



Department
for Business
Innovation & Skills

**FOCUS ON ENFORCEMENT
REGULATORY REVIEWS**

Review of the Adult Care Homes
Sector

OCTOBER 2013

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Executive Summary of Findings

- **No one in the sector significantly challenged or questioned the current regulations.**
 - Concerns raised by the sector related mostly to the way in which the regulations are enforced and to the way in which commissioning roles are exercised.
 - The sector recognises the importance of independent assessment for public confidence, and the role of the regulator in this context.
- **Providers are experiencing significant duplication of activities by local authorities and the Care Quality Commission ('CQC'), and say this is taking them away from providing care.**
 - This is described by the sector as being a significant and widespread problem – and one which imposes some unnecessary burdens on providers.
 - Most in the sector have not talked about the cost of this burden – but rather that it is forcing them 'to provide paperwork not care'.
 - There seems to be very extensive duplication in some localities with local authorities asking for information covered by CQC's framework of *essential standards* – suggesting direct duplication of CQC's activity.
 - Businesses reported that some local authorities are asking homes to provide huge amounts of information. We were told of information returns of 50 pages and more, with one quality monitoring document that was 178 pages long, replicating the CQC's 28 Essential Standards and requiring evidence on each of those standards.
 - Some information requests from public authorities¹ seem to be placing conflicting requirements on providers – leaving them uncertain about what is required in order to be compliant.

¹ The relevant authorities in this context include CQC and those commissioning places for residents such as local authorities and Primary Care Trusts (replaced by Clinical Commissioning Groups since the fieldwork for this review was carried out).

- Efforts to minimise information burdens and to coordinate between different public bodies are better in some areas than others – but this can also lead to increased uncertainty for homes that deal with multiple authorities.
- We have been told of examples of even quite small homes providing information to 7 different public bodies (CQC, 4 local authorities and 2 Primary Care Trusts²).
- **There is evidence of a lack of co-ordination between the CQC and commissioners of places in homes – contributing to the burdens imposed on providers, and meaning it is unlikely that best use is made of information available to public agencies to aid effective enforcement.**
 - The evidence we heard suggested that in at least some areas, there is very limited joining up and information sharing taking place between public agencies.
 - In areas where there is better joining up and co-ordination this seems to depend largely on the individuals on the ground on both the CQC and the local authority side.
 - A protocol was produced to support joint working between CQC and local authorities a couple of years ago – our findings suggest this is not a live document that is actually being used in many areas.
 - We were told by local authorities and social workers that they are generally not consulted by the CQC before CQC carry out their unannounced inspections.
 - We were told that CQC do not favour joint inspections, that they are reluctant to share their programme of planned inspections with local authorities, and similarly do not feel it is appropriate to share their quality and risk profiles.
- **The current pass/fail approach to assessing and reporting compliance is felt by the sector to have serious limitations.**
 - It is felt to be driving behaviour to deliver compliance, not quality.

² Primary Care Trusts have been replaced since the fieldwork for this review was carried out. The bodies carrying out the functions relevant to these findings are now the Clinical Commissioning Groups.

- It doesn't distinguish 'good' from 'acceptable'.
 - It provides (at best) limited incentives to improve – and arguably for some homes that are on the right side of the compliance / non-compliance boundary it provides no incentive to improve.
 - The lack of any finer grading seems to be one of the factors leading local authorities to duplicate CQC's activity, as they seek to differentiate the quality of providers to inform their own decisions, or to inform the decisions of citizens who are choosing a care home.
 - The sector claims that the absence of any quality grading makes it hard for the commissioners of care home places to differentiate their payments and pay more for better homes³.
- **The sector feels there is varied capability amongst inspectors.**
 - Some were described as not being sufficiently knowledgeable about care homes, described as not being specialists and having no background in the sector.
 - In the early days of CQC in particular there was felt to be a lack of expertise in the residential care sector among inspectors.
 - It was argued that this is not helped by the breadth of the role that CQC carries out and the breadth of the essential standards (covering hospitals, care homes, GP surgeries and dentists).
 - There were reports of inconsistency in judgements and assessments.
 - The sector would welcome procedures that can offer a degree of independence in reviewing regulatory decisions, outside the current costly legal appeals process. Providers told us that they generally do not appeal decisions currently because it simply involves asking the inspector to revisit their own decision.

³ Note: The Department of Health has now announced there will be a graded system of assessment with quality descriptors.

- **Some in the sector felt there was too much focus on paperwork by regulators and those commissioning places, and not enough on assessing the actual standard of care⁴.**
 - They felt that public agencies were looking more at paperwork and policies than at the actual standard of the home.
 - They felt that assumptions were sometimes made based on the absence of paperwork, without testing apparent issues in discussion or by looking for other evidence of performance.
 - The sector felt that assessment needed more focus on the actual care provided and on the experience of residents. However there were also some reports of improvements in this context.
- **There is insufficient distinction in CQC's handling of major and minor non-compliance issues.**
 - The sector said there is insufficient distinction in CQC public reporting of non-compliance between major and minor non-compliance issues.
 - This can have a disproportionate impact on the reputation of a home arising from minor non-compliance issues – as they are publicly identified as being non-compliant.
 - The sector told us that minor issues can sometimes be resolved promptly by a home, but that they can still be tarred as non-compliant whilst they wait for a reassessment – which impacts on business.
 - The sector said that re-inspection does not occur quickly – and can mean they are 'tarred with the non-compliant brush for the entire cycle before the next inspection'.
 - The sector also pointed out that this reduces the regulatory incentive to fix the issue promptly.

⁴ Note: it is not clear how far this is a commentary on CQC's activity as the regulator, and how far it may be coloured by the behaviour of local authorities as described above.

- **There is some interest in the potential role for accreditation / standards.**
 - For homes themselves.
 - For improving services that are helping homes build their capability (e.g. after failing to meet compliance standards).
- **CQC statements about their direction of travel have generally been welcomed by the sector.**
 - Felt initially that CQC gave the sector no credit and no trust.
 - Sector reported that they feel that trust is now improving and has generally welcomed the CQC's new strategy document.
- **Some among the wider public feel there is a need for additional regulatory measures in the sector.**
 - There are some among the general public, and representing residents groups, who feel that more regulation and inspection is needed in response to recent high profile failings.
 - Some have questioned whether CQC has used its full powers, like closure, as often as they should have.

Background

Purpose of the Focus on Enforcement Reviews

1. This paper summarises the findings from the Focus on Enforcement review of the adult care home sector. It examines the impact and experiences of regulatory enforcement, and is one of a wider series of sectoral reviews looking at how regulation is delivered in specific parts of the economy. Each review is a short investigation of the evidence relating to business and other stakeholders' experience. The evidence is gathered by a small review team during a fieldwork phase which typically lasts around 6 to 8 weeks.

2. The purpose of this paper is to present findings and the evidence that the review team heard, including both positive examples of good practice and areas where it is felt that regulatory enforcement could be improved. The aim of the report is not to make specific recommendations for remedial action but to identify the impact and consequences of current enforcement practice and to invite relevant regulators to respond with reforms.

Input to the evidence gathering

3. The review team took evidence through visits, face-to-face discussions and through the Focus on Enforcement website; and took into account evidence on enforcement issues submitted via the Red Tape Challenge process. We interviewed representatives from a number of organisations. These organisations included care and nursing home providers and their representative associations, local authorities and their representative associations, regulators, bodies representing residents and the public and other interested bodies. The lead reviewer also accompanied inspectors from the Care Quality Commission on an inspection of a nursing home.

Sector coverage of the review

4. The adult care sector in England is considerably diverse, with a wide range of provision available responding to the differing needs of the adult and elderly population. Care provision ranges from domiciliary or home care through to supported living and to care which is provided in residential facilities such as nursing homes or care homes. The sector also includes specialist provision for patients who have specific care requirements, for instance people with mental health needs, dementia patients or those who require physical health care.

5. The review focussed primarily on all forms of residential care, specifically on registered adult care providers who operate adult social care homes and nursing homes, respite care facilities and supported living accommodation. It covers those businesses that have a requirement to register with Care Quality Commission (CQC) because they carry out regulated activity in the form of *the provision of accommodation for persons who require nursing or personal care*.

Regulatory scope and features of the regime

6. Since 2010 there has been a new system in place for registering and regulating adult care provision which was brought in through the Health and Social Care Act 2008. As a result of the Act there is now one set of 28 essential care standards which applies to all registered and regulated adult health and social care services in England. These standards therefore apply not just to the adult residential care sector, but also to establishments such as hospitals, GP surgeries and dental surgeries as well. For each of the essential standards, there is an associated outcome summing up the experiences people can expect to have as a result of the care they receive.

7. Adult care providers are primarily regulated by the CQC whose role is to monitor, inspect and regulate services to make sure that they meet fundamental standards of quality and safety and to publish what it finds. In addition to the adult social care sector, the CQC also regulates the other services covered by the Health and Social Care Act 2008, including hospitals, GP surgeries and dental surgeries as set out above. The Health and Social Care Act 2008 established the CQC as the independent statutory regulator of all health and social care services in England, replacing the Commission for Social Care Inspection (CSCI) and the Commission for Healthcare Audit and Inspection (CHAI). It also protects the interests of people whose rights are restricted under the Mental Health Act.

8. The CQC carries out inspections on all registered adult care providers to check that required standards are being met and that services are being delivered to the expected quality. While there are 28 essential care standards, the CQC when visiting providers, focus their compliance checks on a sub-set of 16 standards that are held to relate most directly to the quality and safety of care. For each individual visit to a care home CQC will tend to inspect against a selection of 5 from that list of 16 standards. In summary, the 16 'quality and safety of care' standards are:

- Respecting and involving people who use services
- Consent to care and treatment
- Care and welfare of people who use services
- Meeting nutritional needs
- Co-operating with other providers
- Safeguarding people who use services from abuse
- Cleanliness and infection control
- Management of medicines
- Safety and suitability of premises
- Safety, availability and suitability of equipment
- Requirements relating to workers
- Staffing
- Supporting workers
- Assessing and monitoring the quality of service provision
- Complaints
- Records

9. Regulatory activity in the context of this review included:

- provision of advice on compliance with the law;
- inspection visits and assessments of premises and equipment and staff;
- any requirements to make formal applications, or provide specific information to regulatory authorities;
- any requirements on businesses and their staff to attend courses or obtain particular qualifications;
- formal enforcement proceedings taken against individuals or organisations in the event of failure to comply with regulations.

10. Care homes are also subject to a number of other regulatory regimes, including in particular: health and safety regulations; fire safety regulations and environmental health regulations for food safety. This means that, in addition to CQC, providers in the sector will have contact with other regulators such as the Health and Safety Executive, local Fire and Rescue Authorities and local authority environmental health inspectors.

Features of the social care regulatory regime

Registration of providers

11. Subject to certain exemptions, service providers in the adult residential care sector must register with CQC (as set out in the legislation which requires them to register if they perform any of the regulated activities as outlined in Schedule 1 of the Health and Social Care Act 2008⁵).

Registered managers

12. The Care Quality Commission (Registration) Regulations 2009 set out the circumstances under which a service provider must have a registered manager as a condition of their registration. In summary this places a requirement on a company to have a registered manager for each regulated activity that it carries out, where the business owner doesn't intend to act as the manager of the care provision on a day-to-day basis.

Registration fees

13. Providers are required to pay CQC an annual registration fee, based on a scale which reflects the size of their operations and the costs to CQC of regulating them. So, for example, for a residential care home or nursing home location with less than 4 users, the annual fee is £250, whereas for a home with 60 or more users the fee is £11,100 a year.

⁵ The full list of regulated activities can be found at:

http://www.cqc.org.uk/sites/default/files/media/documents/20120621_100001_v4.0_scope_of_registration_guidance_final_1.pdf

The local authority role in commissioning care home places

14. Local authorities are responsible for assessing an individual's eligibility for care provision. They are responsible for commissioning care places for those in their communities who are eligible for public funding support, and they provide advice on available places both for those going into local authority funded places, and for those who are self-funding. The commissioning and procurement role in particular means that local authorities have significant contact with care homes. This arises from their need to ensure access to an adequate supply of appropriate places, and their need to manage the contracts for those places that they fund.

15. Some individuals that move into care homes are able to finance their own places (typically referred to as 'self-funders'), others are eligible for public funding (on the basis of a means-tested assessment), and some are able to combine public funding with 'third party top-ups', for example through additional funding from a member of their family. Public funding can come via local authorities and can come via health bodies such as Clinical Commissioning Groups (and at the time of fieldwork for this review could come from Primary Care Trusts - PCTs).

16. A referral for an eligibility assessment for care provision can be made to local authorities either from the patient themselves or from a GP, friend or family member. Once notified, a local authority has a legal duty to assess a patient's care needs and to provide care which meets their needs.

17. Once an assessment has been completed, along with a means test in order to determine a patient's ability to pay for their own care, a local authority is then bound to provide care which meets a patient's eligibility needs as quickly as possible through commissioning a place for them in a local care facility.

18. Local authority adult care provision is operated according to eligibility rules which are set by central Government but applied locally. These consist of a framework to allow local authorities to determine whether a patient's needs are *critical*, *substantial*, *moderate* or *low*. Each authority sets its own threshold, deciding which categories of need will enable people to receive state-funded community care within their local authority area.

19. There is evidence that councils are tightening their eligibility criteria for state funded care. Figures provided by CQC suggest that the proportion of councils setting their eligibility threshold at 'critical' has reduced slightly over the last couple of years from 4% to 2%, but that the proportion setting the threshold at 'substantial' has increased significantly. The figures suggest that 83% of councils set their threshold for eligibility for state funded care at 'substantial' in 2012/13, in comparison to 78% in 2011/12 and 70% in 2008/9.

20. It was also reported in the course of this review that there is a tendency for local authorities to express preference for patients to stay resident in their own homes receiving

domiciliary care rather than move into a care facility for as long as possible – in order to maintain their personal independence; and particularly in cases where there is a lower care need. Consequently, we were told that when patients do reach the point where they require residential care their needs are often greater and they are also more likely to need nursing care.

The local authority role in safeguarding

21. Statutory guidance for ensuring the safeguarding and protection of adults in vulnerable circumstances is set out in No Secrets (2000) issued under Section 7 of the Local Authority Social Services Act 1970. The guidance designates local authority social services departments as the lead agencies who have a responsibility to investigate and take action to protect an adult who is or may be unable to take care of him or herself, or unable to protect him or herself, against significant harm or exploitation.

22. Local authorities have implemented the formation of multi-agency committees normally referred to as adult local safeguarding boards involving partner agencies, including health services and the police service, in the way suggested by the guidance. The safeguarding board encourages all responsible agencies to work together to create a coherent policy for the protection of adults at risk of abuse and neglect, and to ensure a consistent and effective response to any circumstances giving rise to concerns including the development of local policies and procedures.

23. The Care Bill when made law will place the safeguarding boards on a statutory footing in line with children's boards and make core partners such as health services, the police service and local authorities legally accountable for their responsibilities to protect adults at risk. The local authority will also have a further duty to make enquiries, or request others to make them, where there is a safeguarding concern.

24. The role of local authorities extends to all adults whose independence and wellbeing would be at risk if they did not receive appropriate health and social care support. In the context of residents in care and nursing homes it is not limited to publicly funded residents. Indeed the safeguarding responsibilities are not limited to those in care, but extend to any vulnerable adults at risk of abuse.

25. The CQC has a role in identifying situations that give rise to concern that a person using a regulated service is, or has been, at risk of harm. Where the CQC identifies relevant information of risk or abuse that information is passed to the local authority. Following referral, the CQC will participate in any strategy discussions to consider ongoing risk factors, the well-being of the people who use the service and any necessary protection plans.

26. Through the Care Bill the Government is seeking to strengthen the current arrangements and, for the first time, to establish a specific statutory framework for adult

safeguarding. The Bill proposes placing two specific duties on local authorities. The first being that they must make enquiries where there is a safeguarding concern. The second being to establish a Safeguarding Adults Board in their area to bring together all agencies with a role.

Economic context

27. A recent Skills for Care Report 'The State of the Adult social care sector and workforce in England 2012' estimated that 1.6 million people are employed in the adult social care sector. At present, there are estimated to be over 300,000 people in England who live in residential care homes⁶. It is thought that 'self funding' accounts for around half of care home placements in England. Additionally, around a quarter of placements are estimated to be co-funded whereby the local authority funding is 'topped-up' by third parties, such as patients' families, to meet the actual costs of the care provision⁷. There are geographical differences in the pattern of care provision across England, including differences in the ratio of self-funded to local authority funded places between different local authority areas.

28. Around a quarter of service provision in the sector is nursing care – with the rest being non-nursing residential care. It is estimated that around half of all homes (55%) have dual registration and can provide nursing care – but that in these homes ('care homes with nursing') less than half (45%) of residents are in receipt of nursing care⁸.

Recent history of the regulatory regime

29. Since 2009 when the CQC was established its role has grown as it has taken on operational responsibility for a broader range of establishments – for example as it has begun work to inspect GP surgeries and dental surgeries. There have also been a number of high profile cases in the sector where some providers have failed dramatically in their duty of care for residents. This has led to Government, Parliament, CQC, and a number of independent reviews examining the issues that have led to these failures, and the steps required to improve the operation of the sector and the regulatory regime.

30. In particular this has included a review by the National Audit Office called *The Care Quality Commission: Regulating the quality and safety of health and adult social care* (December 2011). This looked to address apparent issues including the impact of disruption and change upon the CQC. The report made a number of observations and recommendations, including:

⁶ A 2011 report by PSSRU: 'Impact of changes in length of stay on the demand for residential care services in England' estimated that there were 320,000 people in England living in residential care.

⁷ The 'Care of Elderly UK Market Survey, 2012/13', Laing & Buisson Report, estimated that 28% used top up funding in 2012.

⁸ Source: as footnote 8.

- health and social care regulators had experienced a great deal of change and proposed extensions to CQC's remit had a potential to detract away from their core function as sector regulator;
- while the CQC responsibilities had increased, the CQC budget had been less than its predecessors and funding responsibility was falling more to providers (through registration fees) than through central funding of the Department;
- there was a difference between public and provider expectations of CQC, and subsequently what it could achieve; and
- the emphasis on registration meant that compliance and inspection work had reduced during this period.

31. In April 2013 the CQC set out its new strategy for 2013 to 2016 'Raising standards, putting people first' to make major changes to what it does and how it does it, which includes:

- A clear statement of its purpose, to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve, and a clearly defined role to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and to publish what it finds, including performance ratings to help people choose care.
- Plans for the next 3 years, including for making better use of information and inspection, working better with partners, building better relationships and building a high performing organisation. A business plan for 2013/14 that prioritises the delivery of 8 changes, including the appointment of a Chief Inspector for Social Care and Support.

What we heard

32. This section summarises the key evidence gathered through the review. It brings together input from detailed discussions, website postings and other written submissions. Annex 1 sets out a summary of each of the website postings together with written submissions and relevant postings in other reviews, in particular those collected through the Red Tape Challenge care theme in the *Healthy Living* review.

33. This summary deliberately focuses on those issues which could present the most fruitful opportunities for change and development. The summary also acknowledges the positive feedback that was received from care home providers and other stakeholders.

34. The key themes emerging from the review were:

- Providers reported that they are experiencing substantial **duplication** in inspections between local authorities and primary care trusts ('PCT') as commissioners of services, on the one hand, and the CQC as regulator, on the other⁹. The sector also reported inconsistency in approach by different commissioners, particularly in data collection and quality of commissioning which greatly added to the administrative burdens;
- The sector reported a lack of **co-ordination between the CQC and commissioners**. In some areas of the country, co-ordination is better than in others;
- Concerns were raised by the sector about **inspections and enforcement**. In particular:
 - a) a perceived lack of **expertise** by CQC's inspectors in residential care because of the wide variety of premises they inspect including, for example, dental surgeries;
 - b) the **essential standards** are all embracing for a variety of premises e.g. hospitals and care homes, and do not go into sufficient detail for elderly care;
 - c) a perceived lack of moderation to compare and quality assure between CQC inspectors or inspection reports, resulting in **inconsistency in enforcement**;
 - d) concern over some other enforcement and compliance issues including the **time lag** between finding a non-compliance issue and the handing over of the CQC report of the inspection to the home; and also the time lag in confirming improvements from non-compliance to compliance which can have a potentially disproportionate impact on the home's business;

⁹ Primary Care Trusts have been replaced since the fieldwork for this review was carried out. The bodies carrying out the functions relevant to these findings are now the Clinical Commissioning Groups.

- some concern was expressed by associations representing residents over the system for **handling complaints**, with resultant lack of information/intelligence by the CQC;
- many stakeholders, including provider associations, reported that measuring compliance against essential standards (pass or fail) results in a lack of benchmarking with little incentive to **improve standards**;
- the role for **external accreditation** in the sector is being explored;
- **CQC's new Strategy** has been generally welcomed, but stakeholders feel that they have "yet to see it on the ground".
- a concern was expressed over **frequency of inspections** with some among the wider public feeling more inspections are needed in response to recent high profile incidents, though the CQC does have Quality and Risk Profiles for care homes which informs its compliance activities;

35. These key points are explained in more detail below.

Duplication

36. By far the biggest concern raised by the sector was over the perceived duplication and lack of coordination between CQC's role as the statutory regulator and the local authorities' and PCTs' roles as the commissioners of care; in other words where publicly funded residents are placed into care pursuant to contracts made between local authorities or the PCT and the home¹⁰.

37. Some local authorities have established their own inspection teams to check contractual requirements and this involves looking at standards and requiring providers to provide data. In one example, a local authority had issued a 50 page questionnaire to all homes from which it was commissioning care. We were given an example of another local authority which issued an application form of 25 pages and a contract of 60 pages for the commissioning of residents in a home. Concern was also expressed over the length and detail of the NHS contracts used by PCTs when commissioning services from nursing homes. In another example given to us 8 local authority officers were involved in one

¹⁰ Primary Care Trusts have been replaced since the fieldwork for this review was carried out. The bodies carrying out the functions relevant to these findings are now the Clinical Commissioning Groups.

inspection. Not all local authorities commission exclusively within their area so a home might be subject to inspections from more than one local authority as well as the CQC. The nursing home which the lead reviewer visited had in its care residents commissioned from 4 local authorities and 2 PCTs. One stakeholder felt the situation could become even worse with the demise of PCTs and replacement by a number of commissioning boards for each PCT.

38. Some stakeholders felt that the reason why local authorities were making inspections was because they had lost trust in CQC's inspections and could not rely upon their inspection reports. This perception has resulted partly from the fact that initially there was a lack of resource within the CQC for inspections (not least because of the resources needed to re-register homes) and partly from some incidents where failures had not been picked up by the CQC. There is still a perception that CQC's inspections are insufficient, not just in terms of the frequency but also in terms of the quality of the inspection, some stakeholders describing it as "tick box" or "paper" exercise, because only a minimum of 5 of the essential standards are selected for inspection.

39. The CQC and some local authorities we spoke to viewed the CQC's role and the commissioner's role as quite different – the CQC checking on statutory standards but the local authority checking on whether the home is meeting the commissioner's standards in relation to residents it has placed into the home. Some stakeholders view this as a distinction without a difference because in making the assessment the CQC and the local authority are essentially looking at the same issues and asking the same questions. One local authority told us that although the issues may be the same they will look at matters in more depth than the CQC - checking the care plan of a resident was given as an example of that. Some stakeholders gave us examples where the CQC's inspector had recently passed the home as compliant but the local authority were so concerned over standards that, in one instance, it considered withdrawing all its residents from the home. The local authority imposed an immediate action plan on the home. One local authority explained to us that it did not see any inconsistency in the approach because the CQC were only required to check on at least 5 essential standards to a level of detail that would not necessarily satisfy the local authority as the commissioner of the service, who needed to be satisfied on every aspect of service delivery. One stakeholder commented to us that "each different agency is missing the expertise of the other".

40. Comments received suggested that service providers are frequently required to undertake the same governance assurance for the CQC and commissioners of care. Each asks for essentially the same information such as statistics, figures, audits, and staff records, but often in different formats and requiring different collection techniques. This takes up considerable time and removes key players from delivering quality care.

41. Another reason for duplication put to us by one commentator was that local authorities have a range of expectations on them – some clear, such as the commissioner of services, but some not so clear such as their role around investigating complaints where they have a safeguarding but not a regulatory role. This ambiguity, it was suggested, causes anxiety and a culture in which people are ensuring that they "cover their backs".

42. There used to be a star rating system for homes. Several stakeholders, including providers, noted that the removal of the system combined with a perceived lack of trust in the CQC to monitor effectively quality of care has forced commissioners of care to use their own quality assessment criteria to ensure they are commissioning quality care, many based on CQC's essential standards and therefore effectively duplicating statutory regulation. One example was cited in which care homes were required to complete a 178 page quality monitoring document which replicated CQC's 28 Essential Standards and required evidence of each.

Lack of co-ordination between CQC and commissioners

43. Some stakeholders, including providers, still feel that there is a lack of co-ordination by inspectors with local authorities at local level and there should be more sharing of information and intelligence. The reported lack of coordination both adds to the level of duplication and the burden experienced by the sector, and it means public agencies will be failing to make the most of collective intelligence available to them. We had positive feedback from two local authorities about good liaison with the CQC so the picture may vary in different parts of the country. Also, the CQC gave us examples where there had been good liaison between them and local authorities, for example, in one of the London Boroughs; and one example was given to us where a joint inspection had been successfully undertaken following a risk alert. However, the CQC does not favour joint inspections as a matter of routine, because it sees its role as distinct and independent from the local authorities' role as commissioner. Nevertheless, many in the sector reported that in practice they did not see the inspection and monitoring roles as being that different. We were told that the CQC also does not generally favour sharing their programme of visits with local authorities, to enable local authorities to programme their visits to avoid clashes, as they are concerned this will lead to homes being informed of their unannounced visits. Similarly the CQC does not share its quality and risk profiles (see below) with local authorities because they are cautious about releasing sensitive information which requires a degree of subtlety to interpret. There is a protocol in existence between the Association of Directors of Adult Social Services (ADASS) and the CQC (made in 2010) and the CQC has a nominated person for linking up with each local authority. The protocol states that it was to be reviewed in January 2011, but there is no evidence that it has been reviewed. There was also a proposal for an "information portal" but that proposal was dropped by the CQC last year, at the dismay of the stakeholders we spoke to. It is understood this proposal is now being resurrected by the CQC.

44. The CQC's new Strategy acknowledges the need to strengthen how the CQC works with its strategic partners and other key stakeholders, in order, among other things, to share information. The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry ('the Francis report') recommended that the communication of intelligence between regulators needs to go further than sharing existing concerns identified as risks, and it should extend to all intelligence which when pieced together with that possessed by partner organisations may raise the level of concern. This information should be as real time as possible. Francis went on to say that in the Mid Staffordshire case too many assumptions were made that others would be aware of important information. Whilst the Francis report looked at a specific instance in the health sector rather than the care sector

there are likely to be transferable lessons for the protection of vulnerable adults in other sectors.

CQC inspections and enforcement

Expertise

45. Some stakeholders, including providers, felt that the wide variety of premises inspected by the CQC meant that the expertise of inspectors was spread too thinly. Inspectors were required to inspect all types of premises from hospitals, dental surgeries, through to care and nursing homes, and from January this year, GP surgeries. Although it was recognised that inspectors could call upon specialist support it was thought that this did not happen often and that general inspectors were usually unaccompanied by CQC specialists. Suggestions were made that inspectors should be grouped into specialist areas and only inspect in those areas so that, for example, an inspector in the elderly and nursing care sector would not be required to inspect in other areas¹¹.

46. One stakeholder representing residents told us that inspections would benefit from more input from relatives and others who may have more knowledge and information about the home. Local authorities can gain this information from the visits their social workers make. However, this information is not routinely shared with the CQC. Posting 14 on the website suggested the establishment of a Friends Group for every home. We have not looked at similar structures in other organisations (e.g. prison visitors).

Essential standards

47. There was also concern expressed about the generic nature (one size fits all approach) of the essential standards (for example, that the same standards cover both hospitals and care homes) because they do not go into the specific differences for elderly care such as on dietary issues. Whilst prime responsibility for achieving compliance must be for the provider rather than the regulator, the CQC's recent strategy document accepts the need to develop a model of regulation that achieves the very best impact on driving improvement in the quality of services "across a differentiated sector". The Francis report also says that there is a lack of clarity in the essential standards which derives from the regulations combining in one regulatory requirement a number of different concepts, such as "safety" and "welfare".

Consistency of enforcement

48. Comment was made by providers that they have seen inconsistency in approach between different inspectors in different parts of the country and would like to see inspection reports moderated centrally to ensure consistency in standards. The CQC's inspectors work from home, though we were assured by the CQC that there are effective arrangements in place for the sharing of information among inspectors. The CQC does

¹¹ Note: The Government has announced in its initial response to the Francis report that there will be a new Chief Inspector of Social Care appointed by the CQC. The CQC's new strategy says that the CQC will make sure that its inspectors specialise in particular areas of care.

have an “Enforcement Policy” and a “Judgement Framework”. The CQC has confirmed that it has internal quality audit processes in place to assure the consistency of inspectors’ reports, in particular draft reports are subject to review by peers and clearance by the local Compliance Manager. However, it would appear that this practice is not common knowledge within the sector, and in any case may not address the issue of consistency across different areas of the country. The need to ensure consistent application of the regulations is also acknowledged in the Strategy document.

Frequency of inspections and risk

49. The approach of using unannounced inspections was generally welcomed but there was concern that many homes had not been inspected within the CQC’s one year target of the frequency of inspection. Some among the wider public felt that inspections should be twice a year. Against that we found that the CQC does operate a Quality and Risk Profile for homes which supports compliance activity - a summary of this, prepared by the CQC, is set out in Annex 2.

Other enforcement and compliance issues

50. Concern was also raised about the time lag between finding a non-compliance issue and the report of the inspection and also in going from non-compliance to compliance.

51. One stakeholder representing residents felt that the CQC is not tough enough in the language used in reports, for example “the provider may wish to note” rather than saying something must be done. In contrast some providers thought that enforcement was disproportionate, that providers felt intimidated by inspectors and that publishing enforcement notices was unhelpful having a potentially disproportionate impact on their business – with new placements being unlikely whilst they are labelled as non-compliant. Some providers felt that there is a disparity between the impact of findings of minor and major compliance issues on a care home’s reputation.

52. A non-compliant home retains that status until it is re-inspected so that even for minor issues that can be/are resolved quickly, the home is tarred with a non-compliant brush for the entire cycle before the next inspection. This means potential residents may be discouraged, despite the home now being fully compliant. In contrast it was said that those who fail on serious issues rarely face the full force of CQC’s powers such as closures.

53. It was a source of frustration that once compliance issues were resolved and proof can be provided to the CQC, there were not mechanisms in place to allow the compliance status to be changed immediately.

Complaint handling

54. Some stakeholders representing the wider public expressed concern about the fact that the CQC did not investigate complaints, with the consequence that they may not be pursuing these complaints sufficiently to inform and direct their inspection planning, or approach to the inspection of a given home. The CQC is not responsible for *resolving*

individual complaints and we were told that people were often deterred from reporting matters to the CQC for this reason. The CQC told us however, that it records all complaints it receives and that the information is stored in the electronic file for the home and that helps inform the home's risk profile. So a complaint or number of complaints may trigger an inspection or investigation¹².

Improving standards

55. Many stakeholders, including providers, felt that measuring compliance against essential standards (pass or fail) results in a lack of benchmarking with little incentive to improve. Also it constrains inspectors from suggesting improvements based upon best practice in other homes. The system also means that neither commissioners of care, nor the public, have an indication of the relative standards of care provided by those homes who meet the standards, which has implications for funding.

56. There was a view expressed by several stakeholders, including providers, that the ending of the star rating system has left the quality agenda without clear leadership. Many consider this has led to commissioners of care regulating quality themselves, introducing their own systems for monitoring care under the guise of contract monitoring or quality assurance monitoring. However, the approach lacks uniformity, is over burdensome and has created duplications of the CQC's work.

57. It was suggested that the gap in quality criteria at CQC level needs to be filled either with full inspections of care standards within a nationally agreed quality framework grading, or clear guidance should be provided to commissioners of care at a national level on how to regulate quality and what criteria can and should be applied.¹³

Accreditation

58. Some stakeholders have mentioned that accreditation could have an important role in the care home sector. This would involve a certification body checking against a set of agreed standards. The provider would pay the body a fee for the service. The certification bodies, who would be acting commercially and potentially in competition with each other, would in turn be accredited by a national accreditation body to ensure both the competence and independence of the certification bodies. The system would be a voluntary one in that a provider would not be obliged to seek certification. The quid pro quo would be the CQC's acceptance (and possibly the commissioners' acceptance) of the

¹² Note: The CQC's new strategy says that the CQC will improve complaint handling, and recognises that complaints provide important information about the quality of care.

¹³ The question of star rating or other benchmarking systems has been considered by the Nuffield Trust as part of a review commissioned by the Department of Health. In its response to the Francis report the Department has announced that aggregated ratings of provider performance will be developed and published by the CQC. The CQC has included in its plans a proposal to publish performance ratings.

certificate in assessing the risk profile of the home, which in turn could result in fewer inspections and a lower contribution towards CQC's levy. It could also possibly result in lower insurance premiums for the home.

59. The issue of accreditation is a complex one but it could provide a solution for driving forward quality especially if there were different levels of accreditation offered.

60. Some of the membership organisations that we spoke with already have similar certification regimes in place for their members and are interested in how the approach might be more widely adopted.

Other regulators

61. Other regulators include –

- the environmental health departments of local authorities who look at food hygiene and other environmental health issues, and in care homes, at health and safety;
- the Health and Safety Executive (HSE), who cover health and safety issues in nursing homes;
- fire and rescue authorities for fire safety matters.

62. Although this results in providers having to work to a number of different regulators, the main issue to emerge was a lack of consistency within the regulators in different geographical locations, particularly on fire safety issues. There has been a separate Focus on Enforcement Review on fire safety so that aspect is not explored further here. Arrangements also exist for lead authorities on environmental health matters, including the Primary Authority scheme. Liaison between HSE and CQC appears to be working well (there is a liaison agreement between them) but HSE's offer of training to CQC inspectors on health and safety issues has only been taken up in the North. Stakeholders have told us that HSE generally only gets involved when something goes wrong.¹⁴

63. The Nursing and Midwifery Council (NMC) is responsible for the regulation of nurses through its Fitness to Practice Procedures. We have seen the Memorandum of Understanding (MoU) between the NMC and the CQC (signed by the former Chief Executives of the two organisations) for liaison and passing of information between the two regulators. We understand that this MoU was last reviewed and updated in March 2011. Whilst the NMC felt that the relationship between the CQC and NMC had improved over the past 18 months it was felt that the MoU was not yet being implemented as effectively as it could be. The NMC have told us that additional work is now planned on some of the operational processes that are needed to underpin the MoU – for example on intelligence sharing and data handling and that they have begun work on this with CQC. It is self

¹⁴ The Francis report has identified a regulatory gap between HSE and the CQC, in the context of hospitals, through which serious cases of safety breaches are likely to fall. The report recommends that the CQC should be given power to exercise statutory health and safety functions in the healthcare sector.

evident that liaison between these regulators needs to be effective, to ensure, for example, that where there is a complaint to the NMC against a nurse any underlying management or system failures in the home can be identified and acted upon by the CQC quickly.

Summary

64. The emerging key themes from this Review are duplication in inspections, perceived lack of liaison between the CQC and commissioners, concerns about enforcement, a lack of benchmarking in the sector and whether there is a role for external accreditation.

ANNEX 1

CARE HOMES WEB SITE POSTINGS AND LETTERS RECEIVED

The following is a summary of postings made on the Focus on Enforcement website, they appear approximately in the order they were posted, and have been received from businesses in the sector, from regulators, and from others with an interest, including members of the general public.

Posting 1

Non-requirement to use ‘visual aid’ products affects quality of care: Providers are not legislatively compelled to use signage and visual products which are ‘claimed’ to assist dementia sufferers and other patients, resulting in an environment which does not address all elements of patient care.

Posting 2

Evidential burden of compliance: It would be less burdensome to assess compliance with regulation solely through site visit inspections by the inspector rather than wasting time, money and effort having to produce information/evidence of compliance.

Posting 3

Recruit/train volunteer inspectors: Policy makers need to engage, recruit and train members of public as volunteer inspectors particularly those with a vested interest i.e. elderly and middle aged. This could be carried out with organisations such as Age UK.

Posting 4

Poor inspection methodology: Inspectors continue to inspect by identifying weaknesses then linking back to the standards. This does not assess quality. Inspectors are not clear on their role in respect of enforcement versus commenting on the ‘quality’ of services. Published guidance is not being followed by inspectors instead they focus too heavily or solely on the former.

Lack of quality assurance process within CQC: Not identifying when incorrect methodology used by inspectors resulting in inconsistency, unfairness and serious errors of judgment.

Posting 5

Announced inspections: Have yet to see an unannounced inspection where the care home was not already prepared for the visit. These ‘announced’ inspections do not reflect the real day-to-day workings of a care home and leads to ‘compliance’ with regulations that are not in reality being met.

Inadequate staffing levels/training: The true staffing levels and level of training are often at substandard and even dangerous levels (but never on inspection days).

Care v Compliance agenda: The needs of those in care and the managerialist agenda of the care homes are completely divergent. Companies are only complicit for the sake of ‘quality control’, ‘outcome monitoring’ ‘performance management’ and associated other catch all buzzwords more suited to a retail business.

Posting 6

Burden of different regulatory bodies: Care Homes are regulated by numerous bodies including the CQC, local authorities and NHS; each with different and conflicting regulatory requirements and their own inspections. This makes it difficult for providers to meet all requirements. It would be more cost effective/efficient for all 'regulators' to rely on a single "MOT" completed by the CQC.

Posting 7

Feedback on Inspectors: The way current CQC inspectors now work has improved. However, too much emphasis is placed on paperwork rather than the actual quality of care and how the residents are feeling about the service and staff. Effective inspections should include observing and engaging with staff, residents and family members.

Posting 8

Burden of different regulatory bodies: The CQC, local authorities and PCTs each assess care homes using their own sets of standards, rules and reporting requirements. This duplication increases admin burden which is threatening the existence of small and medium sized care homes. Each 'regulator' focuses on different aspects, for example CQC focuses on outcome for users whereas local authorities are driven by policies and procedures.

Onerous PCT reporting requirements: Introduced under the new National Care Homes contracts, often duplicate what CQC monitor and are better suited to hospitals and larger size care homes. They differ from area to area and claim their requirements supersede those set by CQC and other regulators.

Detailed staff references needed to assist safeguarding: Powers should be given to CQC to insist providers give detailed references on staff to other providers. Many providers refuse to give details other than starting and leaving dates to avoid employment claims for victimisation.

Benefit of a single regulatory/care quality system: CQC as sole regulator coupled with a system for recognising level of care as well as compliance (e.g. star rating), would save time, money and improve quality of care.

Posting 9

Inspection feedback delay: CQC frustrates providers by not giving feedback quickly and hence delaying resolution process.

Posting 10

Quality of care v compliance: The administrative burden of CQC's focus on evidential compliance has moved the providers focus away from person centered care to evidence based tasks. Meeting regulations does not ensure a high level of care.

Insufficient staff numbers v quality of care: The legal minimum quota of staff is insufficient to provide quality care, with providers often lacking the capacity to ensure new staff get the obligatory 12 week induction.

Cases of neglect: Stems both from CQC not being tough on inspections or acting quickly to complaints and also the employment of cheaper under qualified and unsuitable staff. Healthcare workers should be registered and monitored.

Posting 11

Suggestions to improve effectiveness of inspections: Inspections need to be more rigorous and standardised; actions followed up sooner if there are any complaints or concerns and inspectors need to have knowledge and experience of the sector they are inspecting.

Posting 12

Failure by CQC to identify poor training and under skilled care staff: Undetected 'failures' impacts quality of care. A training 'record' does not mean a member of staff has actually done the training and nobody assesses the impact in terms of outcomes. Inspector up-skilling required to adequately assess training/skill levels.

Problems ignored by inspectors: With 14 years experience in the care sector it is obvious that problems are ignored by inspectors until Winterbourne type events.

Lack of supervision and support for managers: Managers of independent providers have no support, are isolated and have no leadership or management training to prepare them for the role, leading to failures.

Posting 13

Difficulty recruiting qualified staff due to financial pressures: Diminishing income and rising costs has led to pay freezes and lower wages making it harder to attract and retain suitable staff with less people seeing it as a viable career choice. This could lead to more 'Winterbourne' incidents.

Posting 14

Establishment of a 'Friends Group' in every care home to improve quality of care: A collaborative group of residents, carers, and community volunteers would provide a valuable support mechanism for the home; provide a practical link between the home and the local community; help identify activities that would be beneficial to residents and help make things happen and lead on fundraising, giving the group access to ring-fenced funds to finance therapeutic activities.

Posting 15

Suggestion on how to improve quality of care: Risk responsive regulation has resulted in service standards slipping and failure to protect the most vulnerable people in society. The answer lies not in reducing regulatory burdens or changing the focus of inspection activity but looking at staff status, pay and conditions, training, corporate responsibility from care providers, increased frequency of truly unannounced inspections, better protection for whistleblowers, and investment from Government.

Posting 16

Factors diminishing quality of care experienced: Language barriers (carers first language is not English); unfriendly carers (often a result of being overworked); independence not promoted or individuality respected; lack of regular stimulation or activities; insufficient staff; lack of choices.

Posting 17

Falling standards of care due to financial pressures: Stricter eligibility criteria by local authorities mean residents placed in care now have higher care needs which cannot be met with the available resources. Homes to focus on meeting their legal obligations whilst neglecting quality of life matters.

Posting 18

Appalling standards of care: As an experienced nurse, observed unsanitary conditions, a complete lack of social care and poorly trained staff. It is difficult to see how can the CQC justify some care homes or fail to spot their deficiencies.

Recommendation to improve quality of care: Homes should be required to provide records showing the daily routine of individuals in care to evidence the quality of social care provided.

Posting 19

Compliance failures: Health and safety inspectors noted numerous examples of 'failings', citing poor performance of staff, homes over-run with paperwork and complexity of compliance requirements as major contributors.

Inadequate training of care staff: National compliance standards need to be developed. Presently qualifications are not checked, training records are rarely up to date and no appraisals carried out.

Care staffing problems: Usually on minimum wage, poor communication skills, English not first language, poorly trained, work long hours and not supervised properly.

Co-ordinated enforcement action needed by regulators: Achieved through simplification of legal requirements and ensuring a co-ordinated approach such as joint inspections and a single recoding system, (i.e. a single 'Enforcement File' put in place for use by all enforcement agencies to ensure compliance is achieved).

Care Plan improvements needed: Care plans need to be re-thought and should be in passport format, pages numbered that cannot be torn out, with any annotations signed.

Poor performers: Should not be allowed to get away from their legal obligations. Enforcement should be firm but fair.

Posting 20

Compliance failings and changes needed: Regulation is based on the false premise that 'essential standards' will ensure proper care. A localised compliance model required based on the users and their families being in charge of reporting what actually happens to somebody with the power to act.

Posting 21

Level of funding v standards of care: Standards can only be raised to a level commensurate with society's willingness to fund them. Over the last few years funding has been reduced consistently whilst the demand and the complexity of needs has increased significantly.

Co-ordinated compliance action needed by regulators: Managers spend all their time completing paperwork for various agencies with no two agencies agreeing on what they want in care plans. Greater co-operation required to reduce the number of visits and make them more effective.

End the separation of care and funding by NHS and local authorities: Until they act as a single organisation focusing on delivering the right care seamlessly, nothing will change.

Concerns with Care Home Review: Well intentioned but concerned will have little effect. The changes required are so far reaching to be beyond the interest of elected representatives.

Posting 22

DOLS (Deprivation of Liberty Safeguards): Examples provided of value and support provided by DOLS to those in care as well their families, the homes and hospitals. Concern that value/importance of DOLS not fully recognised; viewed as no more than a “business” issue relating to red-tape.

Role of Relevant Persons Representative (PRP): Advocates importance of PRPs with examples cited. Suggest making it compulsory for PRP or equivalent to be involved.

Best Interest Assessors and similar: The role is part of DOLS and suggests present level of training is inadequate.

Posting 23

Suggestions to improve effectiveness of regulation: Advocates stronger regulation and enforcement with more unannounced inspections, more detailed reports and greater use of local social service teams in planning, checking information and monitoring quality of content and delivery of services.

Posting 24

Use of BSI Standards to drive up quality of care: The collaborative development of independent standards and accreditation thereof would provide CQC with the relevant information and evidence that is needed to drive improvement in the quality of health and social care and add credibility to the health and social care system.

Posting 25

Concern with National Minimum Wage (NMW) compliance in the care sector: The rising costs of care coupled with increased NMW rates and reduced budgets is limiting a providers’ ability to maintain NMW compliance (example provided). There is also a high risk of unintentional non-compliance due to a limited understanding of how NMW applies to a workforce where ‘working time’ is difficult to calculate. Improved NMW guidance required for the care sector with particular clarification on the issue of travel time.

Posting 26

Reduced budgets v non-compliance: The continued downward pressure on prices severely limits a provider’s ability to meet regulations.

Excessive local authority contractual requirements: Examples provided of local authority clauses requiring providers - often at great expense - to go above and beyond regulations. Recommends such practice is removed from contracts.

Lack of trust in CQC: Local authorities have lost trust in CQC’s ability to effectively monitor services; a result of CQC’s focus on maintaining compliance with regulation rather than assessing quality. Re-building this trust and increasing CQC ability to share information will help reduce the costs and time of duplicated work.

Burden of local authority contract monitoring (CM): CM creates huge amounts of work which is often duplicated by that required evidencing compliance with essential standards to CQC and encroaches on areas monitored by CQC but with different evidence requirements, additional paperwork, site visits and notifications. The problem is exacerbated where providers contract with

more than one authority. These unnecessary financial and administrative burdens need addressing/removing.

Posting 27

Problems with non-sector specific “essential standards”: Lack of guidance on how to interpret compliance with standards (being general outcomes applicable to the whole health and care sector) in specific care settings, makes compliance difficult for providers to evidence. Recommends sector specific guidance to increase level of compliance and speed at which non-compliant becomes compliant.

Inconsistent/wrong CQC judgements: A result of a ‘generalist’ inspectors lacking sector-specific understanding which impacts on judgement, creates a knowledge gap and also inhibits the recognition and spread of good practice.

Inspection failings: CQC assess inputs only (policies and procedures) rather than the actual experience of people using services.

Failings of CQC call centres: Insufficient for the needs of providers as unable to provide accurate and consistent information beyond anything rudimentary. Example of incorrect advice given leaving providers exposed to operating illegally.

Posting 28

Lack of continuous quality improvement agenda: Monitoring ‘minimum’ standards does nothing to drive improvements in the quality of care. There needs to be effective regulation for quality to ensure a systematic means of improving quality of services.

Greater transparency on quality of care needed: Current systems lack any indicators of excellence or good practice. This does not allow people to make informed choices about the quality of care provided by different services. A robust system for providing ratings on quality of providers was recommended.

Recommendation for CQC to oversee commissioning practices (CPs): Failing to look at CPs means there is no check on local authority actions, which may have profound impact on the ability of providers to meet standards.

Greater monitoring of financial viability of care homes: Needed to help prevent sudden failures and protect those in care.

Recommendations to improve quality of care and regulatory enforcement:-

- **Regular and unannounced inspections:** Key to understanding the quality of care provided. Inspectors need to have a trained understanding of dementia/other mental health issues and use observation techniques to understand the real-life experiences of those in care.
- **Robust enforcement when standards not met:** Rapid responses required to prevent harm and ensure public faith in the regulatory regime. Regulators must be adequately resourced to do so.
- **A shift to ‘differential regulation’:** Tailored and effective standards for different services with greater focus on quality improvement rather than assurance and assessment.
- **Greater collaboration:** Essential that the feedback of those who use services is sought and placed at the centre of the regulatory regime. Easier reporting processes

are required to encourage complaints/comments to be made (the current complaints system being complex/confusing).

- **Greater and more accessible information made available** to help inform choice over actual quality of care.
- Greater empowerment and support to staff to **encourage whistleblowers** to report issues directly to CQC, being the appropriate regulatory body.
- Processes for gathering and sharing evidence amongst **'regulators' should be streamlined/merged/linked to reduce burden** and support holistic care (e.g. evidence from CQC inspections used by local authorities in their assessments and use made of the regulations covering registration of care professionals).
- Ongoing **training for inspectors to better understand dementia/mental health issues** with consideration of 'specialist' inspectors.

Posting 29

Effective monitoring: Needs to encompass both the physical environment as well as person-centered quality of care.

Greater collaboration between partners required: Regulators target areas of greatest risk which may not be identified until an incident has already occurred. Local authorities and CQC should work together in planning a monitoring schedule in line with level of risks. Example provided of local authorities' use of a Quality Standard Framework used as a monitoring tool and processes developed to ensure the trigger of visits before major issues.

Clearer definition of role of regulator required: Conflicting guidance as to what is expected results in unclear processes putting people at risk.

Concerns over reduced regulation: Any reduction in role of the regulator would lead to lower quality services putting people at risk.

Posting 30

Duplicate regulatory activity by local authorities and CQC: Burdensome and makes for a fragmentary and ineffective approach to quality improvement and monitoring. Example provided of local authorities developing their own extensive quality standards, some modelled on CQC's essential standards, going above and beyond contract monitoring.

Incoherent approach to quality improvement by Government: Lack of focus on quality improvement since demise of CSCI. Sector inundated with initiatives which do little to drive up quality. Presently a number of agencies focus on different aspect of quality of care. There needs to be a single agency dealing with quality of care in a coherent framework where the essential standards should provide the foundation for quality improvement.

Concern over inadequate safeguarding measures: Caused by a lack of clarity over what constitutes a 'safeguarding' issue with numerous examples provided. Need clearer systems for identifying, reporting and dealing with incidences causing concern.

Posting 31

Domiciliary care sector: Loss of National Minimum Standards (for domiciliary care) means sector struggles to understand exact responsibilities under the health and safety care legislation.

Greater monitoring required at grass root level.

Appeals review postings relevant to care homes

Scope of CQC inspections: Compliance inspections focus only on the documentation and not on what actually happens.

Dual inspections: Unacceptable dual inspection and monitoring by local authorities and CQC.

Acceptance by CQC of unsubstantiated complaints: Comments and complaints should not be accepted or published by CQC without being fully substantiated; particularly those made by disgruntled staff on disciplinary/dismissed.

Quality of inspectors: Large differential in quality of inspectors.

Role of CQC: CQC should support companies to be compliant and improve rather than just judging whether compliant.

Red Tape Challenge postings relevant to care homes

Winterbourne type failings

Factors leading to 'Winterbourne' type incidents include a lack of training and supervision of staff; inadequate monitoring by the CQC; a failure to involve families and utilise their experience in monitoring and inspection; poor monitoring of the quality of placements commissioned and commissioning of the wrong type of support for people with learning disabilities and challenging behaviour.

Duplication/burden resulting from a gap in the regulation of care quality

- Local authorities and PCTs are regulating quality themselves due to a perceived lack of trust in the CQC to adequately undertake this role, particularly in light of the ending of the star rating system. Greater clarity of the role of the regulator and how the system works together in assuring quality will reduce duplication of effort.
- The perceived failure by the CQC to effectively monitor quality of care has left the quality agenda without clear leadership. This has led to local authorities introducing their own systems for monitoring care under the guise of contract or quality assurance monitoring; many based on CQC essential standards and therefore effectively duplicating statutory regulation. In one example care homes were required to complete a 178 page quality monitoring document which replicated 28 CQC outcomes and required evidence of each of the CQC prompts under each outcome.
- Each Council devises their own bespoke and unique quality scheme. For those providers who deal with more than one Council this is a huge burden on their resources and adds no value to the overall service.
- Local authorities argue that Department of Health guidance requires them to take responsibility for the quality of care. This does not mean they have to set up new systems but should use information already available through CQC and others. Legislation should be amended to say councils should work in co-operation with other agencies to reduce duplication.
- There needs to be greater clarity as to how different organisations fit together so that there are no gaps in assuring quality. Anything local authorities and PCTs do above what CQC have already done should be justified in terms of cost and benefit.

- Care homes are subject to a wide variety of overlapping and duplicating of quality monitoring systems by local authorities, NHS commissioners, CQC, Monitor and Health Watch producing a confusing picture and waste of public money.
- Service providers are frequently required to undertake the same governance assurance for the CQC, PCT's and local authorities. Each essentially ask for the same information such as statistics, figures, audits, staff records, recruitment and training records which takes up time and removes key players from delivering quality care. Agencies should collate information.
- It is irrational for local authorities and NHS Commissioners to be expanding resources on activities of pseudo-regulation and inspection for which they have no statutory duty to undertake. In recent years local authorities have developed a proliferation of different quality assurance schemes often seeking to replicate the Essential Standards.

Duplication through differing governance requirements

- Many of the local authority standards expected are those monitored by the CQC. To reduce duplications they should use information available from CQC.
- Some commissioners are usurping elements of CQC inspection functions and duplicating CQC inspection processes. This is burdensome, unnecessary and harmful in terms of identifying important issues of care quality. It would be helpful to allow providers simply to refer such enquirers to CQC reports.
- Despite there being a statutory regulator, care homes are subject to a disproportionate level of inspections by way of contract monitoring activities by local authorities and NHS commissioners.

Improving quality of care

- There is too much emphasis on documentation and written evidence than the actual quality of care being received.
- CQCs narrow definition of 'improvement' from unacceptable to acceptable is not one that providers or the public will recognise as improvement. There needs to be a more consequential relationship between measuring compliance against essential standards and encouraging service improvements reflected in legislation.
- The essential standards do nothing to motivate continuous improvement and there needs to be clarification as to how the CQC's claimed intention to "motivate provides to continuously improve" will be delivered.
- Compliance with the basic legally required 'essential standards' does nothing to drive up quality.
- There needs to be greater clarity on the regulators role and purpose; demonstrated by being explicit about the parameters within which essential standards operate and from which improvements in service quality can reasonably be expected.
- Contract monitoring should take account of regulatory inspections.

Regulatory and commissioning relationships

- Regulatory relationships need greater clarity – e.g. the breakdown of responsibilities and accountabilities between Monitor and the CQC is not helpful.
- Through the CQC there is an opportunity to monitor and influence how well local authorities' commissioning is undertaken. Where care is inadequate and the causes can be traced to poor commissioning, the CQC needs to say this clearly.

- Where non-compliance is identified in a care home, concerns of one external agency are often communicated to other agencies resulting in homes having to submit multiple action plans to remedy the issues. A standard action plan (containing the requirements of all agencies) would be useful.

Local authority and NHS contract issues

- Much of the administrative burden on providers arises from local authority contracting requirements ranging from lengthy tender processes and contracts and disproportionate monitoring requirements.

Inconsistencies in governance requirements

- Conflicting requirements between local authorities and CQC inspections. Example where the local authority requires alcohol gel dispensers in rooms of residents with dementia where CQC would see this as a safeguarding issue.
- Local authorities and CQC interpret quality, values and requirements differently e.g. different approaches to the safeguarding of residents and staffing requirements leading to added costs.
- Local authorities' contract requirements differ from CQCs registration and monitoring requirements, leading to confusing in the way guidance is interpreted.
- Each commissioner of services has their own contract wording and approaches. There is currently no standard set of assessment documentations related to either overall assessment of care or individual areas of risk

Complaints/Incidents handling

- Regulations are required to ensure complaints are handles quickly and effectively at the local level whilst placing a duty on regulatory bodies to review their processes and expert advice to ensure they are investigating cases rigorously and fairly.
- Currently local authorities can have different procedures and guidelines. It would be more efficient if all local authorities had the same procedures and guidelines, e.g. national procedures and guidance.
- There are multiple requirements associated with reporting incidents/events externally. The introduction of a standard document would reduce this burden.

Reducing bureaucracy

- Consider whether individual regulations are necessary/poorly designed and also the issue of inefficient monitoring, data gathering and regulation arising from:
 - a huge number of bodies demanding the same or similar information
 - poorly designed data gathering requirements
 - a fragmented commissioning environment
 - a failure of government departments and national bodies to align regulatory activity resulting in duplicative/unnecessary requests for information and a lack of clarity

about which organisation is responsible for regulating specific things and taking action when problems are identified.

Perceived failings of the CQC:

- The CQC misunderstands its primary purpose and ignores key regulatory breaches.
- Care homes are generally inspected on too few standards with a seeming lack of emphasis on some key regulations.
- Inspectors have 'caseloads' which make it impossible for them to do their work effectively.
- Inspectors know little about the service they inspect, which means that providers cannot respect their judgments or take their comments with any seriousness, which devalues their role.
- Inspectors are being recruited without the appropriate experience or expertise.
- Too many serious breaches of regulations are ignored or passed to local authorities for action.
- The central call centre is poorly staffed, leaving people with nowhere to turn for help.
- Relatives are mistrustful of CQC because their reports are not user friendly, often do not reflect the reality experienced by residents and are too infrequent.

LETTERS RECEIVED

Letter 1

Regulating the quality of care

- There should be two key components to a good system of regulation, protecting service users and encouraging improvements. The CQC's current pass/fail system of regulation does nothing to encourage improvements or provide an accurate barometer of the quality of care. This leads to ad hoc regulation, unnecessary duplication of efforts and provides no real incentive to aim for higher levels of care.
- It is vital that consideration of quality is included in the regulatory system. By doing so it will become a key influencer in decision making for local authority providers and service users.
- As the CQC is no longer 'grading' homes, and adopted a pass or fail system, this has meant that PCTs and local authorities who want to ensure they are commissioning quality care, are forced to use their own criteria. However, the approach lacks uniformity, is overly burdensome and creates duplications of the CQC's work.
- The gap in quality criteria at CQC level needs to be filled either with full inspections of care standards within a nationally agreed quality framework grading, or clear guidance should be provided to local authorities on how to regulate the quality of their commissioning decisions and what criteria can and should be applied.

Proportionate enforcement

- There is a disparity between the impact of findings of minor and major compliance issues on a care homes reputation.
- A non-compliant home retains that status until it is re-inspected such that even for minor issues that can be/are resolved quickly, the home is tarred with non-compliant brush for the entire cycle before the next inspection.
- Until re-inspection there is no recognition of what might be a very high level of care in the home. This means potential residents may be discouraged, despite them now being fully compliant and providing high levels of care.
- Once compliance issues are resolved and proof can be provided to CQC, the status should change immediately. Not doing so disincentives providers from rectifying compliance issues in good time and unnecessarily punishes good quality providers in the long term for what may be a minor error, oversight or technical glitch.
- Those who fail on serious issues rarely face the full force of the CQC powers such as closures. Doing so would ensure CQC inspections hold more meaning and accurately reflect the true standard of care. A light would be shone on those homes with a poor track record and help service users better avoid poor quality care.

Regulation of price needed

- As well as better regulation of quality of care, there needs to be regulation of price. The lack of clear national guidelines is leading to a postcode lottery.

Letter 2

Link essential standards to legislation: Providers would benefit from clear traceability between CQC demands and the relevant clauses in legislation.

Over-reliance on paperwork by inspectors: Too much value is placed on paperwork, which does not prove anything. Instead inspectors need to exercise professional judgement by observing the well being of service users.

Clarify/distinguish powers of each regulatory body: Role and responsibilities of regulators often overlap and there is a lack of distinction in identifying specific responsibilities to each body.

Inspectors need to better engage with staff: Greater engagement with staff, giving positive feedback, advice, guidance and constructive criticism would add value to the inspection. Verbal debriefing and the inspection report need to be consistent.

Staffing: By replacing CRB with transferable licence valid for 5 years will improve workforce mobility and reduce supervision burden. The decision as to the type of skills required and style of training needed should be determined by employers.

Appeals: There is a need for independent arbitrator so that providers are able to challenge the decision made without the need for expensive legal representation.

Letter 3

Regulation of care workers needed: Health care support workers should be regulated (they are currently an unregulated workforce).

Financial challenges: Demand for health and social care is increasing whilst budgets are being reduced.

Clearer guidance required: Simpler and clearer guidance around essential standards is needed so that they can be more easily understood and applied.

Inspectors should be industry specific trained/experienced: Inspectors need to possess specialised skills relevant to the establishment they are inspecting (e.g. if inspecting a care home with dementia patients, inspectors need to be able to adapt their inspection to ensure the care home is apt to care for their patients).

Increased risk of missing compliance failures: More pressure is being placed on CQC as other regulators such as the Health and Safety Executive are no longer carrying out inspections of health and social care. This will decrease the likelihood of spotting a failure to comply with regulations.

Enforcement: Greater enforcement action against care homes that fail to comply will have a deterrent effect on providers and the penalty needs to be sufficient.

Duplication: Different regulators often require the same information and providers have to therefore duplicate paperwork. To minimise duplication, regulators need to speak to each other and have one point of contact in the organisation.

Lack of quality assessment: There is an insufficient amount of quality demands/assessments built into the commissioning process. The commissioners are more focused on procuring service and driving cost down rather than wielding influence on standards required and prioritising in service delivery.

Link between funding and quality: If there is a basic underfunding then it is impossible to meet essential standards of safety and quality (such as failure to deliver appropriate staffing/training).

Two comments on Winterbourne: 1) Commissioners from different sectors did not share information so they could not identify trends to raise concern about quality and safety. 2) Where contracts were created they often lacked performance targets, outcomes for patients, parameters for how funding was to be spent and a lack of monitoring by commissioners.

Perceived inspector failing: CQC inspectors are too subjective and inconsistent in the issues they raised.

Recommendations to improve inspection process:

- Inspections have become a remote box ticking exercise where paperwork is paramount and takes staff away from frontline care. A reduction in paperwork and more frequent unannounced spot checks is preferred.
- In addition to talking to managers, talking to frontline staff would assist inspectors in gaining a better understanding and informed impression of care delivered.
- Inspectors need to give more attention to staffing levels and skill mix needed to reflect the composition of the residents.

ANNEX 2

NOTE FROM CQC ON QUALITY AND RISK PROFILES FOR CARE HOMES

A. Quality and Risk Profiles (QRPs) for Care Homes - Content.

A QRP is available to Inspectors, and all staff in CQC, for most providers that are registered with CQC, this includes care home.

QRPs are designed at the location level and are available to Inspectors as web based dashboards within CQC's main CRM system; they include the following sections:-

1. A Home Page. This area contains summary information and links to the following sections: -
 - An inspection history timeline, correspondence timeline and latest judgements table; these detail when outcomes were last inspected, the type of inspection (scheduled or responsive), judgements made by the inspector and whether any actions arose.
 - A quick view of all the data items that have been included in the risk estimates (see 2 below), but on one page, ordered by the most risky first. This provides a view of all the data items in the QRP without the need to look at each outcome individually.
 - Location details, such as the care home address, the *regulated activities* that they provide, the date they were registered with CQC and some other 'background' information (for example, number of beds, maximum number of residents, any accreditation schemes held, fire enforcement notices and the number of times the registered manager has changed).
 - A 'Flagged Events' section which contains details of any notifications that the care home has informed CQC about which would include any that relate to, for example, serious injuries and police incidents.
 - 'Share Your Knowledge' – a facility for inspectors to enter information into the QRP that has come to their attention outside of an inspection and which they judge has a bearing on the risk of non-compliance.

2. Risk Estimates. These contain both quantitative and qualitative data that relates to one or more of the 16 essential standards of quality and safety (the outcomes). Risk estimates are shown for each of the outcomes where data is available; each is a graphical dial depicting one of 8 risk estimates ranging from low green to high red. The risk estimates are produced by a statistical model that considers all the data included for the outcome.

Quantitative data sources included in a QRP for a care home that are used to inform the risk estimates include: -

- Data from Skills for Care who collect data from care homes about the staff they employ; these data cover staff qualifications and training, vacancy and turnover rates and ratios of type of staff to beds.
- Emergency admissions due to specific conditions from the care home to hospital (the conditions include dehydration, certain infections and decubitus ulcer ['pressure sores']).

Qualitative data is also included within the QRP risk estimates and are derived from: -

- CQC's previous inspection reports (or from when the home was registered with CQC if it hasn't been inspected before).

- Comments left by people using the feedback form on CCQ's website (*Tell us Your Experience* [of using this care home]).
- Local engagement comments and that captured via an internal *Share Your Knowledge* facility for CQC staff.
- Fire enforcement notices.
- Serious case reviews notified to CQC.
- Continuous advancement programme.
- Coroners Rule 43 letters.
- Local Involvement Networks, Overview and Scrutiny Committees and other third party groups.
- Local council quality audit framework (one council).

Most information in QRPs for care homes are updated ('refreshed') every other month; as well as showing the latest risk estimates for each outcome, the previous is also shown so the user can see if there has been any change. A section in the QRP also details all the previous risk estimates for the previous 6 refreshes in order to highlight any longer term trends. The 'flagged events' information is updated every night, and the 'latest judgements' information is updated once a week.

3. People's Voice. The section draws together all data items from the risk estimates which reflect the views of people who use services or those who care for them. This section on the QRP's home page is prominent in recognition of how important these views are to CQC's work.

B. Quality and Risk Profiles (QRPs) for care homes – How they are used and how they have evolved.

Written guidance is available to inspectors and users to help them understand how the QRP helps to support monitoring the compliance of adult social care (ASC) providers; it includes how to navigate and use the QRP. It states that the QRP may contain information about potential non-compliance, which should prompt additional information being sought. The guidance also refers to other support material available that the QRP should be used alongside (such as the *Guidance about compliance: Essential standards of quality and safety* (the essential standards) and the *Judgement Framework*).

Analytical support is available to inspectors from members of the Operations Intelligence group within CQC's Intelligence Directorate.

QRPs, including those for ASC providers and care homes, were evaluated during 2012; changes were made based on the feedback that was received which included the introduction of the People's Voice sections (see 3. above), the timelines on the front page as well as the bringing together of all the data items (see 1. above).

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This publication available from www.gov.uk/bis

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BIS/13/1245