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Care Quality Commission – Health Committee report and action taken

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Overview

The Commons Health Committee’s annual review of the Care Quality Commission (CQC) involved interviews with CQC representatives, and written information from interested parties including the Association of Directors of Adult Social Services, the NHS Confederation, Mencap and the Patients Association. This information was summarised by the Committee as expressing ‘frustration’ with the CQC and ‘lack of confidence in its ability to execute its main functions efficiently’.

The Care Quality Commission assumed its role in April 2009, replacing three organisations – the Healthcare Commission, the Commission for Social Care Commission and the Mental Health Act Commission. The organisation’s budget was considerably less than the total of its predecessors – the yearly funding was reduced from around £240 million to £160 million. At the same time, it was required to introduce a new, universal regulatory regime in which health and social care providers were registered against essential standards, to be followed by risk-based inspections. The timetable for registration was:

- by April 2010, 378 NHS providers
- by April 2011, 13,000 adult social care and independent health care providers, 8000 dentists and 350 private ambulance services
- by April 2012, 8000 providers of primary care (GPs, out-of-hours, and NHS walk-in centres).

The Committee found that over the past year, the CQC’s decision to divert resources from its core function of inspection to registration meant that the number of inspections fell by 70%. While recognising that the CQC felt obliged to meet the deadlines required by regulation, the Committee concluded that this represented ‘a significant distortion of priorities’ and that the CQC had failed to meet its main statutory duty to ‘protect and promote the health, safety and welfare of people who use health and social care services’. It was critical of senior leadership for failing to raise the problems ‘persuasively and persistently’ with the government.

The Committee also considered problems with elements of the CQC’s work such as the registration process, the inspection process and the public information available...
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on adult social care – ‘unhelpful and often out of date’. It also recommends that the Adult Social Care Excellence Award, the proposed replacement of ‘star ratings’, should be dropped.

The CQC indicates that the number of inspections is now increasing rapidly. It has also launched a consultation on proposals to simplify and strengthen the regulatory model to increase the focus on inspection. The consultation runs until 9 December 2011.

LGiU affiliates will be aware of wide-ranging concerns about the work of the CQC which have been reported through the bi-monthly health and social care round-up. The Health Committee’s report formalises these concerns. The highest profile example is the abuse at Winterbourne View learning disability hospital. In the Committee’s report, the CQC’s response to this was described as ‘woefully inadequate’. The main implication for local authorities of unacceptable performance in the regulator is that even more focus needs to be given to monitoring the quality and safety of commissioned services.

LGiU affiliates may also be interested in a policy briefing on the CQC's annual report on the state of social care which is also being published.

Briefing in full

The Committee's conclusions and recommendations

Imbalance between registration and compliance activity

The Health Committee identified the following factors as contributing to the imbalance between registration and compliance activity.

- The CQC was set up without a sufficiently clear and realistic definition of its priorities and objectives.
- The timescale and resource implications of the CQC, particularly its new legal requirement to licence providers, were not properly analysed.
- The registration process was not properly tested or proven before being rolled out.
- The CQC failed to identify the implications of these failures adequately to ministers, Parliament and the public.

Much of the thrust of the report focuses on the last factor – the role of the CQC itself. The CQC has had long standing vacancies, and the Committee concluded that the eight months taken to recruit 70 extra inspectors since the Department of Health gave permission in October 2010 was ‘unacceptable’ – the CQC should have been pushing the government for permission to recruit outside an initial limited pool much
sooner. This ‘failure to react with urgency’ severely undermined the organisation’s capacity to carry out its functions adequately.

By July 2011 the CQC had registered around 23,000 organisations in 40,000 locations. There had been some delay in registering dentists and private ambulance services. Negotiations between the CQC and the government eventually brought about delays to the registration timetable – the government announced in August that, following consultation, GP registration has been postponed until April 2013 (except for out of hours services which stay on the April 2012 timetable). However the Committee believes this has come too late. It recommends that the government and the CQC should set out what discussions were had and why action was not taken earlier to modify requirements.

The Committee welcomed the fact that inspection levels are now rising, but pointed to outstanding challenges this year – the need to register the remaining dental providers and ambulance services followed by out-of-hours primary care, as well as dealing with constant applications to vary registration. The Committee recommends that to maintain the confidence of the public, the CQC must demonstrate that it is prioritising its compliance activity. It also expects to see clear evidence by next year that the CQC leadership is openly acknowledging challenges and setting priorities that reflect its core duty regarding the safety and quality of care.

The Committee noted the CQC’s request to government for an additional 10% (£15 million) of its budget to increase inspections. Due to its concerns about how the CQC has managed resources, it does not believe that further funding will address concerns unless it is deployed as part of a clear strategy. It therefore seeks a breakdown of how the CQC arrived at this figure and how it intends to deploy the funding.

**The registration process**

The Committee found significant problems with the registration process itself. Feedback from those involved indicated that it was cumbersome and overly-bureaucratic; communication was poor, the CQC did not appear to fully understand previously unregulated services such as dentistry and private ambulances, and it adopted a one size fits all approach. The Committee states, ‘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’. It is also critical that the CQC launched the process of registering dental practices without sufficiently proving the registration model. It strongly recommends that each future extension of the scope of registration should be thoroughly piloted.

On registration it is worth noting that over the summer the DH ran a consultation on proposals for changes to registration requirements to streamline the process. This included:
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- changes to regulation of fitness of provider so that if a provider is a partnership it would need to have relevant skills and experience as a collective body rather than each individual member
- a minimum threshold of four weeks annual activity beneath which providers of personal care would not need to register (e.g. holiday volunteers)
- removing the requirement for providers of home care arranged by Independent User Trusts, parents or carers to be registered with the CQC. Only home care provided by an agency or a provider arranged by another body e.g. local authority or NHS would be required to register.

The CQC has estimated that the proposals would take several thousand individuals out of the scope of registration.

**Inspection and review**

The Committee indicates that the CQC needs to address growing inspector caseloads through recruitment and that greater support should be given to allow inspectors to focus on frontline duties. It believes it is right that the CQC should operate a risk-based system with unannounced inspections at the core of compliance assessment. It welcomes the CQC’s intention to undertake annual assessments of each provider and indicates that the regulator should monitor its performance against this target and report on performance quarterly.

The Committee expects the CQC to address its problems in providing data and analysis about its compliance activity. It makes a number of recommendations about how the CQC can seek to improve the information by which it comes to conclusions about providers, such as Quality and Risk Profiles. The Committee believes it should be a key part of the inspection process to ensure that the culture of each provider organisation reflects the obligation on healthcare professionals, and staff generally, to raise concerns about failures in standards.

The CQC should ensure that its procedures mean that it follows up all serious concerns – such as those raised at Winterbourne view. The Committee believes that the CQC should be obliged to carry out investigations in response to a recommendation from its forthcoming HealthWatch England subcommittee (rather than just having to consider the recommendation.)

**Public information about adult social care**

The Committee found that CQC information on adult social care providers is ‘unhelpful and often out of date’ meaning that the public faces difficulty in making informed choices about providers. The delay in developing provider profiles is ‘further evidence of a lack of control within the organisation’.

The Adult Social Care Excellence Award is the proposed successor to the quality rating scheme for providers. The award would be given to providers who meet standards of excellence above minimum standards. Providers would apply for the award on a voluntary basis, and assessment would be carried out by a third party organisation on behalf of the CQC, paid for by the provider. Evidence to the
Committee from professional and service user organisations widely opposed the Award. The Committee shared the concerns and recommends that the project be dropped. (The CQC ran a consultation on the award earlier this year, and the feedback was overwhelmingly negative; it has indicated that it will report back on the final scheme before the launch in April 2012.)

Reaction and follow-up

The Department of Health has indicated that it expects the CQC to consider the recommendations in the report carefully and that it will respond formally to Parliament in due course.

There will now be a formal focus on how the organisation manages its finances. The CQC is to give evidence to the House of Commons Public Accounts Committee in December. The National Audit Office has also started a short value for money study on the regulator.

In its response to the report, the CQC indicated that the Committee had highlighted the range of challenges it faced, including ‘aggressive Parliamentary deadlines’. It acknowledged that registration had been ‘a difficult process for everyone involved’ and pointed out that inspection figures are rising rapidly now that the social care registration is complete.

The CQC had previously indicated that it would start a programme of inspections of the 150 learning disability hospitals and related services this October, following a pilot in September.

The measures it is taking to increase inspections require changes to guidance on its judgement framework and enforcement policy, so it has launched a public consultation. The main proposals are described in the next section.

CQC consultation

The CQC intends to inspect most social care, independent healthcare, NHS acute hospitals and NHS ambulance trusts at least once a year. In other NHS trusts, the plan is to inspect one type of service at least once a year. Dental services would be inspected at least once every two years. Inspections would be more targeted to take account of the nature of the care provided, the current level of information about the service, and risks to people using the service. The CQC may focus on a smaller number of standards rather than assessing against all 16 key standards every year. Specific proposals include the following.

- Following inspection, the provider will be judged compliant or non compliant – a change from the current position in which a provider can be compliant but required to take improvement actions.

- Inspections will be focused on identifying areas of non-compliance rather than looking for evidence of compliance as at present.
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- If a provider is judged non-compliant, the level of impact on people who use the service (minor, moderate, major) will inform the regulatory response. This reverses the current position in which a judgement about compliance is made after the level of concern about service users is identified.

- There will be a clearer, more transparent enforcement process through ‘the enforcement escalator’ in which failure to respond to compliance or enforcement actions will usually result in an escalation of enforcement activity. Unlike the present regime, the CQC will not normally extend the timescales given to achieve compliance or issue a second compliance action to follow up a previous action. However, activity will remain proportionate, and there will be discretion to take individual circumstances into account.

- Where the CQC issues a warning notice for non compliance with a regulation it will publish a summary of the notice and refer to it in the compliance report (unless representations about the notice are received and upheld). Currently warning notices are not mentioned in the report which can leave people who use the service concerned that the regulator is not acting on information received.

Comment

Bringing together the regulation of health and social care was a laudable aim, but was the merging of three bodies into a ‘super regulator’, while reducing funding and changing the regulatory regime ever going to be seamless? Some may have thought so, but frankly it was never likely. Also, concerns were expressed when it was first proposed to replace the generally effective quality ratings for adult social care providers without a proven successor, and these concerns have been justified.

Lack of planning and analysis before implementing large-scale organisational change; expecting new organisations to undertake huge new challenges in a tight timescale – this may sound familiar to those involved in NHS reform.

The job of the regulator is not easy. Its predecessor the Healthcare Commission, despite its greater resources and dedicated health focus, has been criticised during the inquiry into the death rate at the Mid Staffordshire Foundation Trust for failing to warn quickly enough about the seriousness of the problems. In evidence to the inquiry the former chair of the CQC who resigned in 2009, Baroness Young, explained that the CQC was, ‘a regulator in a very difficult position, with government, accountable to government, but responsible really to the public, with less resource to regulate effectively, and services being more at risk’.

And yet it can be noted that the financial regulator Monitor received a positive appraisal from the Health Committee in its annual review. It could be argued that Monitor’s role is significantly less diverse than that of the CQC. However, previously
Monitor has shown itself as willing to not always follow the government line when it felt this was necessary. It is possible that the CQC could have benefited from adopting more of this approach.

A regulator with low credibility in the eyes of government, professionals, service users and the public serves the interests of only one group – poor providers. It also places additional burdens on local authorities who, in the absence of up to date inspection information, have been heavily reliant on internal mechanisms for monitoring contracted organisations.

It is essential that the CQC moves beyond this difficult situation to provide a robust regime of inspection that once again ensures high standards. It is equally essential that the regulator takes a measured approach and does not try to improve its reputation through a heavy handed regime. Listening to the almost universal criticism of the Excellence Award would be a good start.

For more information about this, or any other LGiU member briefing, please contact Janet Sillett, Briefings Manager, on janet.sillett@lgiu.org.uk