advice and support for older age
Independent Age

Care Quality Commission inquiry (Public Accounts Select Committee)

November 2015

About Independent Age

Independent Age is a growing charity helping older people across the UK to live more independent, fulfilling lives.

Founded over 150 years ago, we are an established voice for older people and their families and carers, offering free advice and information and providing services, such as befriending, to promote wellbeing and reduce loneliness.

In addition to this, we use the knowledge and understanding gained from our frontline services to campaign on issues that affect older people, like poverty, loneliness and carers' rights.

For more information, visit our website www.independentage.org

Speak to one of our advisers for free and confidential advice and information. Lines are open Monday to Friday between 10am - 4.30pm. Freephone 0800 319 6789 or email advice@independentage.org

Independent Age is also a member of the Care and Support Alliance: a consortium of over 75 organisations that represent and support older and disabled people campaigning to keep adult care funding and reform on the political agenda.

1. Introduction

1.1 We believe the Care Quality Commission (CQC) is performing more effectively than it was three years ago. Its new ratings system is simpler for the public to understand. Its reports are generally of a higher quality. We believe the CQC has made considerable efforts to put older people and other service users at the heart of its model of inspection and regulation. However, there are a number of examples where we believe the CQC could still do a better job and that is what we have focused on in this short response.

2. Independent Age's general reflections

2.1 We agree that the CQC has made a number of improvements to the way in which it registers, regulates and inspects health and social care providers. During its 2013-16 strategy it implemented a new ratings system, which we broadly agree is simpler for the public to look at to help make judgements about, and then use to choose a health or care service.

2.2 We are also pleased the CQC is regularly bringing its reports to public attention, so that where services are inadequate or require improvement, there is real transparency about where providers are slipping behind and safety may be compromised.

2.3 In addition, it is encouraging the CQC also uses its powers to comment more generally on the state of health and social care services and systemic issues that need addressing with regards leadership, quality and staffing.

2.4 However, as the CQC itself acknowledges we believe there is still some way to go before it could be described as a fully effective regulator.

Hinchingbrooke

2.5 Its approach to risk-based inspections and the work it does with regards monitoring and using intelligence to decide where and when to target its inspections needs work, especially in the area of adult social care. But even when it comes to NHS and Foundation Trusts, the CQC has been criticised for inconsistent approaches or contradictory judgements about the risks it originally says it sees in a provider and subsequent reports and ratings it then goes on to publish. The Hinchingbrooke health care trust case in Cambridgeshire is a case in point.

2.6 Prior to undertaking an inspection in September 2014 we understand the CQC spoke with stakeholders and reviewed the information it held about the trust. Hinchingbrooke Health Care NHS Trust had been identified as 'low risk' on the CQC's Intelligent Monitoring system. The trust was in band 6, which is the lowest band. However, inspections that then followed led to Hinchingbrooke being rated 'Inadequate', which then meant it was placed in Special Measures. There were very public disputes about the fairness and accuracy of the CQC reports from September 2014 and early 2015, which as an older people's charity we worry about because ultimately as the most frequent users of health and social care services, older people and their families turn to the CQC to be a reliable and trusted guide on safety and quality.

Merok Park

2.7 Elsewhere, we have concerns about the decisions CQC sometimes takes with regards enforcement action. We recognise CQC has to take extremely difficult decisions and often in the most challenging of circumstances. However, we have seen details of some cases where care homes housing vulnerable and often frail older people are closed but residents and relatives aren't always confident the communications surrounding the closure of a home have been as strong as they could have been. In the case of Merok Park, a care home in Surrey, action was taken to remove the provider's registration when grave concerns about safety meant CQC felt there was no choice but to vacate the home's residents.

2.8 While we understand enforcement action like this is never taken lightly, and shocking practices were exposed, the Merok Park case should be a real learning point for the CQC as it considers its future approach for 2016-2021, its next strategy period. Closing homes with little prior notice or when frail and perhaps confused residents aren't themselves clear on the reasons for closure must always be balanced with a judgement about whether residents face immediate risks to their safety and wellbeing. We appreciate it isn't an easy balance to strike. But in the Merok Park case, and another case like it in Sutton, we understand closures took place in such a way that residents and their families were left very distressed, and in a small number of cases elderly residents died soon after. In the future, we would like the CQC to explore whether a care home that remains inadequate after being placed in Special Measures could lose its registration status, but not necessarily have to get shut down.

2.9 Where schools fail, other teams typically come in to try and strengthen the leadership on offer and to turn the school around. With the care homes sector we would like to see the CQC appraising all the options available to it within its set of legal powers before it necessarily closes an existing care home. We are not clear whether the CQC's legal powers would permit such a course of action, but like failing schools, we would like to think a local authority team or experienced team from a networked care home that was performing well could temporarily be invited in to help the home keep functioning. This might then provide a window for the home to keep on providing an essential service, but under new leadership and as the home looks to both protect residents' safety, but also look to come out of Special Measures. We recognise this has to be a step of last resort. But at a minimum, we would like to hope where closures do take place in the future, the reasons for this enforcement action are proactively communicated to all the relevant parties, with frail and elderly residents supported weeks in advance to get ready for what could be a very distressing move.

Risk-based approach to regulation

2.10 We tentatively back the principle of a risk-based approach to inspecting providers, but as we go on to explain in the next section, we also have concerns about this approach. Where the CQC can draw on intelligence gathered from a wide range of sources including local Healthwatch, it should obviously do so. It

might not always make sense for every provider to go through an annual or comprehensive inspection.

2.11 However, we worry that in the area of adult social care, the CQC is at a serious disadvantage when it comes to monitoring risk and weighing up where it should target its inspections. We agree with the National Audit Office's recent assessment that the CQC does not have access to routine information about adult social care which is "good enough" for it to be able to monitor risk or trigger inspections[i]. Again, like the NAO, we believe the Commission needs complete data about the adult social care sector before we would be fully confident seeing it move to a model of enhanced – provider – self regulation.

2.12 The limits of risk-based approaches and intelligent monitoring were highlighted in the October 28th oral evidence session as part of the Public Accounts Select Committee's Inquiry. Members of Parliament referred to page 32 of the NAO's July 2015 Report, paragraph 3.15, about intelligent monitoring, which explained that the CQC is "working towards a surveillance model that is based on concerns that then trigger actions and target resources where the risks are greatest". We were particularly concerned to learn that when you look at page 33 of the NAO report, *Intelligent monitoring risk banding and inspection results*, it shows that of 50 acute hospitals that were considered as part of new work on intelligent monitoring, 2 in 5 of these providers who went on to be rated inadequate or requires improvement were originally contained in the lower risk bands. We understand the CQC is aware of the limits of intelligent monitoring and indeed its application to adult social care, but nonetheless we would still like to see the Commission proceed cautiously before it considers any substitute to a programme of regular, location-based inspections.

Working in partnership

3.1 We agree the CQC needs to work more closely with providers, and indeed stakeholders like Independent Age, in order that it can effectively fulfil its regulatory functions. The CQC is open and we agree that it lives up to its values of being collaborative and acting with integrity.

3.2 In some cases, working with other organisations makes perfect sense as it will allow CQC resources to stretch further. Working closely with other organisations – so for example local Healthwatch – means the CQC should be able to target resources more effectively and focus inspection activity on providers at risk of poor performance. We understand the logic behind this approach.

3.3 However, it is important to note that the CQC has been asked to model savings of between 25% and 40% for the forthcoming spending review period. It will need to be careful therefore not to promise more than it can realistically deliver, in other words focusing on its core objectives of assuring safety and taking enforcement action where service users' wellbeing is at risk.

3.4 Ultimately, the CQC has a responsibility to service users and patients. We would therefore caution the CQC against taking too light-touch an approach to regulating providers who on the surface appear to be performing adequately but

in practice are coasting. There is always the risk that an agenda which is designed to bring about greater collaboration with health and care providers in the end sees the regulator relying on these providers to self-regulate when not all services are effectively set up to do this. We trust the Public Accounts Select Committee will consider the most effective use of CQC powers, not just in terms of value for money, but also in addressing our concerns about what types of inspection and reporting activity work most effectively for the public.

3.5 We note the CQC has a memorandum of understanding with a range of organisations, and now works closely with Ombudsman services concerning how information from complaints get dealt with, and how repeat problems that get raised with the Local Government Ombudsman or Health Ombudsman end up informing CQC inspection work. We are pleased the Chief Inspector for Social Care has explained inspectors will consider how care providers handle complaints as part of the CQC's overall approach to regulation. If a care provider doesn't have an open culture which actively learns from service users who raise concerns or complaints, we believe this is a fairly strong indicator that other aspects of the service are likely to be poor.

3.6 CQC has already said it will use NICE quality standards to help inform its judgements and ratings, which is positive. But, with so many NICE guidelines and quality standards now in development, again, the CQC will need to be clear and consistent with members of the public about the degree to which it can draw on all the available data – and indeed the limits of data in areas like adult social care – which mean the public may need to look elsewhere to get the fullest possible picture of quality and safety for any given provider.

Limits of CQC action

3.7 There is a further consideration here, which is the extent to which CQC can realistically appraise adult social care providers' performance for things commissioners and funders of adult social care most obviously influence. CQC has very limited powers to regulate and review the relationship between local authority commissioning practices and care provider performance. We recognise the Department of Health doesn't intend for this set of arrangements to change. Given that, it is difficult to see how CQC can meaningfully comment on all aspects of care providers' work, because for a number of care providers it will be the below-inflation rates of care they receive and indeed poor commissioning, that drives poorer performance.

3.8 NICE guidelines on home care generally caution care providers against providing domiciliary care visits of less than 30 minutes, but with recent reports suggesting around 3 in 5 councils in England still commission home care visits of 15-minutes or less, it is hard to see how CQC can be expected to make judgements about quality and safety against every NICE standard, particularly standards which in the end are more related to local authority commissioning. The Public Accounts Select Committee may want to look at whether CQC's existing powers and an inability to regulate local authority commissioning in any way prevent the regulator from fulfilling what the public expects it to deliver. If home care providers routinely provide 15-minute, so-called 'flying' care visits, it

would be helpful for CQC to be able to interrogate the extent to which local authority commissioning is actually driving poorer outcomes for older people, and not just provider performance.

3.9 More generally, Independent Age believes CQC needs to view its role as one of assurance, reporting how registered providers are performing against the key regulations they are under a legal duty to meet. The CQC can never be the sole arbiter of quality and safety across health and social care providers, so it will need to continue finding ways of signposting visitors from its website through to other agencies that attempt to provide public information about providers' performance, such as NHS Choices, Your Care Rating; and the NHS Safety Thermometer.

Comprehensive dataset for adult social care

3.10 We believe the next strategy period will need to see the CQC – with the support of the wider adult social care sector – routinely looking to obtain data on and report key outcomes relating to quality and safety in residential care. The challenges are great, but not insurmountable.

3.11 As the CQC itself reported in its recent State of Care report, one in ten adult social care providers rated so far have been rated as inadequate on safety grounds. This covers all type of service.

3.12 Four in ten care services inspected so far require improvement or are inadequate overall (covering all 5 areas of the CQC's regulatory approach, so for example whether they are considered safe, well-led, responsive and so on).

3.13 Focusing in specifically on care homes and homes with nursing, 1 in 10 nursing homes are inadequate overall while for residential care homes, of the largest homes, amazingly nearly half (46%) require improvement or remain inadequate.

3.14 The reality is that to restore trust in a sector sometimes viewed negatively by the public and the press, care providers themselves will need to improve the information they collect on their residents' quality of life and experiences. Thinking specifically about the residential care sector, the CQC alone cannot rehabilitate the image of care homes and homes with nursing. Care providers will need to take the lead.

3.15 The NAO July 2015 report on the capacity and capability of the CQC to regulate health and social care specifically considered a comprehensive dataset for adult social care. Arguably, no such dataset exists.

3.16 With more than 25,000 locations, adult social care providers are the largest sector regulated by the Commission. Like the NAO, we agree that the Commission's ability to monitor risk is constrained because there are no national datasets comparable to those available for hospitals and GPs. It has to be worrying that only a few indicators exist to monitor some of the fundamental standards the CQC sets.

3.17 Naturally, CQC reports will always play a very significant role in enabling people to make choices about which providers they would like to receive a service form. However, we believe more could still be done to enhance the overall volume and quality of routine data on performance in adult social care providers. For example, we would like to think providers (and CQC) could look to routinely report staff turnover; residents and relatives' satisfaction with care homes; and staff satisfaction with the service they work in as proxy measures for quality and safety.

3.18 While we applaud CQC's efforts to inspect care pathways and health and care services across a single area; we still feel inspections need to be location- and provider -based.

3.19 In conclusion, we would like to see CQC building on its strong foundations. For both health and social care, that means producing timely and accessible reports. It also means being clear with the public when enforcement action is required. It means celebrating good practice where it exists; working collaboratively with partner organisations. But in the area of adult social care, critically it means responding to the challenge from the NAO, which is the biggest challenge in our view: improving the volume and quality of data about basic performance in adult social care. Adult social care is a sector under immense pressure but ultimately older people, their carers and their families need the CQC to safeguard and highlight poor performance. At the moment, it is unable to obtain all the data it needs to fulfil this role, which is why the development of a comprehensive dataset for adult social care must now be the priority.

[i] Capacity and capability to regulate the quality and safety of health and adult social care, National Audit Office, July 2015

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