Written evidence from the Royal College of Nursing (CQC0014)

1. Introduction

1.1 We welcome the opportunity to submit evidence to the Health Select Committee's upcoming accountability inquiry on the Care Quality Commission (CQC).

1.2 As a professional body representing the health and care nursing workforce we engage with the CQC on a number of levels: on behalf of members working in regulated services; on behalf of members working for the RCN; and as a national representative of staff working across the health and care system. Our response to this inquiry is drawn from these dimensions.

2. Key Summary

- **The CQC has made substantial progress over recent years in transforming and improving the regulatory approach and addressing key areas of concern in its work**[1]. Many of the issues it has previously faced in relation to high vacancy rates have been addressed and staff turnover has reduced. However, within the Inspector workforce there continues to be a culture of long working hours and heavy workloads and we are concerned that the financial pressures facing the organisation could undermine the progress that has been achieved.

- **The CQC is facing significant financial challenges but raising provider fees risks diverting resources from patient care.** Facing a budget reduction of £6 million, the CQC is being forced to drastically reduce its expenditure. The decision to move from grant-in-aid funding to full recovery of chargeable costs means that many of the organisations regulated by the CQC are also its funders. These organisations, many of which are themselves facing a dire financial situation, are being asked to increase their contribution to the CQC each year. In light of the well-publicised economic and financial challenges facing the health and care sector, we do not believe that the current financial climate is one in which such substantial fee increases are either appropriate or considered. The risk is that providers have to divert funding away from patient care in order to meet the additional costs[2].

- **The CQC launched an ambitious new Strategy, but clarity is needed on certain aspects of the risk-based approach to inspections.** We welcomed the launch of the CQC's new strategy for 2016-2021 earlier this year, which committed the CQC to further reforms of the regulatory approach, including becoming intelligence-driven and taking a risk-based approach to inspections. We argued that more complete data about the adult social care sector is needed before we could support any move to a risk-based model of regulation for social care[3], and called for more detail about how the deterioration of services will be managed under this approach. We also argue that the CQC must continue to review of staffing levels and skill mix as a core part of the regulatory approach, as a crucial measure of the quality of services.
- **It is more important than ever that the CQC is able to demonstrate impact and value for money.** We welcome the CQC's commitment to report on this annually[4] and agree with the CQC that important measures of impact include the number of providers

[1] NAO 2015 report 'Capacity and capability to regulate the quality and safety of health and adult social care' https://www.nao.org.uk/report/capacity-and-capability-to-regulate-the-quality-and-safety-of-health-and-adult-social-care/
[2] RCN Response to Care Quality Commission Fees Consultation 2016 https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/.../conr-7015.pdf
[3] RCN response to the CQC consultation on its new Strategy for 2016-2021 https://www.rcn.org.uk/-/media/royal-college-of...and...responses/.../conr-1516.pdf
[4] CQC Business plan April 2016 to March 2017 http://www.cqc.org.uk/sites/default/files/20160428_cqc_businessplan_2016_2017.pdf

which demonstrate improvement on re-inspection[5] and the number of providers which report that they found the CQC's inspection helpful in making improvements to the quality of care.

3. CQC progress

3.1 The CQC has made substantial progress over recent years in transforming and improving the regulatory approach and addressing key areas of concern in its work[6]. The CQC's transformation strategy for 2013 - 2016 was a key vehicle for delivering these changes.

3.2 Progress has been made in addressing the issues CQC has previously faced in relation to high vacancy rates and internal culture, and the staff turnover rate has reduced. However, within the Inspector workforce there remains a culture of long working hours and heavy workloads, with significant pressure on staff to complete inspections, which also serves as a barrier to access to training and development. Given the pressure that CQC is under to reduce expenditure over the next two years, we are concerned that the CQC will have to reduce staff numbers which in turn could negatively impact staff morale and undermine the organisation's overall effectiveness.

3.3 In order to deliver its ambitious new Strategy, it is imperative that the CQC has sufficient numbers of staff with the appropriate knowledge and expertise to carry out its work. This necessitates devoting sufficient resources to staffing, workforce training and development and we hope that the organisation will prioritise this in the future.

4. CQC finances

4.1 In order to ensure public confidence in the regulator, it is crucial that the CQC has the sufficient means to fulfil its obligations effectively. However, with the CQC required to achieve at least £32 million in savings over the four years of the Spending Review and its budget for 2017/18 projected to be £6 million lower than in 2016/17, we are concerned that this could undermine the organisation's ability to perform its functions effectively, especially given the new responsibilities set out in the Strategy for 2016-2021.

4.2 We would urge the Department of Health and the CQC to avoid any additional increases to the workload and/or responsibilities of the CQC throughout the term of the new Strategy, in the absence of an increase in government funding.

4.3 Last year the CQC agreed to meet the government's requirement to achieve full chargeable cost recovery over a two year period for most providers, and over four years for community social care providers. We were disappointed by the decision to adopt a shorter timeframe instead of the more staggered option over four years. We argued that a longer time frame would have meant that fee rises could be staged in a more manageable manner, which could better accommodate providers having to meet these rises[7].

4.4 In light of the well-publicised economic and financial challenges facing all parts of the health and care sector, we have argued that the current financial climate is not one in which such substantial fee increases are either appropriate or considered, and we are

[5] As we know from the most recent State of Care report there are still a large number of providers who make no improvement or which actually deteriorate on re-inspection.
[6] NAO 2015 report 'Capacity and capability to regulate the quality and safety of health and adult social care' https://www.nao.org.uk/report/capacity-and-capability-to-regulate-the-quality-and-safety-of-health-and-adult-social-care/
[7] RCN response to CQC fees consultation January 2016 https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/.../conr-7015.pdf

concerned that it could result in providers having to divert funding away from patient care in order to meet the additional costs.

4.5 Our response to the CQC's consultation on fees for 2015/2016 argued that the CQC should instead seek to renegotiate its funding arrangements with government in relation to the balance between grant-in-aid funding and cost recovery monies, such that the burden on health and care providers is not increased to a level which is detrimental to patient care and staff well-being.

4.6 The move towards full chargeable cost recovery poses a challenge for the CQC in that the organisations that it regulates will also be a source of its income. In light of this, it is more important than ever for the CQC to demonstrate impact and value for money, and specifically how it fosters improvement and learning within the services it regulates. We welcome the CQC's commitment to do more on this.

5. The new CQC strategy

5.1 We welcomed the launch of the CQC's ambitious new strategy for 2016-2021 earlier this year, which followed an extensive engagement and consultation process.

5.2 We support the CQC taking all action possible to improve efficiency and be innovative in responding to the changing context within which it operates, as the Strategy commits to do. However, it remains to be seen whether the CQC can achieve its ambitious vision in the face of such significant financial challenges.

5.3 The feedback we gather from our regional staff to inform the CQC ahead of its inspections consistently reports that the main area of concern for patient safety relates to staffing – in terms of recruitment and retention of nursing staff and skill mix. We urge the CQC to maintain a focus on staffing and skill mix in the regulatory approach, and explicitly recognise the long-term link between effective staffing and the delivery of quality services. It is crucial that the CQC works with providers in taking a long term view on investment in staff recruitment and retention, in both the health and social care sectors.

5.4 As the Strategy acknowledges, the new risk-based approach to inspections will require the more effective use of a range of data, something we welcome. However, our response to the CQC's final consultation on the new Strategy agreed with the NAO's view that the CQC does not have access to routine information about adult social care which is good enough to monitor risk or trigger inspections[8], and we recommended that much more complete data about the adult social care sector is needed before we could support any move towards this model of regulation for social care[9].

5.6 The move towards more tailored and responsive inspections is logical, and we support the need for the CQC to take a different approach to inspecting those providers which are deemed to be performing at an outstanding level. However, as we have previously argued, the move towards a risk-based approach to inspections must not lead, even inadvertently, to 'light touch' regulation.

5.5 The Strategy notes that the CQC will change the frequency of re-inspections so that services rated 'good' and 'outstanding' are inspected less frequently than those rated

[8] NAO 2015 report 'Capacity and capability to regulate the quality and safety of health and adult social care' https://www.nao.org.uk/report/capacity-and-capability-to-regulate-the-quality-and-safety-of-health-and-adult-social-care/
[9] RCN response to the CQC consultation on its new Strategy for 2016-2021 https://www.rcn.org.uk/-/media/royal-college-of...and...responses/.../conr-1516.pdf

as ‘requires improvement’ or ‘inadequate’. It gives the example that CQC will move towards maximum intervals of five years for inspections of ‘good’ and ‘outstanding’ GP practices and we would welcome greater clarity about the frequency of inspections for all types of providers rated ‘good’ or ‘outstanding’.

5.6 We would also welcome more detail about how the deterioration of services will be managed under this approach, to ensure that the new model does not focus unduly on failing or failed services at the expense of intervening where early action could help to prevent sub-standard care becoming more normalised. As we know, the rapidly changing external environment means that even outstanding providers can quickly be compromised and such cases must be managed quickly and effectively.

6. Measuring impact

6.1 The new CQC strategy for 2016-2021 committed to “an ambitious vision for a more targeted, responsive and collaborative approach to regulation, so more people get high-quality care”[10]. We look forward to more detail about how the CQC will measure and evaluate the impact of the new Strategy.

6.2 Both the NAO and the Public Accounts Committee have criticised the CQC’s lack of quantifiable performance measures that demonstrate whether it is satisfactorily performing its statutory duties[11]. The NAO recommended that the Department of Health and the CQC should agree quantified performance measures which include targets for the CQC’s efficiency and for measures of the CQC’s impact on the quality and safety of services, using the data from 2015-16 to set a baseline for 2016-17, against which future changes in performance can be tracked[12].

6.3 In light of this, we welcome the CQC’s commitment to report annually on its impact and value for money[13]. As stated in the CQC Business Plan for 2016/17, the key measure of the CQC’s impact is that over time there are more services rated ‘outstanding’ or ‘good’, and fewer that are rated as ‘requires improvement’ or ‘inadequate’[14]. We also agree with the importance of reporting on the number of providers which demonstrate improvement on re-inspection[15] and the number of providers which report that they found the CQC’s inspection helpful in making improvements to the quality of care.

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[10] CQC Strategy ‘Shaping the Future CQC’s strategy for 2016 to 2021’ http://www.cqc.org.uk/sites/default/files/20160523_strategy_16-21_strategy_final_web_01.pdf

[11] NAO 2015 report ‘Capacity and capability to regulate the quality and safety of health and adult social care’ https://www.nao.org.uk/report/capacity-and-capability-to-regulate-the-quality-and-safety-of-health-and-adult-social-care/ and Public Accounts Committee report 2015 http://www.publications.parliament.uk/pa/cm201516/cmselect/cmpubacc/501/50102.htm

[12] NAO 2015 report ‘Capacity and capability to regulate the quality and safety of health and adult social care’ https://www.nao.org.uk/report/capacity-and-capability-to-regulate-the-quality-and-safety-of-health-and-adult-social-care/

[13] CQC Business Plan 2016-2017 http://www.cqc.org.uk/sites/default/files/20160428_cqc_businessplan_2016_2017.pdf

[14] This year’s State of Caring report reported that 47% of those services that CQC re-inspected following a rating of ‘requires improvement’ did not change their rating and 8% of cases had deteriorated to ‘inadequate’.

[15] As the most recent State of Care report showed, there are still a large number of providers who make no improvement or which actually deteriorate on re-inspection.