Consultation on Care Quality Commission Strategy 2010-2015

The Royal College of Nursing submission Final

Executive Summary

1. Regulation of health and social care is undergoing a major period of transition as the new Care Quality Commission begins its work as the regulator for England’s health and adult social care services.

2. This consultation is focused upon the CQC’s strategy for 2010-2015.

3. The CQC is operating a changing NHS. Particular changes include:
   - Commissioning, either undertaken by Primary Care Trusts (PCTs) or commissioning outsourced to independent sector providers, which have the responsibility for deciding what services to buy for their local people and from whom;
   - Patient choice and voice allowing patients choice over their provider and more consultation and engagement with patients. In addition, the potential for greater scope of personal or individual budgets for some service users in both health and social care to purchase those services which best meet their needs;
   - Plurality of providers including Foundation Trusts\(^1\), the independent sector, and the third sector (including for example, charities and social enterprises);
   - A renewed focus on quality as part of the Next Stage Review;\(^2\) and
   - A new NHS constitution.

4. The RCN makes the following overarching points in relation to the strategy for 2010-2015:
   a) The RCN broadly supports the priorities of the CQC, however we highlight the importance of focusing upon avoidable mortality and morbidity. This may be subsumed within the priorities but we highlight these as they represent areas where there is evidence that can be applied in order to minimise mortality and harm (eg medication errors).
   b) Although we are aware that this is a Strategy document, more generally the RCN wishes to see much more detail about the way that the CQC will

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\(^1\) See also RCN Policy Briefing 01/2007 Mergers; Markets; and Monitor: An Update on NHS Foundation Trust Developments

\(^2\) More detail is available in RCN Policy Briefing 12/2008 NHS Next Stage Review
perform its responsibilities. We table a number of specific questions later in this response.

c) The RCN continues to call for a regulator with teeth and an intelligent regulator (more detail on this is included in this response and our previous consultation responses to the CQC). We call upon the new CQC to take action on these issues.

d) The RCN supports the intention to streamline regulation and welcomes the intention to share data across regulators.

e) The RCN will continue to work with the CQC in a number of ways.

f) We also make some more general comments, including:
   I. Whether the regulatory impact assessment has been updated and if so, could this be placed in the public domain?
   II. That the timetable is challenging and that this will need to be monitored as the new regime is fully rolled out. This is particularly crucial given recent announcements that some regulatory activities (eg the publication of quality and risk profiles) will be brought forward at the same time as CQC has been making staff redundant.
   III. That there is a need for more detail on the specific approach to regulation that will be used by the CQC in order to reassure the public about the quality and safety of health and adult social care. The importance of this is paramount given the latest findings on Basildon and Thurrock Foundation Trust and Colchester Foundation Trust and the conflicting findings from Dr Foster analysis and CQC performance ratings which has resulted in many questions being raised about how the public can know that the care they receive is meeting basic standards.
   IV. That the CQC includes both better care and better outcomes when they present the core focus of their work in diagrams etc.
   V. That the CQC provides more detail on it’s approach to self assessment and includes some independent work to build on its regulatory approach.
   VI. That the CQC focuses upon ensuring that organisations learn from and/or adopt best practice as set out by others in the system (eg NICE).
   VII. That the CQC includes standards and measures for staff health and well being in their assessment as recommended by the Boorman Review.
Introduction and context

5. With a membership of over 400,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

6. This consultation is on the strategy of the CQC from 2010-2015.

7. The CQC is operating a changing NHS. Particular changes include:
   - Commissioning, either undertaken by Primary Care Trusts (PCTs) or commissioning outsourced to independent sector providers, which have the responsibility for deciding what services to buy for their local people and from whom;
   - Patient choice and voice allowing patients choice over their provider and more consultation and engagement with patients. In addition, the potential for greater scope of personal or individual budgets for some service users in both health and social care to purchase those services which best meet their needs;
   - Plurality of providers including Foundation Trusts\(^3\), the independent sector, and the third sector (including for example, charities and social enterprises);
   - A renewed focus on quality as part of the Next Stage Review;\(^4\) and
   - A new NHS constitution.

Response to CQC’s consultation questions

1. Have we set the right priorities to improve the quality and safety of care?

   8. We would not disagree with the broad intentions of the CQC, however we have found the language and tone a little out of step with the intention of being people focused.

   9. We also highlight that although it may be subsumed within some of the priorities that there is a need to focus upon:

   a) Avoidable mortality
   b) Avoidable harm

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\(^3\) See also RCN Policy Briefing 01/2007 Mergers; Markets; and Monitor: An Update on NHS Foundation Trust Developments http://www.rcn.org.uk/__data/assets/pdf_file/0012/24024/mergers_markets_and_monitor.pdf

10. We stress the word ‘avoidable’ as there is evidence that can be applied in order to minimise mortality and harm (eg medication errors). This is illustrated, as an example, by Mencap’s report Death by Indifference (2007).5

2. Are we planning to go about our work in the right way?

11. We note that this is a Strategy document and as such does not go into specific detail. The RCN is therefore unable to fully answer this question currently. However, we strongly support the intention to focus on better outcomes and better care, based on patient (and carer) experience and feedback.

12. However, we are keen to understand more about the specific detail, including:
   a) Information that the CQC will have access to?
   b) How often this information will be updated?
   c) What information is included in the quality and risk profile?
   d) What will trigger an inspection?
   e) How often will inspection occur? (including both planned and unannounced inspections and across different settings, including care homes, prisons, hospitals etc)
   f) What are ‘dynamic and flexible monitoring systems to gather intelligence’?
   g) How often are ‘regular reviews’? What will this entail?
   h) What IT system will be used to store and assess the information?

13. We also ask the CQC to implement the Boorman Review recommendation that “the Care Quality Commission’s annual assessment of NHS organisations and their delivery partners should in future include standards and targets for staff health and well-being.”6

14. Whilst we would support the intention of ‘identify[ing] serious issues and act[ing] swiftly’ we would also like to know what mechanisms the CQC will be using so that they are aware of not so serious issues - long before serious issues arise and the need to intervene at an early stage?

15. We also note that ‘monitoring implementation’ of regulations in good performing organisations will not promote high quality care – can CQC provide further information as to how it will go about promoting high quality care in others?

16. We also wish to know how the CQC will be ensuring that the NHS Constitution is actively used within all providers?

17. We are pleased to see the reference to CQC staff, but we stress the need not to focus just upon the management model but rather value the skills and contribution of all CQC staff. We also note that drafting on staffing issues may suggest that some roles are peripheral, rather than rather than recognising

5 http://www.mencap.org.uk/document.asp?id=284
that skilled autonomous practitioners are fundamental to CQC's core purpose. We ask that CQC go further than providing ‘scope for personal and professional development’ and ensure that this is planned for. For example, we ask that CQC ensures staff who are also registered nurses are able to continue to revalidate their NMC registration. We also ask for CQC to provide a ‘staff commitment’ to providing the equipment, facilities, systems, training and development for all staff that is fit for purpose so that they can efficiently and effectively undertake their roles. There should be timely and effective two way communication, and availability of good support and advice to enable staff to do their jobs.

3. Are we clear about our role in improving the quality of care for people in the wider system?

18. We believe that the intention of the CQC is clear, however we have raised specific questions about how the CQC will perform its core regulatory functions as above.

4. How can our regulation:
   Strengthen the voice of people in our assessments of the quality of care?

19. We believe that the CQC has already set out some intentions in previous consultations, and we look forward to their continuing work on including people in assessing quality of care.

Improve services and organisations where performance is poor?

20. We have said in our previous responses to the CQC that we wish to see:

21. “A truly effective regulatory regime given the increase in providers involved in the delivery of health and social care. This includes sufficient levels of monitoring, investigation, and inspections, appropriate metrics and timely intervention by the regulator where quality is poor. This means a regulator with teeth.

22. The RCN is also calling for ‘intelligent’ regulation. This means avoiding a box ticking approach but rather allowing for the use of professional judgement. It also requires investment in leadership by the CQC. This can be achieved by providing continuing training and support to assessors and inspectors and allowing standards to be measured through a mix of questions and indicators. The RCN recognises that this is a longer term agenda but hopes that it will be a focus of the first year of the new regulatory regime and going forward. Regulators need to understand the essence of high quality care and the difference this makes to the experience felt by patients and the outcomes of their care and treatment. They need to see beneath the data and get under the skin of the organisation they are reviewing.

23. This also means recognising the long term link between quality staff and quality services and the need for the regulator and providers to take a long term view on investment in training and appropriate payment to staff working in both
health and social care providers. This is evidenced in previous work from the Healthcare Commission and the Boorman Review on Health and Wellbeing. For example, in the 10,000+ responses to the staff questionnaire as part of the Boorman review over 80% of staff believe that their state of health affects patient care.7

24. We continue to call for CQC to provide transparency and to demonstrate rigour in their approach. This is particularly urgent reflecting the lower budget of the CQC compared to the previous 3 commissions (of 25 per cent less budget), fewer CQC staff, and the recent findings about care in Basildon Hospital and Dr Foster analysis of hospital performance.

Contribute to better integrated and joined-up care?

25. We believe that the focus on commissioning which CQC will assess, will contribute to greater integration and joined up care. However, we are not sure that ensuring joined up care is necessarily a priority for a regulator. There are other systems which need to scrutinise integration between services, such as commissioning.

5. How can we streamline regulation most effectively?

26. We support the intention to streamline regulation and we hope that the CQC will successfully work with others (eg NPSA, Monitor) etc to share information. We welcome the intention for NPSA to share information with the CQC as set out by the Department of Health in their Response to the consultation on draft Regulations for the framework for the registration of health and adult social care providers (published October 2009).

6. How can you support the achievement of our plans?

27. The RCN is actively contributing to ongoing work of the CQC including their special reviews. We will continue to do this.

28. The RCN also regularly meets with the CQC on an informal basis. We will continue to do this.

29. The RCN has also put forward indicators that we would like to see included in the CQC’s approach, particularly relevant in the acute setting. These are:
   a) RN to non-RN ratios (assessed on an ongoing basis)
   b) Use of an appropriate tool to determine staffing levels (which would form part of evidence of ongoing compliance on staffing and would be a less frequent measure)
   c) Actual vs establishment staffing levels (assessed on an ongoing basis)

30. We would also like to meet with the CQC’s methods experts to more fully understand the detail of the CQC’s approach.

7 http://www.nhshealthandwellbeing.org/InterimReport.html
31. We have also asked the CQC whether RCN staff/representatives could join the CQC’s risk summits as part of sharing soft intelligence. We look forward to the CQC’s response to this suggestion.

32. We are also happy to share, as appropriate, ongoing work that is of relevance to the CQC. For example, the RCN is continuing its work on Nursing Care Standards. We suggest that this work could be built upon to develop indicators that the CQC could use in their assessment of providers.

General comments

33. In addition to the responses above we have a number of other general comments.

34. This strategy sets out in some further detail the approach to system regulation by the CQC. We kindly ask if this has led to an update of the Regulatory Impact Assessment? And if so, whether the full assessment, including all analysis and assumptions, be placed in the public domain for appropriate scrutiny?

35. We are also aware of the timetable for roll out of this new regime is challenging. The RCN has already raised this directly with the CQC and we hope that the CQC will continue to plan for what may be a period of uncertainty as organisations adjust to the new regulatory regime.

36. We note that this is a strategy, however more generally the RCN notes the lack of detail available on the CQC’s approach. We would appreciate a specific response to the detailed questions raised earlier in this response.

37. We are concerned about the lack of detail available may not be providing the reassurance to users and the public about the quality of health and adult social care.

38. Although we understand the intuitive link between ‘better care’ and ‘better outcomes’ we are surprised that the CQC uses ‘better care’ as it’s core focus in diagrams in this document (for example, the diagram on page 15). Given the focus on outcomes which has also been highlighted by the CQC (for example, in their draft Compliance Guidance) we would prefer to see the use of both better care and better outcomes as central concepts for the new regulatory regime and presented as such.

39. We welcome the intention of the CQC to evaluate its performance as a system regulator. However, we note that there remain some very important implementation issues which are not addressed in this Strategy. We highlight in particular that the CQC will need to set out in detail how it will monitor performance. In particular, how it will assessed whether or not it is considered as “good employer and an effective regulator by staff” (see page 13 of the Consultation document). In essence, there is considerable work to be done, and the ‘devil is in the detail’.
40. We would also like to see a clear intention from the CQC that it will include independent assessment of its performance.

41. We also question the need for CQC to focus on identifying and setting out good practice. We believe that there are a very large number of organisations which can and are currently doing this. The RCN prefers that CQC focuses upon ensuring that providers take appropriate steps to either learn from and/or adopt guidelines (eg NICE guidelines) rather than set out what is good practice.

42. We also welcome the CQC’s stated intention of supporting their own staff.

Royal College of Nursing
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