. We think a targeted annual inspection annually and a full inspection at least every two years would be appropriate. Agreed triggers for an inspection such as a change of manager or a pattern of very high staff turnover.
(e) Immediate steps to increase staffing with a target of bringing average caseloads down to 40.
(f) Additional skilled administrative support to work more closely alongside inspector and assessors.
(g) A new staffing model to be developed taking account of (a) to (f) above and the resource implications reported to Government and Parliament.
(h) A “return to the floor” programme for all senior managers to shadow inspectors, assessors and call centre handlers.

(i) A programme of urgent training to be put in place for staff who have identified gaps in the training they have received to date.

(j) An ongoing programme of professional development, support for professional registration, and personal development reviews for everyone.

(k) A review of staffing in the Newcastle call centre to increase training and skill levels, and reduce staff turnover and agency staffing. Particular attention to be paid to training staff to deal with sensitive safeguarding and whistle-blowing calls.

(l) An overhaul of the IT system to reduce inefficiencies, processing requirements and duplication of inputting.

(m) A major rationalisation of processes and guidance.

(n) A review of whether the methodology should be same for GPs and dentists as for social care and acute services.

(o) A public engagement strategy to welcome and encourage the public to share information with CQC using an on-line comments facility and targeted literature in GP surgeries, hospitals, schools and community centres.

June 2011

Written evidence from the Equality and Human Rights Commission (CQC 15)

INTRODUCTION

The Commission welcomes the role of the committee replacing that of the Privy Council as a means of regular and transparent national review of these bodies.

The Commission will seek to co-operate with future committee reviews to assist its own role as the regulator for equality and human rights.

The Commission will take into account the conclusions of the current committee sessions in its own responses to the human rights and equality performance of services cited in recent reports.

OUR ROLE

The Equality and Human Rights Commission (EHRC or the Commission) was established by the Equality Act (2006) and commenced operation on 1 October 2007. It is an independent statutory body with a duty to promote equality, human rights and good relations in England, Wales and Scotland. In February 2009 the Commission received “A” status accreditation as a National Human Rights Institution. Under the Equality Act (2010), protected equality characteristics include: age, disability, gender, race, sexual orientation, religion or belief, gender reassignment, pregnancy and maternity, marriage and civil partnership.

SUMMARY OF SUBMISSION

The Commission welcomes the opportunity to submit our comments on the committee’s forthcoming review of the regulatory performance of the Care Quality Commission (CQC) and Monitor, particularly in light of the recent Winterbourne incident, the CQC Report on Dignity and Nutrition in hospitals, and the Parliamentary and Health Service Ombudsman’s (PHSO) report “Care and Compassion”. We also welcome the committee’s recent review of the General Medical Council (GMC) and Nursing Midwifery Council (NMC). This submission only reflects our views concerning the first two above named bodies.

RECOMMENDATION

The Commission would welcome a greater need for all regulators within the sphere of health and social care to have a general duty of co-operation, as proposed in the Health and Social Care Bill.

BACKGROUND

1. The Health Select Committee Report of February 2011 examined the progress and issues faced by the GMC as it was undertaking its long term aim to introduce “revalidation” of doctors. It appeared particularly valuable for the committee in its report to identify a need for a more regular and transparent scrutiny of such bodies. The current sessions indicate that this wider role may now be extended to other workforce regulators as well as to service regulators, including CQC and Monitor.
2. We firmly believe that in all issues concerning the key aims of health and social care in England, there is a need for consistency and shared regulatory principles amongst relevant bodies, even as these are applied to different groups or circumstances. The Health and Social Care Bill proposals seek to strengthen regulation of key health standards such as those around patient safety, but the Commission has been concerned that with substantial devolution of power, the net result would be more of the gaps that continue to arise and are highlighted in the above national reports. We also believe that standards can potentially help with commissioning arrangements.

3. However, the Select Committee proposals (February 2011) may contribute to ensuring regular robust and proportionate national scrutiny of regulators. This would help to challenge poor regulation that contributes to greater likelihood of abuse or lack of care, whilst actively seeking and encouraging better regulatory practice.

4. The Commission will seek to co-operate with future committee reviews in line with strategic priorities, resources and to assist in our role as the regulator for equality and human rights.

5. The Commission is currently undergoing substantial reform which will lead to a smaller more focused EHRC, acting as a regulator. Current challenges to public provision, in particular NHS reform and negative reports of abuse and financial scandals in the care sector, warrant the need for a co-regulatory approach between EHRC and key bodies in the health and care sector. This would help to clarify equality and human rights obligations and how these should be factored into the approach relevant bodies take to regulating the health and adult social care sectors.

6. A Memorandum of Understanding (MoU) was agreed on 11 March 2010 between EHRC and CQC in response to recommendation 2 of the PHSO’s report “Six Lives” (March 2009) “…that those responsible for the regulation of health and social care services (specifically the Care Quality Commission, Monitor and the Equality and Human Rights Commission) should satisfy themselves, individually and jointly, that the approach taken in their regulatory frameworks and performance monitoring regimes provides effective assurance that health and social care organisations are meeting their statutory and regulatory requirements”. The MoU was also an important milestone to help drive the EHRC’s approach to social care reform, set out in our report “From Safety Net to Springboard” (published February 2009). MoU objectives for the first year of operation have been focused on plugging key gaps identified in the CQC’s movement towards a single registration system for providers of care.

7. As part of initial outcomes for 2010–11, EHRC and CQC have scrutinised CQC’s tools for regulating the sector, resulting in identification of a need for guidance for CQC inspectors which extrapolates the equality and human rights dimensions of the CQC’s essential standards (the approach used to monitor providers). This guidance will be published this summer. Another example is intelligence, whereby EHRC officials are working with CQC’s intelligence team to amend how CQC staff will be able to evaluate provider compliance in respect of equality and human rights legal obligations. A further example is training, whereby agreement has been reached for EHRC Transfer of Expertise staff to work with the CQC’s Learning and Development team to advise and assist with the training of CQC inspectors (and other staff). We believe this approach is ground breaking but at an early stage. We will evaluate it in due course to determine how it contributes to tackling the neglect or abuse like that cited.

8. The inclusion of rights as a back stop to what should be about common sense, care and compassion, need not be problematic or complicated. It does however back up risk based inspection that can identify and usually act on issues at an early stage, but if necessary is reinforced by the respective powers of associated regulators. Regulation and inspection must include the meaningful threat of removal of licence but have such transparency in doing so. Regulation and inspection must include the meaningful threat of removal of licence but have such transparency in doing so. Regulation and inspection must include the meaningful threat of removal of licence but have such transparency in doing so.

9. We still unfortunately find that some regulators do not adequately reflect the impact of equality or human rights to their role, creating obstacles to progress in this vital respect, but which we cannot ignore baring in mind the lessons of the above reports. At present this leaves us to either seek legal enforcement of large national bodies which is expensive and protracted, or, we would need substantially greater resources which are not an affordable option, and runs counter to our own reform vision.

10. In this context we believe the committee holds the powers to oversee all bodies, ourselves included, to ensure that regulation and regulators in the health domain are contributing to wider national aims. To this end, we will seek to provide input and to respond to future reviews in line with EHRC priorities and resources.

11. The commission will include the conclusions of the current committee sessions in its own responses to the human rights and equality performance of services cited in recent reports.

12. For some years the Commission has responded to such reports as that of the PHSO “Six Lives”, as well as seeking proactively to establish collaboration between standard setting, regulatory and inspection bodies that
could do more to prevent a “Cornwall Trust”,23 a “Maidstone and Tunbridge Wells”24 or a “Mid staff”25 case. This has been a difficult task, but we argue particularly in health that equality and human rights principles are largely co terminus with service quality, patient choice and above all patient safety.

13. In 2008 as the then Health Bill established the framework for CQC regulation and inspection, we had already agreed with the Department of Health to work with the new body on the need to embed equality and human rights in accordance with regulatory principles. Our MoU with CQC is long term but we have found CQC a willing and committed advocate of embedding rights this way. The MOU is one of our most formal joint arrangements, and there is no one size fits all manner of collaboration. The MOU also does not fetter either of our own regulatory obligations; which in the case of the commission includes the oversight of the CQC’s own equality and human rights duties.

14. EHRC engaged in dialogue with Monitor during 2009–10. However, due to current NHS reforms, we agreed to park discussions about appropriate collaboration until the statutory framework of Monitor was clear. EHRC is keen to engage with Monitor when this happens because Monitor has a significant remit covering NHS foundation trusts, is likely to have an important role as economic regulator in a more diverse care market and also has its own legal obligations in respect of equality and human rights law.

15. EHRC is also mindful that forthcoming social care reform will have a significant impact on vulnerable people, particularly in the harmonisation of care legislation recommended by the Law Commission in May 2011 and the implications arising from the Dilnot Review on funding which is anticipated in July 2011.

16. We are now considering our own response to the spate of reports this spring. This does not preclude some direct enforcement action. Our own powers particularly in respect of human rights are used with great care, but we cannot ignore such reports as that of the PHSO in “Care and Compassion” that use terms indicating possible systemic failures. The Winterbourne View case in particular now re emphasises the need for more robust regulation. The Commission is deeply concerned about evidence of institutional abuse.

17. We still believe that the long term route we are taking alongside CQC is the best way to build proportionate and appropriate but robust regulation; though we hope the committee has the opportunity to discuss with them on the modes of inspection most likely to observe some of the degrading treatment that has been observed in reports this spring. For example, it was very effective for CQC to use experts by experience and unannounced spot visits at odd times in their Dignity and Nutrition report. It may be in the public interest to use the covert forms of inspection via broadcasters like the BBC Panorama programme on Winterbourne View if it will help prevent breaches of fundamental human rights. We do not have such powers to conduct unannounced visits, but as part of our collaborative regulation arrangements we are seeking to use powers in a complementary fashion. For example, we can work with others where indications of risk may flag up an urgent need for them to carry out visits, and/or follow with their own or our powers of further investigation.

18. Winterbourne View also strongly suggests that staff cultures, attitudes and behaviours can be so powerful as to allow them to adopt a caring appearance that would cover up abuse even on spot visits, particularly when they have situational power over people in very vulnerable circumstances. In turn, this suggests the need to cross reference action by service regulators with equivalent steps by professional regulators who must also recognise their role in ensuring the right conduct and competences are in place for both new and existing staff. We welcome the review of some of these bodies now by the committee.

19. As part of the Commission’s submission on the Health and Social Care Bill, we have suggested that the duty of co-operation between CQC and Monitor should in fact be a general duty for all regulators working within health or social care. The scrutiny role of the committee would be a regular effective forum to require bodies to justify their individual or joint action in pursuit of greater patients’ safety, service quality or reduction of health inequalities.

20. The Commission would be happy to further discuss the issues raised in this submission with the committee or individual members as deemed appropriate.

*June 2011*

23 http://www.communitycare.co.uk/Articles/2006/10/12/56048/Cornwall-Partnership-NHS-Trust-gets-lowest-rating-for-quality-of-learning-difficulty-services.htm

24 http://www.guardian.co.uk/society/2007/dec/14/nhs.health/TMTCP=SRCH;

Written evidence from the Association of Directors of Adult Social Services (CQC 16)

Background

The Association of Directors of Adult Social Services (ADASS) represents Directors of Adult Social Services in Local Authorities in England. As well as having statutory responsibilities for the commissioning and provision of social care, including the safeguarding of vulnerable adults, ADASS members often also share a number of responsibilities for housing, leisure, library, culture, arts, community services, and increasingly, Children’s Social Care within their Local Authority.

ADASS welcomes the opportunity to contribute to the work of the Health Committee with regard to the scrutiny of both the Care Quality Commission (CQC) and Monitor and makes the following points:

Care Quality Commission

ADASS acknowledges that the Care Quality Commission has been through a period of very substantial turmoil over the past decade as the role of regulation and performance improvement has seen many changes in policy and direction. Above all, we would like to see CQC develop with confidence its proposals to be a world class regulator, and develop the processes, partnerships and staff competences that would accompany this. It will be critical that as CQC evolves that this is maintained and expanded, and builds on the organisation’s very strong traditions in citizen focus and involvement.

1. ADASS welcomes the expertise and understanding of the value of the social model held by CQC. The achievement of user outcomes rely upon an integrated approach and CQC work reinforces this connection. It will be critical that as CQC evolves that this is maintained and expanded, and builds on the organisation’s very strong traditions in citizen focus and involvement.

2. ADASS welcomes the new arrangements towards “Sector-led Improvement” following the discontinuation of CQC activity in making council annual judgements. Councils (ADASS) are well placed (in terms of expertise) to drive forward sector-led improvement and within these rapidly emerging dynamics. The role of CQC in undertaking risk based inspections is seen as an important dimension in complementing the public assurances provided by the sector. We welcome the new balance being placed upon the sector taking responsibility for itself as the starting point for management. ADASS retains concerns that “sector led” is being applied to councils only and that the care sector as a whole is not investing enough in its own performance and quality systems.

3. Following the cessation of ratings of providers, ADASS retains concern over implementation of the replacement Excellence Scheme (this is still subject to consultation, which closes on 1st August) with specific reference to the proposals to only differentiate excellence to those providers that pay a fee to CQC to register for the Excellence Scheme, whilst other providers not signing up to the scheme will be restricted to being differentiated as either meeting essential standards or not. We think that this “opt in” system will not help the public with easy to access and understandable ratings of all care provision.

4. ADASS expresses concern over availability of updated information on providers judged performance on the CQC website, which can be three years or more out of date. We acknowledge that this is compounded by the change in legislation under which CQC stopped awarding quality ratings from July 2010, but the considerable time-lag restricts the public from making informed choices about providers at a time when national policy supports choice as a core value.

This concern about currency of existing CQC judgements is also compounded by the experience of Directors (and reinforced by recent analysis by Community Care magazine obtained by FOI requests) of significant drop in the number of inspections and the availability of CQC Inspectors and support staff. We think on reflection this movement has been ahead of the ability of providers and commissioners to strengthen the sector led approaches.

ADASS notes the shift by CQC towards risk-based inspections and the proposed increased use of remote intelligence to trigger inspections. Whilst the emphasis upon reduce burden is welcomed, ADASS is concerned as to the reliability of remote intelligence systems as opposed to face-to-face contact, alongside the perception that service users, carers and families do not always exercise their rights to complain and staff maybe reluctant to whistle-blow on poor practice.

5. In response, ADASS acknowledges the collaborative approach being taken by councils, health partners and providers in leading improvements, and ADASS has developed Advice Notes to further strengthen approaches to safeguarding vulnerable adults.

6. ADASS also notes the considerable attention that councils give to work with providers to drive up standards. Councils are heavily engaged in contract monitoring and have extensive contact with service users through assessments, reviews and ongoing working. These activities provide councils with the intelligence and leverage to seek improvements in service delivery and securing improved outcomes for service users and carers. ADASS would want to work with the support of providers to reinforce the legitimacy of these roles.

7. ADASS welcomes coproduction with the Department of Health in the design of a new integrated outcomes framework and ADASS notes the valued input of CQC in this process. This collaborative approach signals a new relationship between national and local structures and importantly establishes the pursuit of improved outcomes as the key driver for the health and social care sector.
8. ADASS welcomes the Government’s response to the NHS Future Forums recommendations to increase level of user, carer and citizen engagement in the health and social care system. The interface between CQC, HealthWatch, Councils, Health &Wellbeing Boards, the NHS Commissioning Board and providers require further details but ADASS feels confident that the expertise held in both CQC and councils can greatly contribute to the development of the approach.

9. Finally, ADASS is fully engaged in the development of quality standards through active participation in the NICE work programme. The development of these standards has clear reference to the work of CQC and provides another example of collaborative approaches to secure improved outcomes for service users and carers.

Monitor

10. ADASS welcomes the Government’s response the NHS Future Forum’s recommendations to re-focus the emphasis of Monitor upon choice and quality. This is considered an important development to providing cohesion across the whole sector towards securing improved outcomes for service users, carers and the wider public, whilst also stimulating choice and control. This is entirely consistent with the Vision for Adult Social Care, published by the DH and endorsed by ADASS.

11. ADASS suggests that Monitor’s role in pursuing choice and quality imperatives alongside competition will need to develop explicit guidelines for the development of integrated services under partnership with other public sector provider (these guidelines should have flexibility to identify risks and rewards across the system in preference to a solution driven by profitability in the Foundation Trust model). We presume too that this will require the evolution of relationships between Monitor and local Health and Wellbeing Boards.

12. ADASS welcomes the role of Monitor to add financial audit /scrutiny into the system and ADASS strongly urges that this financial expertise is also applied in the financial evaluation of large providers as part of the commissioning process. This expertise should complement the service delivery expertise held by commissioners and combined should provide public assurance on both the quality and stability of providers.

June 2011

Written evidence from the Foundation Trust Network (CQC 17)

Introduction

1. The Foundation Trust Network (FTN) is the membership organisation for authorised NHS foundation trusts and those aspiring to achieve foundation trust status. We have over 200 member organisations providing care across the acute, mental health, ambulance and community services sectors.

2. The FTN welcomes the opportunity to inform the annual reviews being carried out by the Committee. Our comments are limited to the Care Quality Commission (CQC) and Monitor as the primary regulatory agencies to which FT boards are held to account.

Executive Summary

3. In our brief submission we argue for:
   — Continued separation of regulatory functions in respect of quality and finances;
   — A pan-NHS dialogue on appropriate applicable quality standards;
   — Clarity on the role commissioners have in quality oversight;
   — A risk-based, proportionate and effective approach to quality regulation;
   — An appropriate accommodation of different care settings by the regulators;
   — Further exploration of how care pathways as well as organisations can be regulated effectively;
   — A continuing clear rationale for data collection;
   — Appropriate inter-action of CQC and Monitor in exercising their functions;
   — Alignment between policy and regulatory activity;
   — Monitor to develop appropriate community services indicators as soon as possible.

Care Quality Commission

4. The FTN agrees that there should be a robust system of quality regulation that gives the necessary assurances to patients and the public about the standards that can be expected from the service. We are in no doubt that achieving this will be a significant challenge.
The need for separation of regulatory functions

5. There is a question of whether quality and financial regulation should be integrated into the functions of a single regulatory body—we do not consider this would be appropriate in health given the experience of other industries, where because quality potentially loses out relative to financial concerns they have been kept separate. To give an example, in the case of the water industry, Ofwat undertakes pricing and the Environment Agency and the Drinking Water Inspectorate are between them responsible for water quality standards. However, there does need to be a coherent understanding between the regulators of the cost of achieving requisite quality standards for the purposes of price setting and affordability in the system.

Standard setting

6. As there is no direct payer relationship between the provider and the consumer accessing NHS services and because a finite resource available through government allocations, a tailored approach to determining industry-wide quality standards is necessary distinct from other regulatory regimes. An accommodation needs to be reached between the regulator, providers and other stakeholders on what quality standards are required and acceptable.

Role of commissioners

7. Among the other stakeholders, commissioners will undoubtedly be concerned with health outcomes which suggests a legitimate concern in respect of quality, but the shape and extent of this role is as yet unclear and would benefit from further clarity, having due regard to who is accountable for quality and avoiding undue bureaucracy.

A risk-based approach

8. CQC must be risk-based regulator. While the CQC states this intention we consider that this needs to be demonstrated more in its actions—there should be a more strategic analysis of issues which lead to appropriate responses. There is growing evidence from recent inspection activity that the CQC needs to re-examine its approach to the principles of Better Regulation, including proportionality, transparency and consistency.

9. We are concerned that the CQC currently has insufficient means of compiling and analysing data into a reasonable set of risk profiles which we believe has led to behaviours being exhibited which are unhelpful in the promotion and support of improved quality outcomes.

10. We believe CQC interventions are occasionally disproportionate and inappropriate with an undue focus on, and escalation of, essentially immaterial matters leading to the consequential risk of issues of greater significance becoming more difficult to distinguish and observe. The FTN is receiving escalating member concerns that the classifications of incidents in its inspectors’ reports are causing unnecessary problems for providers in mental health and community services—in particular:

   — The current classifications of minor, moderate and major and the lack of proportionality in the approach of inspectors on allocating breaches of compliance by category, where we have many examples of relatively trivial breaches that are clearly recognised as not being systemic and which do not impact of patient care being categorised as major;
   — An inconsistency around guidance on registration where some organisations have had to register many sites and other only a few leading to the lack of a level playing field;
   — A large number of examples showing a lack of consistency in categorisations between different inspectors across different sites;
   — The lack of dialogue around reports;
   — A media approach that sensationalises incidents and unnecessarily damages the reputation of organisations for relatively trivial breaches;
   — A number of organisations having lost business as a result of an intemperate approach by the CQC when dealing with minor and moderate concerns;

11. The detrimental impact can be further compounded by how these measures are reflected in the Monitor Compliance Framework risk ratings. The FTN has discussed its concerns directly with the CQC which has appeared receptive and responsive to our concerns. We look forward to working with them on resolving these issues at the earliest opportunity.

12. We would also observe that the approaches taken by the CQC are dominated by an acute care mindset which is an inappropriate means of gauging the standards of, for example, mental health and community services. All healthcare services should be judged with equal rigour but the judgement should be made with due regard for the setting in which the care is provided.

Care pathways and being fit for purpose

13. There is increasing focus in the service on the need to develop patient-centred care pathways as a means of improving patient experience, quality outcomes and productivity levels. However, to date, the CQC has
been a regulator of organisations rather than pathways. As pathways become more widespread it will be
important that the regulatory regime reflects this in its working.

14. As part of the debate on being fit for future purpose, it will be important that organisational resources
required to be given over to the task, both at a CQC and provider level, do not divert any more resources than
are necessary away from patient care.

15. There should be a clear rationale behind data requests and there needs to be a wider public understanding
of the resource implications of collecting data—information is a powerful and welcome driver to underpin
performance improvement and accountability but within finite resources of the NHS spend, new data requests
will necessarily impact on what funds remain available to invest in patient care.

Inter-action with Monitor

16. The CQC’s judgements and analysis of quality are fundamental to the functioning of the system and as
such they need to be credible. The inter-action of the CQC and Monitor’s activities and how they inform each
other means that if CQC escalates issues through defensive behaviours, this impacts on the risk-rating that
Monitor will give organisations and give rise to perhaps unnecessary monitoring activity.

17. The CQC should have at least some regard for economic data to be able to appreciate the relationship
between financial pressures and quality thresholds—though the decision about trade-offs between finances and
quality (assuming market-entry quality criteria are met) should remain a clear responsibility of provider boards.

Monitor

18. Monitor has been enormously important in bringing better standards of financial discipline to NHS
providers. It takes a welcome risk-based approach to regulation (insofar as it can rely on others’ judgements
by way of proxies as outlined above) and the Compliance Framework has provided a useful set of disciplines
to which FTs can work.

19. We are presently evaluating the impact of the revised proposals for Monitor’s role as a result of the NHS
Future Forum’s listening exercise and government response, but will limit our comments here to extant
arrangements.

Flexibility

20. Monitor’s approach is rational and while we would sometimes consider that their chosen measures could
be better if different, or that there could be greater discretion around interpretation of measures, this is normally
a direct consequence of having to regulate with regard to the extant DH operating framework requirements.

21. We would observe that while this has been reasonably acceptable to date, we do have concerns that the
extension of this principle to current DH operating framework policy, for example on readmissions, could soon
put unnecessary strains on the sector—as such there could be some benefit in Monitor being given further
freedom to apply a degree of flexibility.

22. To illustrate by example, our experience of the readmissions policy has highlighted incongruence between
Monitor acting as regulator and DH wanting to evaluate the impact of new policy. Here, Monitor legitimately
wants to see progress on realisation of cost improvement plans across all year quarters, whereas DH wants to
evaluate the impact of the readmissions policy in quarter 1 which suggests it would be prudent for providers
to wait for the conclusions of this review before committing irretrievably to a particular course of action.

23. It will be important that Monitor develops with some urgency appropriate measures for community
services and we note the current consultation taking place in this regard. We would make the same point that
we made about the CQC above that the indicators chosen need to be appropriate to the care setting.

24. The key concern we currently have is in the inter-action between Monitor and the CQC. Monitor rightly
relies upon the CQC for judgements on quality. If these are disproportionate, this is compounded by the
Monitor Compliance Framework risk ratings and what can be a minor series on non-systemic issues that do
not in any way endanger patients, and where the recovery plan has been accepted by the CQC, can earn the
foundation trust an “amber-red” or even “red rating” for governance. This can have a knock on impact on the
financial arrangements with banks and other lenders that puts well performing foundation trusts in danger of
losing banking arrangements that were agreed on a more favourable risk rating.

June 2011
Written evidence from the NHS Confederation (CQC 18)

About the NHS Confederation

The NHS Confederation is the only body to bring together the full range of organisations that make up the modern NHS to help improve the health of patients and the public. We are an independent membership organisation representing all types of providers and commissioners of NHS services. The NHS Confederation includes the NHS Employers organisation, which represents NHS organisations in England on workforce issues and has particular expertise of professional regulation.

Our response complements that of the NHS Confederation’s Partners Network, which represents independent sector providers of NHS care, and of the Foundation Trust Network, which reflects the particular perspective of NHS foundation trusts.

1. Executive Summary

— Our submission covers general points on regulation, including the contribution of professional regulation and commissioning, but concentrates on the operation of the CQC and Monitor.
— Effective regulation is fundamental to maintaining public confidence in services and ensuring patients receive safe, effective care.
— Clear, realistic expectations are needed of what regulation can achieve in terms of standards of care: the NHS Confederation believes regulation should only be responsible for minimum standards of entry either to a profession or for organisations to the market.
— CQC, Monitor, GMC and NMC regulation are just part of NHS regulatory and oversight mechanisms. There is a complex range of requirements that result in overlap and duplication, but potentially also failure to act on issues of poor quality care because of confusion about responsibilities. Better alignment of the different types of regulation and processes is needed.
— The legislative framework and associated regulations have provided an unduly onerous framework for CQC registration, which has been hampered in its operation by insufficient CQC resources.
— The trust or organisation-level unit of registration is too large to provide the public with meaningful assurances of care standards care in particular units or facilities.
— Our members have particular concerns about the operation of the CQC and question whether it is fit for purpose including:
  — The CQC is insufficiently risk-based or proportionate in its approach.
  — It is insufficiently independent of government.
  — CQC’s model of regulation and inspection is:
    — Too generic and takes insufficient account of the particular considerations for different types of service.
    — Insufficiently flexible to respond to emerging models of care or service changes readily.
    — Inconsistent with variations of approach between regional offices and inspectors.
    — Not sufficiently effective in influencing standards of care provision and does not represent value for money.
  — Registration processes are cumbersome, bureaucratic and poorly administered and subject to significant delays.
  — CQC information, advice and guidance have been inadequate and not available sufficiently early in processes.
— We recommend the CQC:
  — Develops a constructive relationship with our members to determine a more effective regulatory model and approach.
  — Adopts a more-tailored approach to regulating the different types of services.
  — Provides named CQC contacts to give consistency and continuity for providers.
  — Reviews the use of “location” as a key concept for registration as this has been difficult to apply meaningfully in some services.
— The costs of regulating health and social care are significant and primarily met by providers, including the costs of administrative and management processes to comply with regulatory requirements. For public-funded services, this can divert resources from front-line care.
— Economic and quality regulation should remain separate but closely-aligned. Monitor and CQC must be held accountable for how they discharge their duties to cooperate.
— Setting the legislative framework for Monitor’s new role will be crucial to its effective operation as sector regulator. However, it will be essential to learn and develop future policy from its operation. This would be aided by setting out how it conducts its role in secondary legislation which could be more-easily amended if unintended consequences occur.
— We would like to see a clearer statement of intent at the outset about how the procurement and competition regimes will operate and how Monitor will balance its competing duties.
— We welcome proposed amendments to the Health and Social Care Bill that would allow the Secretary of State (SoS) to report on national organisations, and we expect the SoS to assess regularly how Monitor fulfils its role and duties in the interest of patients and taxpayers.
— When considering our evidence, we urge the Committee to bear in mind the following points on the overall regulatory system:
  — Member concerns about the bureaucratic nature of many requirements.
  — The need for the government to take a systematic and longer-term approach to regulation, which should be informed by the findings of the public inquiry into Mid-Staffordshire NHS Foundation Trust.
  — The need to clarify the role of commissioners in promoting and assuring quality.

2. Introduction

2.1 The NHS Confederation supports strong, effective regulation. This is fundamental to reinforcing public trust in both the individuals and organisations providing care, and to helping safeguard patients and ensure they receive high-quality and safe care provided by well-run organisations.

2.2 As organisations working in the public interest, regulators must be accountable for their performance and practice. We therefore welcome this opportunity to submit evidence to inform the Health Select Committee’s scrutiny of the CQC and Monitor. Our members have direct experience of the requirements and operation of these regulators on a daily-basis and are well-placed to make observations about their effectiveness.

2.3 Our submission draws extensively on member feedback and intelligence, as both providers and commissioners of care, and employers of healthcare professionals. It also draws on NHS Confederation seminars held in winter 2010–11, which considered how economic and quality regulation should operate and included participants from patient groups, other interested parties and NHSC members.

2.4 Our submission covers:
  — The proper role and operation of regulation.
  — The extensive regulatory and oversight structures for healthcare, and their inter-relationships, including between regulation and commissioning.
  — CQC’s role as a quality regulator, including detailed comments about its operation and registration.
  — Bureaucracy and the costs of regulation.
  — Monitor’s future role.
  — Coordination of quality and economic regulation.

3. The Proper Role of Regulation

3.1 The NHS Confederation believes that it is essential all regulators have clear objectives and understanding of their role (and how this relates to other regulators), which underpins their operation. Our recent regulation seminars identified five key elements as the proper focus of regulation:
  — Protecting people from harm, especially the most vulnerable in society.
  — Protecting and promoting the patient interest.
  — Assuring the quality of services and delivery of good outcomes for patients.
  — Ensuring access to essential services.
  — Changing behaviours and internalising good practice to achieve the desired objectives.

3.2 All regulation should be consistent with better regulation principles, ie risk-based, proportionate, consistent, targeted, transparent and accountable. However, we question whether current healthcare regulation consistently adheres to these principles.

3.3 We suggest there is a need for much greater honesty with the public about what both professional and service regulation can deliver. A realistic understanding is needed of what regulators can actually achieve, and the likely costs of different regulatory approaches, which should inform their practical operation. We believe regulators should be responsible for setting minimum standards that guarantee entry to a profession or allow organisations to provide care. Responsibility for improving quality lies elsewhere, not least with providers themselves.

3.4 Recent debate has questioned whether existing regulatory structures can prevent failures in care, often advocating a more inspection-based approach. However, inspection-based regulation can only give assurance that things were right at a particular time and location, although inspections (including unannounced inspections) should be an important tool for any regulator. No regulatory system can ever prevent all failures of care, and designing a system that seeks to do so is likely to be unsustainable financially and overly-disruptive to delivering care.
3.5 The NHS Confederation believes primary responsibility for delivering safe and high-quality care and ensuring organisations are well-run and financially viable lies with the Board and frontline clinicians. The regulator’s role should be to encourage providers to develop more robust systems for monitoring and delivering quality, and to reinforce that with an effective enforcement regime.


4.1 While important, the GMC, NMC, CQC and Monitor are not the only regulators with oversight for healthcare standards. In the joint NHS Confederation/Independent Healthcare Advisory Services report *What’s it all for?*, we identified over 69 bodies with oversight of healthcare providers, including powers of regulation and inspection. These include the Health and Safety Executive, other professional regulators (such as the Health Professions Council), the Medicines and Healthcare products Regulatory Agency, and many others. Additionally, commissioners have an important role in assuring quality.

4.2 We are concerned there is a tendency to view individual regulators in isolation, without recognising the interconnectivity of their roles and impact on healthcare provision. Often responsibilities overlap and there is insufficient clarity about respective roles and functions. This can not only result in duplication, but also cause things to slip through the cracks, as there is insufficient clarity about who is responsible for taking action. Effective regulation requires all regulators to find ways of managing their respective roles and inter-relationships, and any potential tensions between their different roles and objectives (such as between quality and access, competition and safeguarding services) to deliver over-riding benefits for patients.

4.3 Despite the many bodies with oversight of the quality and safety of healthcare, high-profile failures of care continue to raise significant questions about the effectiveness of current regulatory structures. This undermines public confidence in the regulators’ ability to prevent unacceptable standards of care and safeguard those using services. Recent events have particularly called into question the CQC’s effectiveness, and its ability to safeguard vulnerable individuals.

4.4 Each high-profile failure of care tends to result in ad hoc regulatory responses, and the incremental growth of regulatory and oversight processes. These are often costly, burdensome, duplicative and bureaucratic, and add little to guaranteeing quality, safety and access for patients.

4.5 A more systematic approach is needed, and we hope the public inquiry into Mid Staffordshire NHS Foundation Trust will result in a sensible and considered approach to the respective roles and functions of the different parts of the regulatory and oversight structures. This should avoid another costly and radical revision of regulatory structures. Such an approach is particularly important given current proposals for Monitor to take on the role of sector regulator for health and social care, particularly to clarify how it should operate and work with the CQC in discharging its responsibilities.

4.6 A significant gap in the current structures is how to deal effectively with service failure and closure of services, particularly where they are uneconomic or (as in the case of Southern Cross) are provided by financially unsound organisations where the market seems unable to develop an acceptable solution of its own accord. This issue must be addressed before the proposed health reforms begin to take effect.

5. Professional Regulation

5.1 Professional regulation should set the standards for education and training, competence and conduct for individual professionals, which help to create a culture and guide individual professionals to act in patients’ interests. These apply and be enforced whether individuals work as clinicians or as managers.

5.2 The NHS Confederation has supported the revalidation of doctors and NHS Employers has worked to develop appropriate processes to achieve its implementation. Revalidation can provide useful checks of individual professionals’ competence, but these should be part of a wider system of appraisal and performance assessment by employers. Employers must have appropriate systems in place, and it is their responsibility to pick up early indications of a failure to deliver appropriate care and take action.

5.3 It is also important that professional regulators and the CQC are clear about their reciprocal responsibilities in the quest to maintain quality and ensure that information is shared readily and appropriately with each other.

6. Regulation and Commissioning

6.1 Commissioning can play an important role in driving quality and access, but there is currently no agreement about the role of commissioners as part of NHS regulatory and oversight structures.

6.2 The Health and Social Care Bill is clear that clinical commissioning groups will have a duty to seek to secure continuous improvements in the quality of services and health outcomes. While agreeing these are core functions for commissioning organisations, our members have warned against loading responsibilities for quality monitoring and service improvement on commissioners in a way that is inappropriate and undeliverable.

26 NHS Confederation and Independent Healthcare Advisory Services (2009) *What’s it all for?*
6.3 A distinction should be drawn between these commissioning responsibilities and the responsibility of all organisations providing NHS services to ensure their quality, safety and effectiveness. A more realistic view of commissioners’ responsibility and scope in the new system should include:

- assuring themselves only registered providers are added to local service directories;
- gathering patient and public feedback of their experiences of using services;
- monitoring trends in reported experience and outcomes, complaints and serious incidents;
- making this information available to the public and to individual referrers in accessible formats; and
- taking prompt, appropriate action if any information received gives cause for concern or further scrutiny.

6.4 In practice, the “right” approach will depend on factors such as the number of providers a commissioner relates to, their quality and safety record and the local priorities for health and service improvement, but no approach will be comprehensive or fail-safe.

6.5 The NHS Confederation believes agreement is needed on what is a reasonable and appropriate role for commissioners in assuring and promoting quality, and their responsibility to quality regulators. It will be especially important that the new clinical commissioning groups and NHS Commissioning Board do not develop additional regulatory-type requirements for providers that duplicate CQC requirements or act as barriers to entry for new providers.

7. CQC’S ROLE AS A QUALITY REGULATOR

Strategic concerns about the CQC

7.1 Many of our members, both NHS and independent sector providers, have considerable concerns about the operation of CQC, the current registration system and its model for monitoring quality. They question whether the CQC is sufficiently risk-based or proportionate in its approach and model of regulation is well suited to current and emerging models of care, particularly its ability to assess quality across patient pathways.

7.2 Fundamentally, there is insufficient clarity about whether CQC’s focus should be “quality” regulation or assuring minimum standards. We suggest CQC can only set and enforce the minimum standards of safety and quality all providers must meet in order to provide care. While these standards may rise over time, operating these minimum requirements for entry to the market effectively must be CQC’s core role, particularly given proposals to encourage new providers of NHS services.

7.3 We suggest the CQC lacks sufficient independence from government, making it difficult for them to be an objective advocate of quality, particularly at a time of significant public expenditure constraints. This raises questions about whether the CQC should speak out about the impact of funding constraints on its capability to discharge its functions and, more generally, the impact on quality for publicly funded health and social care services.

7.4 We are concerned the CQC is being expected to do more, including taking on regulatory functions from other bodies, but with limited resources and when the efficacy of its current approach is being fundamentally questioned. Pressure on CQC resources has resulted in the demise of positive initiatives to promote active information sharing with other regulators and co-ordination of activity (planned collaborative reviews) and the end of service reviews looking across pathways.

7.5 We also suggest that the CQC is insufficiently accountable for the cost-effectiveness of its operation and quality and performance of its regulatory approach. Feedback from our members continues to question CQC’s effectiveness and its actual impact on quality and safety standards. We believe the CQC should consult regulated providers to help determine its regulatory model and approach, which would be consistent with better regulation principles.

Concerns about the CQC’s approach to registration

7.6 These include:

- Their generic model underpinning registration means that sometimes guidance does not make sense in the context of the particular service being inspected or inspectors do not understand the services they are inspecting adequately. This is a particular concern for providers of mental health, ambulance and community services, who often state that the CQC’s approach is too acute and social care focused. For example, it took significant time to resolve issues for the registration of air ambulances.
- CQC’s approach lacks sufficient flexibility to accommodate new service models or rapid service changes readily. At a time of major service change in the NHS, this presents particular problems for maintaining service continuity while changes to registration are made.
— The unit of registration (the NHS trust or group in the case of independent sector healthcare and social care providers) is too large to provide a meaningful assessment of quality for users of services. This will be increasingly important as NHS trusts amalgamate and provide a range of services in different settings.

— Some service providers have found the key concept of “location” difficult to apply meaningfully to their registration, particularly ambulance services and services provided in the community and people’s homes.

— CQC’s apparent failure to coordinate activity and share information internally, e.g. between those undertaking assessments of mental health providers under the Mental Health Act and more general inspections.

Use of Quality Risk Profiles

7.7 Our members have several concerns about the CQC’s Quality Risk Profiles (QRP) and CQC’s reliance on QRPs to pick up early indications of poor quality care and provide the basis for action. These include:

— the accuracy of some information contained in their QRP; and

— whether QRPs take sufficient account of the intrinsic risks associated with certain procedures and types of care or the vulnerability of service users.

7.8 Members of our Mental Health Network have particularly questioned the CQC’s understanding of risk in a mental health context.

CQC processes

7.9 Members have found CQC processes often cumbersome, bureaucratic and poorly administered, with delays in responses. This results partly from the current legislative framework, which requires providers to notify the CQC of detailed service changes. This imposes significant burden on providers and the CQC, which has apparently not had sufficient resources to deal with these applications quickly and effectively. Examples include:

— Providers must notify any change in registered manager, even if the registered manager held this position at another of the provider’s locations.

— Providers must submit a new Statement of Purpose with each registration application and variation.

— Delays in providing submission references for forms submitted electronically making it difficult for providers with multiple CQC applications.

— Delays in issuing certificates and processing variations to registration.

7.10 Our members indicate that CQC advice and information has not been sufficiently consistent, clear or timely. In particular:

— ambulance trusts, mental health trusts, community and independent sector providers report inconsistent advice and approaches by different regional offices;

— the CQC website is poor with limited availability of online forms and inadequate guidance to support their completion; and

— CQC helpline staff do not appear to have the necessary knowledge to provide the clarification of guidance required.

7.11 The requirements of registration and ongoing compliance are complex, and organisations need practical, detailed information to help navigate them. Our members suggest that registration should be underpinned by a better understanding of how different types of service are provided in the NHS, with more tailored guidance for different types of service, including using specialist inspectors. They would like to see named CQC contacts to provide continuity and consistency, and improve the quality of advice. This should contribute to a more effective and tailored approach to quality regulation that is better able to pick up early indications of poor quality care.

Bureaucracy and the costs of regulation

7.12 The costs of operating the CQC and associated administration in providers to monitor and demonstrate compliance are significant. Preparing for registration and on-going compliance are immensely bureaucratic processes demanding significant resources. Our members continue to question whether this provides value for money, particularly its impact on quality and safety standards.

7.13 All providers, including the NHS, pay fees to cover CQC’s costs of operating registration, and are on a trajectory to cover these costs fully. Despite initial promises that registration would be cost-neutral to the NHS, NHS organisations pay significant fees to the CQC. Some providers have faced considerable increase in this year’s fees, which have been difficult to fund in the current financial climate, and in some cases, diverted funding from frontline services.
7.14 NHS Confederation members continue to highlight the significant, on-going costs, processes and functions associated with CQC registration. Given current government commitments to reduce bureaucracy and red-tape, we find it surprising the statutory regulatory systems are major drivers of this. Many members believe more could be done to simplify CQC’s burden on providers without undermining its effectiveness. This should yield administrative cost savings for providers and result in reduced fees.

7.15 The NHS Confederation believes the CQC should be more transparent in setting its fees, particularly explaining how these relate to the costs of regulating different sectors, and the CQC fee structure should include incentives for providers to improve their quality. We are concerned that the latest scandals may result in a significant shift to the CQC adopting a more direct/inspection-based approach, with all providers having to bear the full extent of these costs irrespective of their quality and safety standards. We suggest that if a level of regulation and scrutiny is required in the public interest, these costs should be borne centrally by the public purse rather than diverting resources from front-line patient care.

8. DEVELOPING THE ROLE OF MONITOR

8.1 NHS Confederation members are familiar with Monitor’s risk-based operation as regulator of NHS foundation trusts, which has helped to drive up financial and governance standards.

8.2 Current health reforms propose a new role for Monitor as sector regulator for health and social care. This has caused significant concerns, particularly the rigid application of economic regulation and competition principles to the English health market, which is relatively undeveloped and has some peculiarities, such as commissioners as third-party payers.

8.3 The NHS Confederation believes creation of an appropriate economic regulation regime and regulator is an essential part of the new system. However, this must be:

— based on a primary duty to protect and promote the interests of people who use healthcare services and taxpayers by promoting the economic, efficient and effective provision of NHS services; and
— tailored and able to be applied flexibly to different types of service and locality.

8.4 We welcome the government’s recognition that the Health and Social Care Bill should place an additional duty on Monitor to promote co-operation and integration where appropriate, alongside its duty to promote competition.

8.5 A clearer statement of intent at the outset about how the procurement and competition regimes will operate and how Monitor will balance its competing duties would provide some reassurance. It is important to be clear that Monitor’s role is to provide a framework to support local commissioners rather than make local decisions, but that where local commissioning decisions are challenged, Monitor will judge the appropriateness of them.

8.6 Careful consideration is needed in setting the legislative framework for Monitor’s new role as sector regulator to avoid creating perverse incentives and unintended consequences. These might be overcome by setting out Monitor’s high-level duties in primary legislation, with detail of how it conducts its role expressed in secondary legislation, which can be amended if unintended consequences emerge.

8.7 There will undoubtedly be a period of learning and it will be important to ensure there is an opportunity to learn and develop policy and carry out proper evaluation. We believe that the Secretary of State for Health could be responsible for regularly assessing how Monitor is fulfilling its role and duties in the interests of patients and taxpayers.

9. COORDINATION OF ECONOMIC AND QUALITY REGULATION

9.1 Ensuring close integration and alignment between economic, service and professional regulation is vital, in theory and in practice, for effective regulation and to minimise duplication and overlap, and ensure the adequate provision of safe care. For example, some elements of CQC registration already relate to the financial viability of organisations.

9.2 Recent evidence sessions at the Mid-Staffordshire public inquiry have highlighted the benefits of a single economic and quality regulator for health and social care. While this could lead to better co-ordinated economic and quality regulation, we are concerned there is a danger quality will be continually trumped by economic considerations.

9.3 On balance, the NHS Confederation believes separate economic and quality regulators are more appropriate. However, Monitor and CQC must be held accountable for how they discharge their duties to cooperate and practically work together to safeguard and promote patients’ interests effectively. We also suggest better alignment of financial incentives and quality objectives is essential to ensure better coordination of approach.

June 2011
Written evidence from The Relatives & Residents Association (CQC 19)

SUMMARY
1. The Relatives & Residents Association (R&RA) speaks up and speaks out on behalf of older people in care homes. It is the only national charity for older people providing a daily helpline which concentrates entirely on residential care for this age group. The Association has a number of key concerns about CQC. They are spelled out in this paper and they are, in short, about its failure to regulate effectively in a number of key areas:
   (a) registration;
   (b) inspection;
   (c) self-assessment;
   (d) complaints;
   (e) closure and financial viability;
   (f) the new “excellence” proposals; and
   (g) enforcement practice.

ABOUT THE RELATIVES & RESIDENTS ASSOCIATION
2. The Relatives & Residents Association (the R&RA) is a small charity which was founded in the early 90s to campaign for a better quality of life for older people living in care homes and other types of “long-term care”. Dorothy White OBE, our founder started her career in the 1940s, as a young civil servant, working with Nye Bevan to set up the NHS. She had come to realise, from her own experience with her mother in a care home, how important it was to provide a voice for those who, all too often, were unable to represent their own interests because of their frailty and dependence. Also how difficult it was for many relatives to speak up for the people they cared about because of their dependence on the home and their desire for good relationships.

3. By using the unique perspectives of relatives and residents, we work in harness with others to help improve service and standards. We also try to influence policy and practice by reflecting the experience of our members and callers who use our daily Helpline and thus can make evidence based comments on the case we make, the research and training we carry out and the policies we advocate.

4. We provide support and information through our Helpline which operates every weekday and helps older people and their relatives make better informed decisions about looking for a home, their rights under DH and other guidance and regulations, and the benefits and standards they should expect. All too often, people are totally confused about the labyrinthine system and in particular, by how care is organised and what elements of the cost have to be met by whom. Local authorities often do not give correct information and people become extremely anxious and perplexed by the complexities of an impenetrable care system.

5. We also act as a listening ear to help support families and individuals at what is often a time of crisis and trauma for them, when it becomes apparent that a partner, parent or friend can no longer live at home. We also help them when there are difficulties and complaints about the standard of care and often act as brokers between the relative/concerned individual and the care home.

6. Most of our Trustees have worked in the sector and have also had their own experiences of their own close relatives in residential care. We have a small core staff, supported by experienced and dedicated volunteers. In all its activities, the R&RA’s emphasis and mission is to put the needs of the resident first.

7. Our evidence is based on our Helpline service and our activities, including training, research and feedback about the reality of life in care homes for older people. We have submitted much, although not all, of this evidence to the Department of Health.

CQC—REGISTRATION
8. Unlike the rigorous system that obtained previously, we understand that many providers are now being vetted by being interviewed by telephone. This is allegedly replacing what should be and had been a painstaking and meticulous procedure (and face-to-face interview) to ensure the owner’s fitness to understand and operate a service for vulnerable people. We have been informed that this, like many other changes, has happened largely as a result of budgetary constraints.

CQC—REGULATION
9. Helpline and other evidence continues to reinforce our, already deep, disquiet about CQC’s manifest lack of effectiveness in several key areas, in particular:
   (a) its failure to inspect with appropriate frequency, which causes bewilderment to relatives on the role of the regulator;
   (b) the consequent loss of information for prospective residents, reinforced by the lack of up-to-date reports—an examination of the CQC website suggests that most reports on care homes are now two to three years out of date;
(c) the seeming retreat from proportionate and necessary regulation—we can provide you with a number of worrying examples of this in confidence;

(d) there is generally no response from CQC to our letters or those sent by relatives we have helped and supported; and

(e) CQC’s communications are made even more difficult for consumers by the frequent changes in terminology and jargon which means that the system becomes even more confusing for all of us.

10. People really are not interested in baffling terms like “reviews” or “site visits” or other strange distortions of language. They do not understand why schools, nurseries and prisons can be inspected but that care homes need a distinct vocabulary for this seemingly straightforward activity. In addition, the firm view of the Association, based on all our individual and collective experiences, is that the current regulatory regime is the least effective for over 25 years.

11. We see no logic in continuing to inspect children’s establishments twice a year yet failing to give the same rigour to care homes for older people, who can so rarely express their own needs. We are, therefore, calling for a statutory requirement of two unannounced inspections a year.

CQC—Self-assessment

12. In the absence of visits and with no local presence, CQC relies almost entirely on information provided by the provider when risk assessing a service and when compiling an annual review. The increased reliance on self-assessment is both unreliable and misleading (and, by the way, has recently been abandoned as a “waste of time” by the Australian regulator). Good providers see and understand where they fail or under-perform, poor ones almost by definition often have little understanding of high standards and first-class management.

CQC—Complaints

13. We are deeply worried about the effect on residents of the failure to deal with complaints. This has been an intrinsic part of regulation ever since the 1984 legislation. It was key to the Burgner report and its recommendations, which were accepted by all Parties. The importance of giving appropriate priority to complaints and giving them prompt and serious attention has been a fundamental finding from each major social care—and health—scandal for the last generation, including Longcare, Cornwall, Mid-Staffs, and now Winterbourne View, among a long and shaming list.

14. Responding to complaints had been a key component of the NCSC’s work and also for the first part of CSCI’s regime. No one can understand the logic of moving complaints investigation to the LGO, with puny resources to develop the expertise needed in this area. Most lay people see information from complaints as a major source of intelligence to the regulator about a provider, and most good providers agree with this analysis.

15. This does not, of course, imply that complaints should not be dealt with as near as possible to the source of the problem, but we know that often the management is the problem. We have regularly referred relatives to CQC where they have received little or no response, replicating and reinforcing the Winterbourne View experience, revealing that it was not an aberrant experience.

16. Serious complaints about care homes generally involve the complainant or whistle blower writing to at least five different authorities with overlapping responsibility for the service. This is not sensible or sustainable.

17. The regulator should once again be given the key responsibility for responding quickly and effectively to all complaints that affect a home’s compliance with the regulations or standards (or “compliance requirements”). They should also be required to produce an annual report detailing the type and number of complaints about care homes in each local authority area.

Closure and Financial Viability (Southern Cross)

18. Many in the field, particularly those involved in regulation have been aware of the latent current Southern Cross situation for some time. This is not only in relation to their well-known poor reputation over the years, for example in cutting costs, staff, activities and budgets. All this was in train well before the latest financial catastrophe.

19. In addition, the way in which the regulation of the corporate providers—now the majority—is managed within CQC is as we see it, for their benefit and convenience, rather than the protection of the resident.

20. We (R&RA) wrote to CQC in April, suggesting that their parlous financial situation merited scrutiny and inspection to ensure that basic services for residents were not affected. On 12 June 2011, the Observer reported that 164 Southern Cross homes had been served with improvement notices, nevertheless CQC in its response to the Association, received in June, seemed to consider that other services had a potentially higher risk of non-compliance.
21. There is also a need, as we have said, to have a clear policy and strategies, backed by regulation for all care home closures, so that public money and other resources are not employed to rescue a company characterised by such poor management and poor care.

22. Southern Cross residents are largely paid for and supported by the public purse. It would, therefore, be totally unacceptable for them to be bailed out at a cost to the taxpayer and ratepayer. Emergency legislation needs to be introduced to make it possible for local authorities to take them over to ensure stability and security for residents, pending further decisions. This can mean continuity and security for them and the staff (where they are of sufficient calibre).

23. This not unlike the role of the liquidator in the case of business bankruptcies, with the possibility for decent not-for-profit or private operators to take over the property or properties at minimum or no cost. Southern Cross shareholders should forfeit their assets and not be rewarded for playing the market at the expense of vulnerable people at the end of their lives. Others who break the law and their contractual obligations generally have to pay similar penalties.

24. Southern Cross’ irresponsible programme of acquisitions and disposals should not be rewarded. The seeming lack of knowledge or appropriate checks on their financial viability is yet another key failure on the part of this and former regulators. This has occurred, despite the fact that it has been an intrinsic part of the regulator’s role for many years in order to provide proper security to commissioners and residents. However, it was rarely properly thought through and resourced, as a result this aspect was hardly ever given appropriate status and expertise.

25. DH also needs to develop, in harness with other Departments, an appropriate Emergency Closures Strategy, so that responsibilities can be allocated and understood before disasters happen. Homes close regularly and currently have the same status in law as the corner shop or Woolworth’s. This is wholly unacceptable when the “commodity” is the care of fragile human beings. Local authorities have to plan and exercise for other unforeseen events.

THE “EXCELLENCE” AWARD

26. We have made it quite clear to CQC at a consultation meeting that we totally rejected this concept. It also appeared to be the unanimous view of all care home providers there. The proposal was roundly condemned on grounds of cost, equity, and total inappropriateness.

27. We and others at that meeting simply wished the regulator to inspect all homes on a regular basis and issue useful intelligible reports, which help care homes improve and give potential residents, relatives and commissioners the information they need. We also know that so-called good homes are often fragile and cannot be left for two years uninspected.

28. Inspectors must have a professional background and expertise in the areas they are making judgments about. We feel strongly that more resources need to be devoted to the training of inspectors so that both providers and consumers can feel reassured about their knowledge and competence. Urgent attention needs to be devoted to this in order to provide a consistent and sound basis for their judgments and reports.

29. CQCs model of a generic regulator who can assess any service leaves staff, who are unable to use their expertise, frustrated and, more importantly, leads to vulnerable people receiving insufficient protection.

30. The Australians manage to inspect each care home at least twice a year and they are also coping with a recession. They have approximately half our population and half the number of care homes and are, therefore, comparable.

31. The Association (R&RA) carried out an analysis of the star ratings used by the previous regulator (CSCI) in 2009, which were found to be inconsistent and unsatisfactory. We examined in some depth the reports written on 100 “One Star” homes. However, these reports seemed to indicate clearly that there was little common ground among inspectors, which could probably be explained by a lack of training to ensure that different inspectors had similar concepts of poor and good practice. Another concern was that many inspectors seem to have a lack of appropriate expertise in relation to care homes for older people. Unless this is resolved, there is little purpose in devising new and different systems.

32. While this system had a number of flaws, it did begin to provide prospective residents and their families with a frame of reference when seeking a home, particularly where they had no local knowledge.

ENFORCEMENT

33. We know that practice on enforcement is uneven and unreliable. Some homes are allowed to breach regulations with little or no follow-up. Our work in this area is reinforced by evidence from inspectors themselves, as well as recent research carried out and documented by the BBC. All these demonstrate clearly that there are major flaws in the enforcement process.

34. For example, enforcement notices issued by the regulator are all too often not followed up, and despite clear time-tables having been given to providers for compliance, no further action is taken. In addition, even
where enforcement action has been stated to be imminent in a report, it often does not appear to be followed up with sufficient energy or sometimes at all. This is clear from many reports we have examined.

35. Under the regulations, all homes are required to have a manager in post, a large number of homes appear to be in breach of this, which is extremely worrying for standards of care. It means that homes are being operated often with unskilled and untrained staff, with little leadership and supervision, caring for the complex needs of a frail and vulnerable population.

36. We also have a number of examples of homes which have allegedly been “closed” (also based on data received from CQC) as a result of action by the regulator and yet continue to operate unlawfully.

37. It is also evident that some homes avoid enforcement action after a poor report by voluntary closure and then appear to re-open under a different name, often run by the same failing operator. It appears that the owners of Winterbourne View may well avoid any enforcement action by having “chosen” to cease operation. It is as though a fraudster or bankrupt could avoid sanctions for the consequences of their actions by a simple name change and by stating that he/she is no longer in business. It should not be possible to manipulate the regulatory system in this way.

The Association would, of course, be happy to amplify any of the points made above either by telephone, correspondence or in person if the Clerk or members of the Committee would find that helpful.

June 2011

Written evidence from The Patients Association (CQC 20)

1. The Patients Association welcomes the opportunity to contribute to the scrutiny of the activities of the Care Quality Commission (CQC). The Patients Association is a national healthcare campaigning charity aiming to represent the interests of patients, working under the motto “listening to patients-speaking up for change.”

REGULATORY APPROACH

2. The Patients Association accepts that primary responsibility for ensuring patients receive high quality care rests with the management and Boards of provider organisations. Commissioning organisations also have a responsibility to ensure the services they commission are of a suitable standard.

3. However, it must be recognised that as the CQC provides reassurance to patients and the public about the quality of their services locally, they have a considerable duty to ensure this reassurance is reliable. It could reasonably be assumed that patients and the public will give external reassurance more credibility.

4. Furthermore, the CQC actually provides the legal basis for the provision of services.

5. The CQC uses a risk based approach to regulation. This approach is not unique to healthcare and is designed to allow a regulator to operate with less resources as it devotes its resources to organisations where there is the greatest risk of a breach of standards.

6. The CQC model relies on accurate assessment of risk to allow for a narrow targeted deployment of its inspection resources which are limited. It uses a “Quality and Risk Profile” (QRP) for every organisation which is a sophisticated analysis of all the information it holds on an organisation. The vast majority of this information is taken from third party sources.

7. Each QRP produces a score that indicates the likelihood that a particular organisation is not meeting one of sixteen essential standards chosen from all the standards against which the CQC regulates. None of the outcomes are considered to be more or less important. The expectation is that providers will be meeting all of them.

8. Local inspection teams review the QRPs of the organisations for which they are responsible. They are expected to review and decide whether an organisation is meeting essential standards but their activity and decisions will informed by the risk scores ie paying closer attention and possibly performing a site visit at organisations with one or more standards reading as at high risk of breech.

9. In order for this approach to work with limited resources the risk profiles must be accurate. They must reliably inform the inspector where they should be focusing their activity. If it rates risk highly when the organisation is compliant inspectors will waste time reviewing compliance unnecessarily. If it fails to rate organisations as being at risk of not meeting standards when they aren’t then inspectors may not review compliance and patients will continue to have to use services not meeting standards.

10. The QRP statistical model is sophisticated in how it produces scores but it can only be as effective as the underlying data about services that it is using.

11. We would recommend that the Committee reviews the quality of the data sources that the QRP uses and tries to reach a view as to whether as a whole they are produced from timely, accurate and reliable information about providers. Importantly, exploring whether detailed analysis has been done of each of the data sources eg
Patient Environment and Action Team Visits and NHS Litigation Authority ratings are reasonably well weighted in the scheme but failed to detect problems at Mid Staffordshire NHS Foundation Trust.

12. The statistical model does have an ability to recognise when there is insufficient data to produce a reliable risk score. It may be useful for the inquiry to explore how often this is the case and what action is taken if this is the case. If this is a frequent occurrence this could either place considerable demand on inspection activity as inspectors have to assume non-compliance when there is no risk score or result in the CQC providing reassurance without a risk score to inform this decision.

RECOMMENDATIONS

13. The Patients Association does not believe that the standard approach of using the QRPs is an effective approach to the regulation as there is insufficient high quality information available about the performance of NHS organisations to use a risk based approach. Hospitals are complex organisations which will have a patchwork of services, wards and clinical teams with a huge variation in quality.

14. The recent inspection programme that found 1 in 10 NHS Acute Trusts not fully compliant with essential standards of dignity and nutrition for patients highlights the scale of the problem. Most inspections reviewed care on two wards and often standards were very different between wards.

15. This was an unplanned programme of activity not part of the normal regulatory framework and represents the minimum level of intensity that the Patients Association would wish to be the norm for regulation.

16. We believe this is proportionate to the problems (eg failings in the absolute basics of care) being experienced by patients.

17. As the information agenda progresses and more high quality performance data exists a more targeted approach could be re-instigated more safely.

18. We have recommended considering the introduction of “independent matrons” based within hospitals, able to monitor and report on the issues of basic care (eg help with eating, toileting care) most pressing our Helpline callers and the public at large. As well as clinical inspection they could also collect comparable performance information at ward level to feed into wider information about the performance of an organisation. They could sit within the Care Quality Commission and later local Health Watch, acting as an independent source of clinical advice.

19. We believe this could be cost effective as monitoring of standards in this way is already an activity that Trusts should be undertaking and will increasingly be required to undertake to meet demands for information. This approach would simply represent a shift in resources for this activity to the regulator instead of the provider, providing independence and external communication of their findings. This could be accomplished through an increase in the CQC registration fees.

June 2011

Supplementary written evidence from the Care Quality Commission (CQC 02A)

I am writing to follow up several points that were raised in Committee on Tuesday 28 June.

I wrote to you ahead of the hearing stating that it was crucial to have a realistic view of the potential and limitations of regulation in the NHS and social care sectors. I am concerned that the Committee’s expectations may be unrealistic in relation to the scope of our task and the challenges facing care regulation.

The public puts its faith in those who run and work in care services—boards of governors, chief executives, senior managers, clinical directors, consultants, GPs, nurses—and in those who commission services. Poor care always features a failure somewhere along this line, often compounded by pressure on resources.

CQC’s task is to regulate against 16 outcome-focused “essential standards” and hold providers to account for ensuring these are maintained throughout people’s experiences of care. This includes seeking assurance about the mechanisms care providers have in place to listen and learn from the user experience—and to encourage their workforce to raise concerns.

Someone, somewhere always knows that care is going wrong which is why people need to tell us. As we have seen time and again, data and statistics rarely tell the full story.

I am determined to make sure CQC acts swiftly to respond to signs of poor care and takes strong action when things do go wrong. But neither CQC nor any system of regulation can offer the sorts of assurance some members of the Committee seemed to be seeking.

Providers, professionals and commissioners cannot abdicate responsibility for the quality of care to regulation. Regulation is not a panacea. Failures in regulation alone never lead to poor care unless other responsible people or bodies have failed first.
In this context, my priorities for the next year are to build confidence in CQC and raise awareness of what we can do—we must to do this to stimulate the flows of information we need to identify concerns about care. I want to see us add value to the system by giving the user voice a powerful role in holding poor care to account. We must ensure the regulatory model improves on top of the step changes we have seen in the past six months; and get up to strength and push for the resources we need to do our job properly.

We gave the Committee top line information about vacancy levels at CQC. As requested, I enclose a monthly breakdown of vacancy levels since April 2009.

As you may be aware, CQC has (in common with other public bodies) been subject to the government-wide recruitment freeze introduced after the election. The Department of Health agreed that CQC could recruit to business-critical inspector posts in October 2010. This allowed us to begin to recruit from within the NHS, other arm’s-length bodies and the Audit Commission, which we have done (these were the roles we referred to where we have recently made job offers).

We received approval from the Department of Health to recruit outside the NHS and other arms’ length bodies on Monday 27 June 2011, having exhausted that pool. We will now recruit with alacrity.

You asked about the way CQC’s senior team sets its priorities (including the reasoning behind registering dentists for 1 April 2011). I should make it clear this was not optional. This deadline was set by Parliament in secondary legislation. On my appointment I argued this was not the right course of action, but this was rejected (in part because of timing—the deadline for opening registration for the sector was imminent). We were therefore forced to meet the deadline set in law, with the inevitable impact on resources available for inspections.

The registration deadline for GPs was also set by Parliament (for 1 April 2012) but on this occasion there was real opportunity to secure change. As I explained to the Committee, I asked the Secretary of State to support a change in legislation to give us an extra year to prepare. His backing for this has been appreciated and I am going to make sure we take every advantage to address the challenges we know we are facing in terms of process and delivery.

The “bureaucratic nightmare” in terms of the way we register is largely a reflection of a complex piece of legislation. The regulations generate dozens of transactions for a single provider. The forthcoming review of regulations is our first opportunity to tackle legislation that has made our model more onerous than it needs to be.

Meeting the demands of this complex legislation with a reduced workforce—factors outside of our control—means we have worked with speed at the expense of quality. We must now address this and our achievements in the first half of 2011 give me confidence that we can do so. CQC has made a public commitment to review and evaluate its model in order to improve our processes and performance management.

The Committee asked about our meetings with providers. Our provider advisory group meets quarterly and receives fortnightly briefings from CQC. I have enclosed details of the membership. We also meet representative bodies—trade associations, and other similar organisations—on a regular basis in the course of our work. This is in addition to the day in, day out contact between providers and our front line staff. Our online provider reference group is made up of around 2,000 individual providers, drawn from all sectors. They help us develop our methods and guidance and offer a frank sounding board for CQC to improve the way we work.

The Committee suggested CQC should set and monitor expected ratios of staffing for health and social care providers. We actively look at staffing levels where they affect the quality of care and do take action where necessary to ensure services are staffed at a safe level. The Commission is not, however, in a position to mandate staffing levels across a complex range of care settings and sectors. In many cases, Royal Colleges and professional regulators have been unable to specify these ratios within their own profession. I do not believe CQC is in a better position to make these judgements and would urge the Committee to bear this in mind when drawing up its report.

The Committee also asked about the number of referrals we have made to the Nursing and Midwifery Council, and to the General Medical Council. We have Memoranda of Understanding with both bodies under which we make referrals. At present, referrals are recorded on a case by case basis but are not centrally collated. I can confirm that we have made a small number of referrals this year but we will begin to collate this data from September.

I believe this covers the main points raised by the Committee.

In closing, I want to emphasise that we are seeing month on month increases in inspection, compliance activity, and in publishing information for the public. We have undergone a step change in delivery in the past six months, free of the pressures of a new tranche in registration.
If views on CQC’s performance are tempered by realistic expectations, we are well set to maintain this positive direction. I look forward to the challenges the Committee will no doubt want to raise.

Dame Jo Williams  
Chair, Care Quality Commission  
30 June 2011

CARE QUALITY COMMISSION

CQC establishment and vacancy figures April 2009–June 2011

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Source: CQC Human Resources

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Source: CQC Human Resources

Notes

CQC inherited 55 inspectors from the Commission from Social Care Inspection that were in excess of the original planned establishment of CQC.

A decision was made in May 2009 that a voluntary redundancy programme would be run to reduce to the required establishment target and enable cost savings to be made.

CQC then delivered its operational function without any further changes to its structure or establishment until May 2010, when the CQC Field Force Model was implemented.

The Field Force Model structure allowed CQC to increase the establishment number of Compliance Inspectors and Registration Assessors by a total of 127 full time equivalents, deliver a generic skills model whilst ensuring delivery in our key operational areas of registration and compliance.

A government-wide recruitment freeze came into effect on 24 May 2010, the same month as the implementation of the CQC Field Force Model. The Department of Health do not consider CQC inspectors and registration
CQC exhausts this pool in June 2011 and on 27 June 2011 the Department of Health granted CQC permission to recruit to business critical posts from outside this pool. CQC is now in the process of advertising these business critical posts outside the pool.

CQC does not employ temps or interims in Inspector or Assessor roles because the length of time for training and the cost of that training outweighs the benefits.

Chair  
John Harwood

Providers  
NHS Confederation  
Frances Blunden  
Mental Health Network  
Shaun Clee, Chief Executive—2gether NHS Foundation Trust  
PCT Commissioning Rep  
Vacant  
Ambulance Network  
Lynne Paramour, Associate Director of Strategic Communications & PR/FT Programme  
Lead from South Western Ambulance Service NHS Trust  
PCT Network  
Vacant  
NAAPS  
John Dickinson, Head of Service NAAPS UK  
NHS Partners  
Dr Vivienne Mcvey  
Acute trust network  
Carole Heatley, Chief Executive—North Cumbria University Hospitals NHS Trust  
NHS Alliance  
Vacant  
Independent Healthcare Advisory Service  
Sally Taber  
Association of Directors of Adult Social Services  
Kieran Hickey, Assistant Director Older People & Mental Health, Derbyshire  
English Community Care Association  
Ann MacKay, Director of Policy  
National Care Association  
Sheila Scott, Chief Executive  
National Care Federation  
Des Kelly, Executive Director  
UK Home Care Association  
Colin Angel, Head of Policy and Communication  
Registered Nursing Homes Association  
Frank UrSELL

User led services  
The coalition of RADAR/Shaping our Lives/National Centre for Independent Living  
Andrea Humphrey  
John Adams  
Voluntary Organisations Disability Group