**CQC proposals for new approach to inspecting social care services**

29 October 2013

Fiona Campbell, LGiU associate

**Summary**

- The Care Quality Commission has announced proposals for a new system for monitoring, inspecting and regulating social care services and for monitoring performance ratings.

- A new approach to monitoring the finances of some adult social care providers will be introduced - those that would be difficult to replace if they were to go out of business.

- The changes will be introduced under the leadership of the new Chief Inspector of Adult Social Care, Andrea Sutcliffe.

- CQC will be carrying out formal consultation on the proposals in Spring 2014, some changes will be introduced from April 2014 and tested in Summer 2014, with all the changes including new ratings of care providers in place from October 2014 (subject to enactment of the Care Bill).

- Advance publication of the proposal provides an opportunity for local authorities to develop their thinking and consult their local community, including service users, carers and service providers on the proposals and on ethical issues arising from them.

- This briefing will be of interest to directors of adult social care and their senior staff, including commissioners and procurement staff, portfolio holders for adult social care and health and chairs of health and social care scrutiny.

**Briefing in full**

These proposals (have been developed against the background of recent changes to the way in which CQC regulates health and adult social care services, following criticism of the mismatch between its findings and some recent news stories and reports of very poor care. These changes include:

- the introduction of a Chief Inspector
- the development of expert inspection teams
- a ratings system
• a focus on highlighting good practice
• what CQC calls “a commitment to listen better to the views and experiences of people who use services”.

Alongside these proposals, CQC has also published its analysis of the responses to its recent consultation, *A new start*. This described CQC’s future operating model represented in the diagram below:

CQC has concluded that the responses it has received to *A New Start* indicate strong support for the new framework, principles and operating model that it proposes to use, including the **five key questions** that it will ask of services:

• Are they safe?
• Are they effective?
• Are they caring?
• Are they responsive?
• Are they well-led?

The services covered by these proposals and for which the Chief Inspector of Adult Social Care will have specific responsibility are:

• care home services with nursing
• care home services without nursing
• specialist college services
• domiciliary care services
• extra Care housing services
• Shared Lives (where people with care needs are looked after in the homes of other residents in their community)
• supported living services
• hospice services
• hospice services at home.

The proposals
The document points out that the social care sector is very varied, with a large number of providers, including both the private and voluntary sectors, different types of care provided and, importantly, “a lack of consistent, high-quality data”. This means that CQC will need to consider carefully the type of information it uses to trigger and guide inspections and how this can be improved to ensure that its “scrutiny is robust without imposing an unnecessary burden on small providers and enterprises”.

The personalisation of care and the importance of integrating health and social care services are acknowledged and the document proposes that the quality of each of these should be a consideration in assessing the effectiveness of services.

The need for a “culture of quality, safety and openness” in residential care homes is emphasised in the proposals. One way for this culture to flourish, CQC believes, is to encourage care home providers to think about how they can be more involved with their local communities, for example by organising a ‘twinning’ relationship with a local school. The role of Healthwatch and its use of ‘enter and view’ powers will also be considered. It is also in discussion of this issue that the controversial suggestions of making use of ‘mystery shoppers’ and hidden cameras are introduced – it is these suggestions that have received most media coverage.

CQC accepts that assessing the quality of care delivered in people’s own homes, which is a hugely increasing part of the sector, is much more difficult to assess comprehensively than care delivered in residential care homes. The document acknowledges that more needs to be done to assess care provided in people’s own homes.

The document outlining the proposals lists 10 “top changes” that would take place.

1. More systematic use of people’s views and experiences, including complaints.
2. Inspections by expert inspectors, with more Experts by Experience and specialist advisors.
3. Tougher action in response to breaches of regulations, particularly when services are without a registered manager for too long.
4. Checking providers who apply to be registered have the right values and motives, as well as ability and experience.
5. Ratings to support people’s choice of service and drive improvement.
6. Frequency of inspection to be based on ratings, rather than annually.
7. Better data and analysis to help us target our efforts.
8. New standards and guidance to underpin the five key questions CQC asks of services – are they safe, effective, caring, responsive and well-led? – with personalisation and choice at their heart.
9. Avoiding duplicating activity with local authorities.
10. Focus on leadership, governance and culture, with a different approach for larger and smaller providers.
Other ideas that CQC wants to discuss as part of its consultation are as follows.

1. Better use of technology to capture people’s views and experiences.
2. Specific guidance on expectations for the induction and training of staff who work in adult social care services.
3. How we might encourage services to be more open and better integrated with local communities creating an open culture that helps demonstrate a service is well-led.
4. Allowing providers to pay for additional inspections if they believe the quality of their service has improved.
5. Finding a better way of regulating supported living schemes.
6. Potential use of mystery shoppers and hidden cameras to monitor care, as mentioned above.

Ratings
It is proposed that, as indicated in A new start, providers of care will be rated in one of the following categories:

- outstanding
- good
- requires improvement
- inadequate.(this may be changed to ‘poor’ following consultation).

Operation of the ratings system is to be outsourced to ‘rating providers’ subject to enactment of the Care Bill currently before Parliament.

If legislation, consultation and evaluation of the ratings system permits, CQC will begin to award shadow ratings in Summer 2014. It anticipates that all adult social care services will be rated by March 2016.

Registration
CQC makes a commitment that the registration process will:

- make sure providers have the right values and motivations for providing care, as well as the right skills and experience.
- be flexible and will not stifle innovation or discourage good providers of care services
- ensure providers understand the commitment they are making and the consequences of not meeting registration requirements.

Inspection
The inspection process will change in a number of ways to include the following.

- The frequency of inspections will be based on previous ratings backed up by a ‘surveillance model’, rather than being based on an annual inspection.
- Inspections will be carried out by ‘expert inspectors’.
• Use insight from various sources to target where, when and what to inspect, for example trigger factors such as a change in ownership.

• There will be a much stronger focus on ‘leadership, governance and culture’.

• Integration with health will be a factor in assessment.

The proposals contain a separate section on listening to people’s views, complaints and whistleblowing, making it clear that CQC wishes to facilitate all of these and to ensure that it responds to them and to other information and evidence in the inspection and assessment process.

Guidance and standards
CQC proposes to develop guidance on how it will rate care services. The guidance will be tailored for each sector and for some services within each sector. It will also consider how to use accreditation and kite marking and whether to give specific guidance on the induction and training qualifications it expects care professionals to have.

The document also points out that the Department of Health has recently consulted on proposals to take tougher action to hold directors or leaders of organisations to account for failures in the quality of care. This is subject to further legislation (in the Care Bill), but in any case CQC says that it will take tougher action in responses to breaches in the quality of care.

Monitoring the finances of providers
Following recent events, including the failure of Southern Cross, a large care provider, CQC expects to monitor the finances of some providers, from April 2015, subject to the Care Bill. The Bill is intended to:

• clarify the duties on local authorities to ensure continuity of care for those receiving care in their area if their care provider fails

• establish CQC as the financial regulator for the sector overseeing the finances of an estimated 50 to 60 care providers that would be difficult to replace were they to go out of business.

Support for CQC staff
The qualifications of CQC inspection staff have been questioned in recent media and other commentary. The proposals make certain commitments to developing specialist inspectors of adult social care staff and to supporting staff in understanding up-to-date evidence on good practice and receiving training on the Mental Capacity Act and safeguarding.

Comment
The LGA has broadly welcomed the proposals as “a move away from a tick box approach to care inspections towards a more integrated system of care monitoring”. It has also welcomed the proposals to address issues of market failure. Other commentators have largely concentrated their comments on the suggestions about hidden cameras and mystery shoppers. For example, Carehome.co.uk, the guide to care homes, warned of the possibility of “a Big Brother culture where people are afraid to do this vital job [of caring]”.

It is to be welcomed that CQC has explicitly recognised in these proposals that there is more to adult social care than residential care or care in people’s own homes, including community-based services for people with a learning disability; extra care housing services, Shared Lives schemes, and supported living services. The proposal document makes a commitment to inspecting and regulating all of these forms of care in ways that are “sensitive to their differences but retain a common purpose”.

As the proposals acknowledge, millions of unpaid carers play a critical role in delivering social care. The document makes a further commitment to involving unpaid carers in its work, which is to be welcomed.

As noted above, the most controversial suggestions that are raised as part of the proposals are the use of ‘mystery shoppers’ and, especially, hidden cameras. It is suggested that discussion of such techniques is needed by the public, by providers and by CQC. The vital question is whether the use of such techniques would contribute to promoting a culture of safety and quality, while respecting people’s rights to privacy and dignity. Recent scandals, such as the abuse uncovered at the Winterbourne View care home, suggest that these techniques might well reveal abuses at an early stage and, if it was known that they were generally in use, might act as a deterrent to abuse and ill treatment which themselves infringe people’s rights to dignity and privacy. But is the general use of such techniques justified in terms of what might be sacrificed, particularly where there is no specific suspicion of abuse?

There is no clear right or wrong answer as to how far techniques to promote safety and quality should go – this is surely an ethical issue and a matter for a public debate about what we value as individuals and as a society and about what trade-offs we think are merited between different goods. How much of our parents’, our children’s or our own privacy should be given up to ensure their safety? Does it make a difference whether privacy is given up to the state, to private providers or to altruistic and/or charitable groups? Recent innovations in telecare have raised similar questions – for example, is putting sensors in someone’s home to trigger an alarm when they get out of bed, or fail to open their fridge an acceptable encroachment on their privacy, if it protects a mentally and physically vulnerable person? Together with the wider issues of privacy that are raised by technological innovations such as social media, these proposals provide fertile ground for an extensive and interesting public debate.

Facilitating public understanding and exploration of the issues raised by these proposals is not something that can happen in a couple of week. Aside from the highly-publicised suggestions in relation to hidden cameras and the like, there
are other important issues on which it will be important to seek the views of all those with an interest, which includes pretty much the whole population. Local authorities can, therefore, usefully use the time between now and the launch of the official consultation on the proposals to initiate and facilitate a local debate among their residents, which includes but is not confined to service users, their families and carers, social care professionals and providers. Involving the local print and broadcast media, as well as social media may help to make the debate as inclusive as possible, as well as other engagement strategies with which local authorities will be very familiar. There is clearly a role for local Healthwatch, as well as potentially for health and social care scrutiny committees in facilitating, overseeing and systematically gathering views and ensuring that the views of people who are seldom heard, are enabled to contribute.

At the same time, local authorities will need to think about the extent to which they themselves need to monitor and assess the care they commission and how they can work with CQC and with other local groups such as Healthwatch in doing so. One of the “top 10 changes” CQC wants to introduce is avoiding duplication with local authorities. When two different organisations are carrying out similar roles, duplication is certainly a danger, but so also is the creation of gaps, especially when both types of organisation are financially hard pressed. Very efficient liaison and communication between CQC, its regional representatives and local authorities will be important factors in making the new system work.

Some of the proposals will only become clear when more flesh is put on their bones. For example, CQC acknowledges that it needs to work with people to define what its ‘five key questions’ (listed in the introduction above) will mean for its inspection system. For example, what standards will it use to assess whether a service is safe? The ratings system will also need to be developed fully, with clarity about what will quality a provider as meeting each of the four categories. It will also be important, therefore, for local authorities to develop a view on these issues, as well as on the more controversial issues which have had the most media coverage.

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