CMA
Competition & Markets Authority

CYGNET/CAS MERGER INQUIRY

Summary of hearing with the Care Quality Commission on 20 June 2017

Background

1. The Care Quality Commission (CQC) said that its role in the health and social care sector was to independently assess the quality of care that patients could expect to receive in the facilities where they are being looked after. Therefore it acted as an independent quality regulator across the sector.

2. It said the inspection of mental health services was consistent between the NHS and independent providers. However, when the CQC developed its new approach to inspection, it focused initially on NHS trusts.

3. The CQC said that it did not have any regulatory responsibility with regards to funding or commissioning and hence could not shape commissioning behaviour directly. CQC inspectors may interact with clinical commissioning groups (CCGs) in the local areas when conducting fieldwork. The market was shaped by how supply and demand interplayed locally.

4. The CQC's focus was on the quality of care that a patient could expect. Although it wanted to see commissioning based on quality of care and outcomes, it did not shape the market. The outcome of a CQC inspection was an overall rating but within it there were component parts. The CQC's five lines of enquiry that underpinned all of its inspections were whether a facility was safe, effective, caring, responsive and well led.

5. The CQC said it operated a register and any new facilities opening or closing would be captured by this. The CQC said that for a new facility, it would look at the environment and staffing, along with the policies and procedures in place. It aimed to inspect the facilities when they became operational to ensure that they were operating adequately and that the policies and procedures were being implemented.

6. If the CQC had concerns about the quality of provision, it could impose a restriction around further referrals. However, it emphasised that facilities received an overall rating and within a facility there may be a number of different wards and types of ward which may or may not have issues of

concern. Therefore Commissioners would seek to understand the specifics of individual wards if they were thinking of making or not making a referral.

Capacity and trends

7. The CQC said it could and had taken capacity out of the market or local area (ie restricted admissions or closed a ward or facility) if it was not satisfied with the quality of the service. However, the CQC had no other role or responsibility in what capacity was available.

8. It stated that capacity was a key limiting factor with regard to where patients were placed. It would like to see all commissioning based on quality of care and outcomes. However, in reality it was frequently driven by where capacity existed to cater for the condition that was presented.

9. At present the patient was often remote from the funding authority due to capacity constraints in the local area and this presented a problem regarding how frequently reviews of care plans and patients could be conducted. Therefore, if services were provided more locally/in area, the geographic barrier would be removed and Commissioners, and staff working in local provider services who might be expected to provide aftercare, would be closer to the patients. This would result in greater focus on individual care pathways and particular outcomes could be more targeted.

10. There was a desire to reduce out-of-area placements. More local provision of facilities would help. Supply drove where placements were made. The CQC said that mental health was more likely than other health sectors to have to re-engineer provision. It was not impossible for locations to be re-engineered to provide different service types. The care pathway where patients progressed through the system to live as close to community settings as their circumstances allowed did not necessarily fit in with the traditional hospital setting. Therefore there was the question of how a provider could change their offering and reconfigure their wards, perhaps to other care types if there was demand.

11. It gave examples of collaboration between the independent and public sectors, for example in the North West where there was an arrangement with Alternative Futures to care for people in independent hospitals through a block contract, but the mental health support was provided by the NHS and in London the accommodation was provided by a housing association, but the clinical input was provided by the local authority.

12. It mentioned that a CQC rating of outstanding was often linked to innovation. The CQC had seen pockets of outstanding provision in locked rehabilitation but not more.

Providers

13. The CQC said that it did not matter if the provider was large or small, the challenges seen across all providers could be equally difficult. It thought that one of the advantages of scale could be in being able to have the additional infrastructure to support the teams, but that could be balanced out with remoteness of management and a lack of knowledge regarding what was going on in particular locations. The CQC emphasised that the strength of the provider depended on individual culture and management abilities in connection with what systems were in place.

14. The CQC mentioned that when a new facility was opened as part of a larger corporation, the CQC may have a better understanding of their approach and support systems. However, any new facility would have to build a presence in the local market.

15. The responsibility for driving improvement rested with the provider, not the CQC. However, the CQC would sit down with the major groups and go through the results of its inspections with them at the top level, as well as at a local level to understand how providers proposed to drive improvement. It said that if there were common trends coming out of the assessments, it would want to understand what the corporate action plan was to ensure that patients would receive the quality of care that they had a right to expect.

16. If a provider received an ‘inadequate’ rating, the CQC would follow up with the provider, but it stated that ‘requires improvement’ was a broad category and it could be that the facility was more towards either the good or bad end. Hence the facility would be under scrutiny, but the level of concern would depend upon where on the spectrum it fell.

Trends and local markets

17. The amount of NHS provision had reduced and it had been picked up by the independent or third sector. Independent providers were being increasingly challenged by budgetary pressures manifesting in reduced fees even in the more specialist sectors, of which mental health was one.

18. The provision of NHS rehabilitation services, and the likelihood that they may expand, depended on local decision making and local markets. Even where

change of policy or approach is national (eg in light of Winterbourne View and its impact on LD provision), decisions are still driven by local capacity.

19. All providers were focused on the level of demand to support particular wards and innovation was about understanding what was needed locally and then what the provider was able to do.

20. CQC said pricing and how terms were negotiated was down to the interaction between CCGs and providers. There were a number of block contracts in place. Some for legacy reasons, but also in response to the needs of the local market. However, the vast majority of purchasing appeared to be done on a spot basis.

21. The providers both had a good background on quality. Whether a merger worked or not depended on the adequacy of the integration plan and the extent to which it was resourced, along with the relationships with the Commissioners and what available capacity was like in the local areas.