Coventry City Council

Public report
Council Report

Council 23 July 2013

Name of Cabinet Member:
Leader of the Council – Councillor Lucas

Director Approving Submission of the report:
Director of Community Services

Ward(s) affected:
All

Title:
A New Start – Consultation on changes to the way the Care Quality Commission regulates, inspects and monitors care – Consultation response

Is this a key decision?
No

Executive Summary:

This report details the City Council's response to a Care Quality Commission (CQC) consultation on the way it regulates, inspects and monitors care. CQC is the independent regulator for health care and adult social care services in England. The 'A New Start' document details proposals to change the regulation and inspection framework from one with a simple compliance focus to one based on professional, intelligence-based judgements around 'five key inspection questions' coupled with clear standards of care, including but not limited to the 'fundamentals of care' recommended by the Francis Report.

As part of the changes CQC are appointing Chief Inspectors of Hospitals, Social Care and General Practice to lead national teams of Inspectors who specialise in particular types of care. The proposed inspection teams will include independent clinical and other experts, such as people with in depth experience of using care services. A rating system will be introduced to help people compare services. It will highlight where care is good or outstanding and expose instances where care is judged as inadequate or requiring improvement.

The consultation document states these proposed changes will involve a phased implementation over a three year period. The initial focus during 2013/14 will be changing the way NHS and independent acute hospitals are inspected and regulated. In 2014/15 CQC will begin to change the way they inspect social care services, and this will be the subject of a further consultation during the Autumn.

The proposals do not focus particularly on the potential role of inspection in identifying good quality services, although this is implied. The Council also considers that inspection processes should look at what is being done well and what people value from services as well as highlighting failures or poor quality care. Some of the proposals contained in 'A New Start' are reminiscent of intentions expressed in previous CQC documents around sharing intelligence with partners and developing better relationships with patients and service users. Following the significant controversies recently surrounding the CQC, their success as a Regulator will depend on the successful implementation of their current proposals.

Overall, the Council welcomes the proposals as significant step forward in improving the current system of regulation. Returning to a rating system for NHS Trusts and clearer more transparent inspection judgements based on five key criteria should improve the confidence of patients and service users in the services and also lead to service improvements.

Recommendations:

Council is requested to approve the consultation response.

List of Appendices included:

Appendix 1 - Consultation response

Other useful background papers:

None

Has it been or will it be considered by Scrutiny?

No

Has it been or will it be considered by any other Council Committee, Advisory Panel or other body?

No

Will this report go to Council?

Yes – 23 July 2013

Report title: A New Start – Consultation on changes to the way the Care Quality Commission regulates, inspects and monitors care – Consultation response

1. Context (or background)

1.1 The Care Quality Commission (CQC) is the independent regulator for health care and adult social care services in England. Its purpose is to make sure that health and social care services provide people with safe, effective, compassionate, high quality care and to encourage care services to improve.

1.2 Their role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety, taking action where a service is found to be not meeting standards, involving people in its work and publishing information about the services it regulates.

1.3 Since its creation in 2009, CQC has focused on registering providers into the new regulatory system. In April 2013, CQC published their strategy for 2013-2016 which outlined their intention to radically change the way it inspects and regulates services within health and social care. This consultation marks the beginning of these changes which will affect all sectors under the jurisdiction of CQC over a three year period.

1.4 Due to the unusually short period of time allowed by the consultation it was not possible for a draft response to be considered by Cabinet, therefore with the agreement of the Leader of the Council this report is only being considered at the 23rd July Full Council meeting.

2. Options considered and recommended proposal

2.1 CQC has developed its future operating model for regulating, monitoring and inspecting health and social care services. There are a number of key principles which will apply to all care services. These are:

- A better registration system for those applying to offer new care services, including holding senior managers, boards and directors to account for poor quality care
- Increased use of intelligent monitoring information and evidence to decide when, where and what to inspect, including listening better to people's experiences of care
- Improvements on how inspections will be made, including the introduction of Chief Inspectors to lead expert teams and the use of five key inspection questions
- Clear standards of care including, but not limited to, the fundamentals of care below which no provider must fall.
- A ratings system to help people choice between services and to encourage improvement
- The action taken in response to poor care.

2.2 Alongside the general principles, they have set out detailed proposals on how they will inspect and regulate NHS and independent acute hospitals.

2.3 The twenty one consultation questions and responses are detailed in the appendix to this report. In addition there are six further consultation questions located in the consultation annex about initial proposals for key indicators to be used for monitoring NHS acute hospitals.

2.4 Overall, the Council welcomes the proposals as significant step forward in improving the current system of regulation. However they do not focus particularly on the potential role of inspection in identifying good quality services, although this is implied. The Council

considers that inspection processes should look at what is being done well and what people value from services as well as highlighting failures or poor quality care.

2.5 The use of a ratings system will enable the public to make informed choices, and have greater confidence about their care but there is a need to ensure within published information and/or inspection reports that the public can understand the difference between the basic fundamentals of care, expected standards of care and high quality care.

2.6 The Council welcomes the introduction and monitoring of the proposed 'duty of candour' that is to be included in the revised CQC regulations. Making sure services are open and honest about things that have gone wrong and why will be important in ensuring that people and their families are able to make informed decisions about the care and support provided to them or the person that they care for.

2.7 The Council is in agreement with the proposals to increase the regulatory powers of CQC to enable them to take action against poor providers who breach the 'fundamentals of care' without the need to issue warning notices. This will enable the regulator to act swiftly when poor standards of care are identified. In order to increase public confidence in the regulator, the Council considers that it will be vital for CQC to demonstrate the use and effectiveness of these powers to the public.

2.8 The Council considers that the issues raised by the Francis Inquiry most recently, and other similar inquiries before that during the past two decades (including Winterbourne View and the Bristol Royal Infirmary) require a measured and systematic response, on an holistic, health and social care economy-wide basis. It will be important not to rush any review of the regulatory framework, whilst the implications of the Francis Inquiry are still emerging, ensuring an effective system for oversight and regulation of health and social care commissioning and provision.

2.9 The CQC needs to ensure that it fully reflects on criticisms of previous inspection failures where 'soft intelligence' from members of the public and patients groups was considered as of secondary importance to data produced by NHS professionals. Arrangements should be put in place (as have been suggested by CQC previously) for effective and reciprocated information sharing protocols to enable patients and services users, local authorities, Local Healthwatch and others with information about the quality of care services to interact meaningfully with the regulator.

2.10 The CQC will need, as part of its "new start", to makes itself more open to scrutiny and oversight in the discharge of its regulatory responsibilities. This will need to include more regular dialogue with, and presentations to, Health Overview and Scrutiny Functions, Health and Wellbeing Boards, and local commissioners and providers of services, as well as the wider public. The "duty of candour" should equally apply to the CQC itself, as well as the functions it is responsible for regulating.

3. Results of consultation undertaken

3.1 The consultation response is from the City Council and therefore wider consultation has not been undertaken.

4. Timetable for implementing this decision

4.1 Responses to the consultation are required by 12 August 2013.

5. Comments from Director of Finance and Legal Services

5.1 Financial implications

There are no direct financial implications arising from this consultation.

5.2 Legal implications

There are no direct legal implications arising from this consultation.

6. Other implications

6.1 How will this contribute to achievement of the Council's key objectives / corporate priorities (corporate plan/scorecard) / organisational blueprint / Local Area Agreement (or Coventry Sustainable Community Strategy)?

The proposed changes to the way CQC regulate, monitor and inspect health and adult social care services will contribute to ensuring the quality and of care and support services in the city and ensuring non-compliance is addressed effectively and promptly. This may contribute to people living longer, healthier lives.

6.2 How is risk being managed?

There are no specific risks relating to the consultation response itself.

6.3 What is the impact on the organisation?

The consultation response itself will have no specific impacts on the organisation.

6.4 Equalities / EIA

An Equalities and Human Rights Duties Impact Assessment has been completed by the Care Quality Commission.

6.5 Implications for (or impact on) the environment

N/A

6.6 Implications for partner organisations?

The consultation response itself will have no specific impacts on partner organisations.

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Appendices

Appendix 1

Consultation on Care Quality Commission (CQC) – A New Start – Consultation on changes to the way CQC regulates, inspects and monitors care

Consultation Questions and Responses

General Questions

Question 1: What do you think about the overall changes we are making to how we regulate? What do you like about them? Do you have any concerns?

Overall the proposals would be a significant step forward in improving the current system of regulation. In particular, the emphasis on moving to specialist inspection teams rather than a generic approach to inspection will help ensure that inspection teams are able to quickly identify problems in a service or organisation and ask the right questions. This will however need to be appropriately resourced. It would also be helpful if CQC could provide a definition of the 'experts' that will be part of an inspection team.

The model used by other quality assurance processes of staff from relevant related services being seconded to CQC inspection teams for specific reviews may be a useful one to follow. We also welcome the emphasis on 'intelligent monitoring' which combines qualitative and quantitative data sources.

The current proposals do not give much consideration to the role of inspection in identifying good quality services, although this is implied. Inspection processes should look at what is being done well and what people value from services as well as highlighting failures or poor quality care. There is much to be learned from best practice and the CQC has a potentially important role in this.

The Council notes the appointments of the three Chief Inspectors as adding a significant amount of expertise to the CQC inspection regime. It also notes that the initial focus of CQC will be around developing an inspection regime for NHS acute trusts. Whilst this is clearly an important focus, inspections need to have the capability to look at how the system works as a whole and in particular at how patients and service users transfer between different parts of the NHS and social care services. Effective use of user and carer stories will help to identify whether there are problems with pathways of care which may not be highlighted by looking at single organisations. The Council therefore welcome the emphasis in proposals to take a thematic approach to inspection by for example looking at care for people with dementia.

The Council welcomes the introduction and monitoring of the proposed 'Duty of Candour' that is to be included in the revised CQC regulations. Ensuring that services are open and honest about things that have gone wrong and why will be important in ensuring that patients, service users and their families are able to make informed decisions about the care and support provided to them or the person that they care for.

Previously CQC has made efforts to develop arrangements for sharing information in local health and social care economies, and to develop better working relationships with the public, patients and service users. Local Healthwatch has recently taken a place in localities promoting patient and service user voices and making sure these are heard in places like local authority Health and Wellbeing Boards. CQC need to ensure that they develop appropriate and effective local arrangements with Local Healthwatch and other patient and service user groups to make sure that local intelligence such as that which was missed in Mid Staffs is fully captured. Similarly information sharing with local authorities needs to be set at the level to ensure that intelligence flows both ways and informs both CQC and local authority agendas.

The Council supports proposals to increase the regulatory powers of CQC to enable them to take action against providers who breach the 'fundamentals of care' without the need to first issue warning notices. This will enable the regulator to act swiftly when poor standards of care are identified. In order to increase public confidence in the regulator, the Council considers that it will be vital for CQC to demonstrate the use and effectiveness of these powers to the public.

Ultimately inspection and monitoring information produced by CQC will need to be clearly understood by the public; with this in mind CQC should ensure that the public understand the differences between fundamentals of care, expected standards of care, high-quality care, the regulations and the five key inspection questions.

The CQC will need, as part of its "new start", to makes itself more open to scrutiny and oversight in the discharge of its regulatory responsibilities. This will need to include more regular dialogue with, and presentations to, Health Overview and Scrutiny Functions, Health and Wellbeing Boards, and local commissioners and providers of services, as well as the wider public. The "duty of candour" should equally apply to the CQC itself, as well as the functions it is responsible for regulating.

The Council considers that the issues raised by the Francis Inquiry most recently, and other similar inquiries before that during the past two decades (including Winterbourne View and the Bristol Royal Infirmary) require a measured and systematic response, on an holistic, health and social care economy-wide basis. It will be important not to rush any review of the regulatory framework, whilst the implications of the Francis Inquiry are still emerging, ensuring an effective system for oversight and regulation of health and social care commissioning and provision.

Question 2: Do you agree with our definitions of the five questions we will ask about quality and safety (is the service safe, effective, caring, responsive and well-led)

The questions are all appropriate and well defined. There is however some overlap and there is potential to combine questions. For example is a service 'caring' and is it 'responsive to people's needs'. If members of staff are not responsive to people's needs, how can they be caring and vice versa.

The Council welcomes the emphasis on using inspection to drive up quality and to ensure that services are delivered in line with relevant quality standards. It will also be important to ensure that patients and service users perspectives of what good quality services look like are adequately captured and promoted.

From a provider perspective, expectations for each question need to be understood and clear guidelines developed to assist providers in ensuring they are able to demonstrate quality and safety within their services.

Question 3: Do you think any of the areas in the draft fundamentals of care should not be included?

No.

Question 4: Do you think there are additional areas that should be fundamentals of care?

Yes.

The following additional areas should be considered fundamentals of care:

1. That people will be involved in decision making about their medical treatment or care options and enabled to make informed choices.
2. That people will be told when there are concerns about their care provider, so that people can make informed choices about who provides their care in future.
3. Outlining values within health and care delivery.

Consideration should also be given to recognising the importance of carers and relatives and the need to involve them appropriately, if this is something the person would like.

Question 5: Are the fundamentals of care expressed in a way that makes it clear whether they have been broken?

It is not clear from the consultation document what evidence will be required in order to make a judgement about whether a fundamental of care has been broken or not. At present this is open to interpretation. Following the consultation, clearer information needs to be provided about how CQC intends to evidence broken fundamentals of care in order to make providers accountable for poor quality care.

It is also worth noting that pain relief may also be in a non-pharmacological form**.**

Question 6: Do the draft fundamentals of care feel relevant to all groups of people and settings?

Yes, although further consideration may be need to be given on how these would apply to people who are unable to communication for themselves or rely on a carer to support them. The needs of carers and relatives need to be considered as part of these basic standards. There will need to be consideration of the individual settings when applying these standards, residential settings will require a wider interpretation of some of the personal care points, vulnerable individuals in settings remote from their friends and family also may need additional support to articulate their experiences of care.

Intelligent monitoring of NHS acute hospitals

Question 7: Do you agree with the proposals for how we will organise the indicators to inform and direct our regulatory activity?

The proposals represent a significant step forward and the focus on using data from different sources (both quantitative and qualitative) is extremely welcome. How data from different sources is triangulated will be a key challenge and is likely to require a culture change in how people use and interpret data and 'soft' intelligence (which may act as an early warning system before problems become evident through other sources) to drive quality improvements. Consideration should be given to use inspection visits to 'drill down' into the data to identify where further intelligence is needed to understand the true picture. This could involve more detailed analysis of data, audit or interviews with staff, people who use services or their carers'. Greater consideration should be given to how people's stories can be used by inspection teams to understand quality issues.
Local CQC inspection teams need to make appropriate arrangements with local sources of intelligence around health and care services (including Local Healthwatch) to ensure these are

captured and inputted into risk management accordingly.

Question 8: Do you agree with the sources we have identified for the first set of indicators?

Yes.

Question 9: Which approach should we adopt for publishing information and analysis about how we monitor each NHS Trust? Should we:

a) **Publish the full methodology for the indicators?**
b) **Share the analysis with the providers to which the analysis relates?**
c) **Publish our analysis once we have completed any resulting follow up and inquiries (even if we did not carry out an inspection.**

The City Council supports option (a). In the interests of transparency it will be important to share the methodology for collating and analysing data about each trust, including qualitative data sources. This should focus on what data was collected, from whom and how data was used to inform the inspection process and inspection conclusions. This should recognise the potential limitations of specific data sources and how data was triangulated or explored through the inspection process to reach a conclusion.

Inspections

Question 10: Do you agree with our proposals for inspecting NHS and Independent acute hospitals?

Yes, the City Council welcomes in particular the focus on specialisms within the inspection teams, and the inclusion of lay inspectors. Also the commitment to spend more time talking to patients, carers and frontline staff delivering care should lead to more rounded inspection judgements as opposed to ones based on data and targets. The proposal for the majority of inspections to remain unannounced is also important given the experience of past high profile inspection failures.

Ratings

Question 11: Should the rating seek to be the single authoritative assessment of quality and safety? Although the sources of information to decide a rating will include indicators and the findings of others, should be the inspection judgement be the most important factor?

It is important that the CQC is able to act as the authoritative and decisive voice on quality and safety and that the public can have confidence in their judgement. There is potential for confusion if there are several judgements from different sources about a single service or provider. Should CQC inspection findings differ from those of other organisations or views, it will be important to understand and explain why this is the case.

CQC needs to be better at sharing with the public information about their inspection findings and what exactly they mean. In general the public are unclear about the system of regulation around health and social care and CQC managers should be mindful in planning their activities of the importance of good communications with local communities.

The Council is of the opinion that the ratings should be piloted and tested against a large sample of user and carer views to inform their validity.

Question 12: Should a core of services always have to be inspected to enable a rating to be awarded at either hospital or trust level?

Yes, and there should be some further discussion about this. Although there may be a need for focused visits of particular service, especially where concerns have been raised about the quality of this service, if there is going to be a single rating for a hospital or trust, the public will expect this to act as a benchmark for the whole organisation.

Accordingly this should therefore include as a minimum high-volume and/or core services, including accident and emergency, care of the elderly, general medicine, general surgery and maternity /paediatrics.

Question 13: Would rating the five key questions (safe, effective, caring, responsive and well-led) at the level of an individual service, a hospital and a whole trust provide the right level of information and be clear to the public, providers and commissioners.

There is potential for confusion around having a rating for the whole trust or hospital without adequate information about quality in respect of specific services. People can often have a good experience of one service (e.g. maternity) but experience poor care in another. A single rating across a hospital could disguise significant variation between services and be potentially misleading to the public. However, there is also a need to assess the overall quality of the hospital, particularly around leadership issues. This may be better achieved by producing an overall summary measure that reflects the quality of a number of different services but also reports the results of individual services.

Question 14: Do you agree with the ratings labels and scale and are they clear and fair?

Yes

Question 15: Do you agree with the risk adjusted inspection frequency set out which is based on ratings, i.e. outstanding every 3-5 years, good every 2 to 3 years, requires improvement at least once per year and inadequate as an when needed?

This appears to be a balanced approach. However services can change within short periods of time and there needs to be the capacity to reduce the frequency of time between inspections if data or local intelligence indicates issues or concerns. This would be especially important in relation to a providers currently ranked outstanding as an inspection period of up to five years is an extremely long time without review.

For ‘outstanding’ or ‘good’ providers consideration should be given to shorter unannounced inspections focused on walking the wards and speaking with patients and front-line staff to gain a snapshot of how hospitals are performing. These would add confidence for patients who may be concerned at the prospect of four or five year gaps in inspection activity.

In order to amend the frequency of inspections based on data or local intelligence, CQC need to adequately resource its inspection function to monitor the information sources identified in the document and meet the potential demand for more regular inspections. This will also enable the regulator to ensure that it does not become over reliant on the ratings system as a measure of quality.

Question 16: The model set out in this chapter applies to all NHS acute trusts. Which elements of the approach might apply to other types of NHS provider?

Many of the elements set out in this approach will apply to other types of NHS provider. There is a clear distinction for many non-acute trusts which provide a variety of different services. Whilst measures of organisational health will be of some value for a trust which covers for example mental health, learning disability and general community services some separate measures may be appropriate. There is likely to be less good quality data and fewer evidence standards for many community services for example. User feedback is also likely to be less easily available so more attention will needed as to how this data is collected for community services within the NHS.

Duty of candour

Question 17: Do you agree that a duty of candour should be introduced as a registration requirement, requiring providers to ensure their staff and clinicians are open with people and their families where there are failings in care?

The Council definitely agrees that a duty of candour should be introduced, although this needs to apply to both clinical and managerial staff and its implementation needs careful thought.

There needs to be collective responsibility among clinicians and managers to take action where there are failings of care within an organisation and patients need to see clear evidence that failures are being dealt with appropriately.

Clarity is required on what constitutes a failing in care and what evidence would be required to support a prosecution. Clarity would also be needed as to how information is shared and how others might be involved in the communication, for example Local Authorities to ensure that appropriate support is available to those people who are affected.

Question 18: Do you agree that we should aim to draft a duty of candour sufficiently clearly that prosecution can be brought against a health or care provider that breaches this duty?

Yes.

Question 19: Do you have any other comments about the introduction of a statutory duty of candour on providers of services via CQC registration requirements?

The timing of the information about quality of provision is important. The duty of candour should apply at the point where concerns are identified and not after they have been rectified. The duty of candour should extend to providers being clear about action taken to rectify issues and keeping people informed of progress.

The following questions relate to the Impact Assessments that accompany the consultation document

Impact Assessments

Question 20: Do you have any comments on the draft Regulatory Impact Assessment?

No.

Question 21: Do you have any comments on the draft Equality and Human Rights Duties Impact Assessment?

No.

The following questions are set out on the separate Consultation Annex – Proposed Model for intelligent monitoring and expert judgement in acute NHS trusts

A1: Do you agree with the principles that we have set out for assessing indicators?
Yes largely although there are issues with "Easily gathered". Whilst few would disagree that the regulatory burden needs to be minimised if an indicator is vital to our understanding of quality every effort needs to be made to gather the information as it is all too easy to dismiss data gathering as "too hard"

A2: Do you agree with the indicators and sources of information?

They all appear valid. It is important to ensure that quality indicators are used. It might be possible to streamline some indicators to ensure quality of indicators and information is maintained.

A3: Are there any additional indicators that we should include as 'tier one' indicators?

No.

A4: Do the proposed clinical areas broadly capture the main risks of harm in acute trusts? If not, which key areas are absent?

Yes

A5: Do you agree with our proposal to include more information from National Clinical Audits once it is available?

Yes.

A6: Do you agree with our approach of using patient experience as the focus for measuring caring?

Broadly this is supported however CQC need to constantly cross-check hospital generated data on patient satisfaction with other measures, particularly those which give feedback on care following discharge. As discussed previously Local Healthwatch with its links into CQC should be a good source of local intelligence on the quality of local services.