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Additional written evidence

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The Health Committee

The Health Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and its associated bodies.

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Additional written evidence may be published on the internet only.

Committee staff

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1 Mr Stephen Dorrell was elected as the Chair of the Committee on 9 June 2010, in accordance with Standing Order No. 122B (see House of Commons Votes and Proceedings, 10 June 2010).

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Written evidence

Written evidence from Alex Trouton (CQC 02)

SUMMARY

— There is a move in health and social care towards greater transparency, accountability and patient and public involvement. In tandem with this, the government's preferred way of delivering public services is though user choice and provider competition. For both of these, intelligence and accurate information regarding outcomes are essential.

— The current system for disseminating the results of CQC inspections by putting them up on a website which is not well-known or frequently visited by the public does not seem to me to serve these ends at all.

— I describe my experiences of finding out by chance that the care home in which one of my parents is a resident had been inspected five months after the inspection report had been issued. Issues of moderate concern had been identified on several key outcomes as well as a number of minor concerns on others.

— I contacted the CQC as I was concerned that, as the person with overall responsibility for my parent's care, I had not been informed and had no knowledge of the improvement plan that the home had been required to put in place.

— I discuss the issues and recommend that there be legislative change to require providers of residential and home care services to alert service users and other interested parties to the fact that inspection has taken place and how to obtain further information about any resultant improvement plans.

EVIDENCE

1. I was dismayed to discover by chance in December 2011 that the care home in which one of my parents (aged 90) is a resident had been inspected by the CQC and that the compliance review of August 2011 reported moderate concerns around two very crucial areas: *Outcome 1*: Respecting and Involving people who use services and *Outcome 13* Staffing. In addition there were minor concerns around *Outcome 4* Care and Welfare of People who use services, *Outcome 7*, Safeguarding people who use services from abuse, *Outcome 12* Requirements relating to workers and *Outcome 14,* Supporting Workers.

2. At one level I was reassured as these findings served to corroborate some of my own feelings and observations over the three years that my parent has been a resident—things that I had felt powerless to do anything about. However I am deeply concerned that I made this discovery by chance—I came across the report only because I work in the field of Public Health and needed to use the CQC site for other purposes and just thought I would look up my parent's care home. This access puts me in a relatively privileged position—16.3 % of the adult population do not use the internet at all and many older people do not. It is also clear from the evidence submitted by Dame Jo Williams at the June hearing that many other people are unaware of the CQC and its function. The limited number of calls she reported it received from the public (during the June hearing) is, I fear, testament to that.

3. I was shocked to find that an establishment costing self-funding residents £42,000 a year, and with additional money being paid towards nursing care by the local NHS had been found to have moderate concerns both around its standards of treating people with respect and involving them in their care and also its standards of staffing. This state of affairs appeared to me to put my parent's welfare and well-being at risk and when I contacted the CQC I was glad to learn that an improvement plan had been put in place and that re-inspection would follow in due course. However I return again to the point that it should not be left to family members to discover these things by chance. The improvement plan has not been shared with me or promulgated in any way and I understand there is no obligation for the home to do so.

4. I think it is deplorable that the CQC inspection regime does not incorporate robust and proactive processes for informing users of care services (either home care or residential and nursing care) or key family members (next of kin, power of attorney etc) or others who may have an interest such as Healthwatch that inspections have taken place and what the results are. This would allow them to take appropriate action and monitor where deficiencies of care are noted—or indeed be pleased and reassured that the results of the inspection are positive. When I raised this with the CQC I was told that the current legislation does not allow the CQC to require providers to disseminate the results of inspections to service users and other interested parties.

5. When contacted the CQC I also asked at what threshold of concern they would contact family members/next of kin/holders of powers of attorney to inform them of compliance failures in care home/home care services. I was horrified to be told that this would only happen when the CQC had concerns that continuing non-compliance might result in enforcement action. This seems to me to be an appalling example of technocratic callousness—is it really acceptable to leave vulnerable users in care services that are malfunctioning to a substantial degree without informing those who care about them? This approach leads to the CQC making private risk assessments with a real lack of accountability to service users and their families. Generally consumers are warned when there is a problem with a product they have bought and there is a right of redress if goods are found not to be fit for purpose. In the case of purchasing home or residential care the

principle of caveat emptor seems to reign. This seems to me very wrong, particularly where vulnerable people are concerned.

6. I would hope and expect that local authority commissioners for health and social care ensure that they are kept informed of inspections. If so, this would mean that they are in a position to monitor the welfare of residents and home care service users they pay for and ensure that providers rectify problems. They also have the ultimate sanction of terminating contracts. I see that as an important safeguard. However there are many care homes and services which only cater for privately funded clients and there seems to be no way in which warning bells are rung at an earlier stage before possible catastrophic meltdown/market failure or enforcement action ensue.

7. In my parent's case, I operate an enduring power of attorney and am responsible for dealing with all matters relating to care and finances. This puts me in the position of commissioning care and yet nothing is done to alert me to the fact that an inspection has taken place. Does the CQC expect that relatives and people holding powers of attorney will regularly monitor the CQC website on the off chance that an inspection may have taken place? This seems unlikely to me.

8. Although I understand the rationale for unannounced inspections, under the present system, family members, holders of powers of attorney etc are, in effect, excluded from the inspection process unless they happen to be visiting at the time when the inspector is in the care home. For people such as myself who can only visit at weekends, or for family members living at a distance, this method of becoming aware of that an inspection has taken place is impossible and we are also unable to contribute our views. I certainly hope that when announced inspections are taken place the CQC ensures that a questionnaire goes to *all* service users and interested parties prior to inspection so that issues can be raised and further information collected during the inspection.

9. The current system for disseminating the results of inspections seems to me secretive and technocratic and to takes the pressure off poor providers as their deficiencies remain known to very few. This is in strong contradistinction to the highly visible inspections carried out by OFSTED in schools followed up by letters to parents, meetings, shared action planning etc. It also makes it hard it hard for family members, holders of powers of attorney etc to exercise our duty of care adequately if the evidence is not readily available to us. Potentially too it is a driver of health inequalities where people who are adept at understanding the social care system and making use of the opportunities offered by the internet, are more able to locate and act on accurate information more easily than the general public.

10. From a public health perspective, I consider that greater openness regarding the results of inspections and truthfulness towards service users and other interested parties regarding issues of concern at minor/moderate level would let light and air in at an earlier stage and perhaps serve to prevent care services slipping below acceptable standards. Such honesty is also a precondition of co-production of care. I appreciate that this would be quite a cultural challenge to care home providers, many of whom may wish to shelter behind "commercial confidentiality" but I strongly believe that in the long term this would help improve standards in care services as well as public awareness of and contribution to the work of the CQC.

11. This point is made in a slightly different way in the recent National Audit Office's Principles paper: *Delivering public services through markets* (June 2012).[1] There it states; "Oversight bodies need to ensure that users have reliable and useable information about the choice and quality of services and the quality of outcomes (where available)." At the moment, due to the gap in legislation referred to in para. 3, the CQC is unable to discharge this responsibility effectively.

Recommendations

12. I note that the CQC states that it intends to follow a clearer, more transparent process to enforce compliance with the regulations. My suggestion to strengthen this and to ensure a healthier and more open relationship with care users and their families is to make it compulsory for care homes/home care services to inform them that an inspection has taken place. *I therefore suggest that legislation should be put in place to require providers to communicate the results of inspections to service users (where appropriate) and key family contacts, holders of powers of attorney, the local Healthwatch and all funders whether private or adult social care commissioners.*

13. Following an inspection, the receipt of the report and the preparation of any action plan, a letter should be sent to users (as appropriate/next of kin/powers of attorney/Healthwatch etc. The letter could be a brief one but it would need to make the following points.

- The home has been inspected by the CQC on such and such a date and a copy of the report can be found on the website (http://www.cqc.org.uk/) or a hard copy can be obtained from the manager of the home.
- The action plan prepared by the home in response to the report can be obtained from the manager.

[1] Available at http://www.nao.org.uk/publications/1213/delivering_public_services.aspx

A hard copy of the report should also be made publicly available in the home along with any improvement plan prepared by the home as well as being placed on the home's website (if it has one).

14. This, it seems to me, is the only way in which the process of inspection and remediation can be made more transparent and we can be sure that the process is properly accountable to service users and their families. I hope that this suggestion can be given very serious consideration. I think that the lack of an enforceable dissemination strategy for the results of inspections is a serious flaw in the CQC's approach and may give aid and succour to indifferent services as they are able to hide their deficiencies from public scrutiny.

July 2012

Written evidence from Nigel Newton (CQC 03)

I submit that the Regulation of primary dental care by the CQC has been:

— Inappropriate.

— Incompetent.

— Irrelevant.

— Unnecessary and a duplication of other regulatory bodies.

— Grossly wasteful of resources, (even without the duplication of regulatory functions).

— Unlawful, contrary to S 6 and Article 8 of the Human Rights Act 1998.

There are about 35,000 U.K. dentists the vast majority of whom provide N.H.S. treatment.

WITHOUT ANY NEED FOR THE CQC

All U.K. dentists are already regulated by the General Dental Council, The Health and Safety Executive and by the requirements of their own, compulsory, defence and insurance organisations, in addition to all the Health and Safety, Public Liability and Consumer Protection legislation and all the EU Directives that apply to dentists and to public services.

NHS dentists are already regulated by the General Dental Council, the NHS Business Services Authority, Primary Care NHS Trusts, The Health and Safety Executive and by the requirements of their own, compulsory, defence and insurance organisations, in addition to all the Health and Safety, Public Liability and Consumer Protection Legislation and EU Directives that apply to other public services. They are also subject to the National Clinical Assessment Service.

Dentists also comply with the Management of Health and Safety at Work Regulations administered by the Health and Safety Executive and the Ionising Radiations Regulations 1999 (IRR99) and the Ionising Radiations (Medical Exposure) Regulations 2000. (The Radiation Emergency Preparedness and Public Information) Regulations 2001 (REPPIR) are also relevant.

Dentists are subject to al the rigors of U.K. Consumer Protection Legislation, including:

The Unfair Contract Terms Act 1977.

The Sale of Goods Act 1979.

The Supply of Goods and Services Act 1982.

EU Directives apply to dentists. Examples of these are THE UNFAIR TERMS IN CONSUMER CONTRACTS REGULATIONS 1999, the Active Implantable Medical Devices Directive (90/385/EEC), the Medical Devices Directive (93/42/EEC), (This Directive was amended in Directives 2000/70 and 2001/104) and the In Vitro Diagnostic Medical Devices Directive (98/79/EC).

THE CQC

The CQC invoked Statutory authority to require every dentist to state as a condition of registration:

1. Whether dentists will be providing maternity and midwifery services.
2. Whether dentists will be providing termination of pregnancies.
3. Whether dentists will be providing accommodation for patients needing treatment for substance abuse.
4. Whether dentists will be providing accommodation for patients needing personal care.
5. Whether dentists will be making Assessment or medical treatment for persons detained under the Mental Health Act.

6. Whether dentists will supply blood.
7. Whether dentists will provide services in slimming clinics.
8. Whether dentists will provide Family Planning Services.
9. What is the purpose of dentistry?—the CQC required every dentist to provide a "statement of purpose".

While reports of serious patient abuse and neglect in a number of nursing homes were being ignored by the CQC, the CQC was intent on getting dentists to complete their 31-page idiosyncratic form and supply the peculiar attachments prescribed by the CQC.

Any form where a dentist who made any minor error in completing the form, perhaps not realising that the CQC interpreted "personal service" as having specific meaning in respect of assisting with toilet hygiene, had the whole form returned to be completed again and signed again and re-submitted. If in the meantime the CRB check had expired since first submitting the form, the form would be returned to the dentist again and the dentist required to obtain and to pay for a further enhanced CRB check, before resubmitting the form yet again, while abuse in care homes and sexual exploitation in children's' homes and continued unabated.

Dentists were also required to explain and justify to the CQC their skills and competencies in managing their dental practice, the regulated activity which dentists has been doing for years and which the dentist has to apply to the CQC to register for, as if the CQC has any competence to judge the dentists' skills.

The CQC insisted as a condition of registration on the right to be allowed to publish unlimited personal data about any dentist, including dietary preferences and requirements, embarrassing childhood habits, details of any scars and skin blemishes, or allergies or any other personal information that the CQC might hold.

Criminal Convictions

Any criminal offence (and indeed certain matters that would not be disclosed by a CRB check) by any dentist is automatically reported by the police and by the courts to the existing regulatory body, the General Dental Council:

> *GDC maintaining Standards:*
>
> > *8.6 Information to be considered under the Council's disciplinary jurisdiction may be received from a number of sources:*
> >
> > 1. *(i) the police report criminal convictions to the Council but may also provide information about formal cautions or other matters of concern;*

The GDC has power to stop a dentist practicing. The GDC has an annual budget of over £30 million, funded by dentists.

The CQC insist on every dentist obtaining an Enhanced Criminal Records Bureau disclosure, countersigned by the CQC.

The cost of the Enhanced CRB disclosure is £44. Not including administration and secretarial costs, this equates to over one and a half million pounds for 35,000 unnecessary checks.

If the CQC is to carry on with trying to regulate dentists, does the government intend to refund dentists for the cost of current regulation by the General Dental Council, Health and safety Executive and all the other current regulators?

Will the government introduce legislation to ensure that there are sufficient qualified dentist members of the Commission to enable meaningful regulation?

Is the government willing to contest an appeal to Strasbourg on the contravention by the CQC of Human Rights?

If a dentist is allowed to practice by one regulator but not by another, who will pay the legal costs of a dispute between the regulators?

Does the government intend to repeal the Dentists Act?

Dentists Act 1984

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(7) The Council shall cause a correct copy of any list for the time being kept by them in pursuance of subsection (4) above to be appended to any copy of the dentists register printed, published and sold in accordance with section 22 above.

PROFESSIONAL CONDUCT AND FITNESS TO PRACTISE

Erasure or suspension of registration for crime or misconduct

1. (1) Where the Professional Conduct Committee are satisfied that a registered dentist (whether before or after registration):
    1. (a) has been convicted in the United Kingdom of a criminal offence or has been convicted elsewhere of an offence which, if committed in England and Wales, would constitute a criminal offence.

These are just some of the U.K. bodies which are involved in the regulation of dentists:

Body	*"What we do"*
General Dental Council	We are the organisation which regulates dental professionals in the United Kingdom. All dentists, dental nurses, dental technicians, clinical dental technicians, dental hygienists, dental therapists and orthodontic therapists must be registered with us to work in the UK.
Business Services Authority, Dental Services	Clinical Services employs a team of experienced and calibrated dentists to monitor and advise on quality within the General and Personal Dental Services through a risk-based monitoring system. Formal practice inspections are carried out by DRS clinicians, usually at the request of PCTs and may be as a result of concerns raised by patients or practice staff. In Wales, there is a three yearly, rolling programme of routine practice inspections. All DRS clinicians hold the Faculty of General Dental Practitioners (UK) Certificate of Dental Practice Appraisal.
National Health Service Primary Care Trust Commissioning	This part of the site deals with dentistry policy and regulation; workforce, contracts, pay and entitlements; oral health matters, with a strong focus on embedding prevention in practice; and other vital information for PCT staff involved both in strategic commissioning and in the operational detail.
Dental Complaints Service	The Dental Complaints Service is here to assist private dental patients and dental professionals resolve complaints about private dental services.
Health and Safety Executive	HSE is responsible for enforcing health and safety at workplaces
National Institute of Clinical Excellence	Our public health guidance is for local authorities, the NHS and all those with a remit for improving people's health in the public, private, community and voluntary sectors.
National Clinical Assessment Service	NCAS is a UK-wide service bringing expertise to the resolution of concerns about professional practice. We provide high quality advice and support to healthcare managers who have concerns about the performance of doctors, dentists and pharmacists. Whenever you have a concern with the performance of a practitioner, contact us at the earliest opportunity. Our advisers provide a 24 hour, 365 days of the year service. They will be able to provide you with advice and in-depth support and, where required, direct you to other interventions such as mediation, a range of assessment services and remediation action planning.
Care Quality Commission	We are the independent regulator of all health and social care services in England. We have just started regulating primary dental care for both private and NHS services and we publish up-to-date information from our assessments. Our job is to make sure that care provided by hospitals, dentists, ambulances, care homes and services in people's own homes and elsewhere meets government standards of quality and safety.
The MHRA	The Medicines and Healthcare products Regulatory Agency is the government agency which is responsible for ensuring that medicines and medical devices work, and are acceptably safe. The MHRA is an executive agency of the Department of Health.

July 2012

Written evidence from Alzheimer's Society (CQC 04)

Alzheimer's Society

Alzheimer's Society is the leading care and research charity for people with Alzheimer's disease and other forms of dementia, their families and carers. The Society has expertise in providing information and education for people with dementia, carers and professionals. It provides a helpline and support for people with dementia and carers, runs quality day and home care, as well as funding medical and scientific research. It campaigns for improved health and social services and greater public understanding of all aspects of dementia.

Summary

— Alzheimer's Society welcomed the launch of the new Care Quality Commission (CQC) in May 2009. A single organisation to regulate the quality of health and social care services is vital if we are to see improvement in quality of care for people with dementia and their carers.

— The Society also welcomed CQC's stated commitment on dementia. In signing up to the Dementia Action Alliance,[2] CQC identified three key areas for improvement:

1. Ensuring that the care of people with dementia becomes more people-centred, including a focus on person-centred care plans.
2. Ensuring that people with dementia receive care that meets the essential standards of safety and quality.
3. Improving the commissioning of services for people with dementia.

— However, Alzheimer's Society does not have confidence that CQC is in a position to effectively regulate for quality. There remains a widespread failure by health and social care to provide high quality dementia care. This is despite the fact that raising the quality of care for people with dementia and their carers is a major priority in health and social care, with the Government committed to accelerating the pace of improvement. The regulatory system is a vital component of the whole systems approach that is needed to drive up dementia care and CQC must be provided with the resources and powers necessary to allow it to carry out its role effectively.

— In particular, CQC must be supported to drive up the quality of dementia care in care homes. This is vital given that two thirds of care home residents have dementia, yet poor quality dementia care is widespread. Regulation in a care home setting is very different to regulating the NHS, and inspection is essential for ensuring that good quality dementia care is being provided, which focuses on the outcomes that matter to people with dementia and enables them to live their lives well. Yet CQC is working in a context where inspection rates are reported to have fallen by 70% and where cases such as Winterbourne View residential hospital are raising questions about the effectiveness of regulation in its current form.

— In addition, CQC is working within a context where the Dilnot Commission on funding of care and support is due to report its conclusions in July. The Commission is looking at how to secure the highest quality care outcomes and any new system of care must therefore have a robust way of ensuring better quality care. Now is the time to ensure that there is a robust regulation and inspection system in place that works with services to ensure consistent safety and quality. People using health and social care services will look to CQC to ensure standards are being met and to take action where they are not.

— This submission will highlight background information on dementia and the challenge it presents to health and social care services. This is to help the Committee understand the scale of the challenge. The submission then outlines the range of activity that CQC must carry out to improve dementia care, to highlight the scope of powers and resources needed.

— Alzheimer's Society thinks it is vital that CQC must set the bar high for dementia care. It seems that poor quality care is tolerated and providers must understand that they could do much better in terms of the quality of dementia care that they provide. Levers must be introduced to support improvements. In particular CQC should:

1. Prioritise the driving up of quality in care homes.
2. Implement a robust inspection system, including unannounced inspections and inspectors with an understanding of dementia care.
3. Assess how well health and social care services are working together.
4. Ensure that there is an adequate system in place to give people buying care a way of judging quality.
5. Use its power to enforce good care, particularly early intervention in care homes to prevent situations reaching crisis point.
6. Involve people with dementia and carers in its work.

[2] The Alliance is a coalition of over 50 organisations, who are committed to improving quality of life for people with dementia and their carers in England.

1. Dementia and Health and Social Care Services

1.1 There are 750,000 people with dementia in the UK. This is forecast to increase to over 1 million by 2025 and 1,735,087 by 2051.[3] One in three people over 65 will end their lives with a form of dementia.[4]

1.2 Dementia is a complex condition and people will require a broad package of care from a range of agencies across health and social care. Dementia is progressive, which means people with dementia and their carers are coping with a changing pattern of abilities over time. As the disease progresses, people with dementia will need more support. Eventually, they will need help with all their daily activities.

1.3 People with dementia are core users of health and social care services:

- Two thirds of people with dementia live in the community.
- One third of people with dementia live in care homes. Two thirds of care home residents will have a form of dementia.
- Up to one quarter of hospital beds are occupied by people with dementia aged over 65 years at any one time.

1.4 Dementia currently costs the United Kingdom £20 billion each year. By 2018 dementia will cost the UK £27 billion per annum.[5] Yet this is not being spent effectively. The National Audit Office's report in 2007 found that health and social care spending on dementia was late in the condition and was often not contributing to good outcomes for people with dementia.[6]

2. The Current State of Dementia Care

2.1 Dementia is a key example of where urgent action is needed to improve quality. For example:

- *Home from Home* (2008)[7] found that huge variations exist in the quality of care between care homes; half of all respondents reported that their relative did not have enough to do and one in 4 said that they weren't involved in the decisions made about their relatives care.
- In the Commission for Social Care Inspection's (CSCI) report *See me, not just the dementia* (2008)[8] 100 thematic inspections of care homes were completed, which examined the experiences of people with dementia using an observational process (the Short Observational Framework for Inspection—SOFI). The majority of homes had previously been rated as adequate or good through inspection, with a few rated as excellent. Despite this, the dementia care provided in these homes was not found to be adequate.
- The All Party Parliamentary Group on Dementia found in their report *Always a last resort* (2008)[9] that over 100,0000 people with dementia in care homes were being inappropriately given antipsychotic drugs. Inappropriate use can cause significant harm to people with dementia.
- Counting the cost (Alzheimer's Society, 2009)[10] found that people with dementia are staying in hospital longer than those without dementia, in part due to the poor quality dementia care provided. The longer people with dementia are in hospital, the worse the effect on their symptoms of the dementia and the individual's physical health; discharge to a care home becomes more likely, and antipsychotic drugs are more likely to be used.

3. The Dementia Policy Context

3.1 *Living well with dementia: a National Dementia Strategy for England*[11] (NDSE) published in February 2009, sets out 17 objectives designed to support people to live well with dementia. In September 2010, the Department of Health published its revised, outcomes focused implementation plan for the Strategy.[12] It states that:

- Raising the quality of care for people with dementia and their carers is a major priority under the new Coalition Government.

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[3] Alzheimer's Society (2007). *Dementia UK*, a report to the Alzheimer's Society by King's College London and the London School of Economics. Alzheimer's Society: London.

[4] Brayne C, Gao L, Dewey M & Matthews F E, Medical Research Council Cognitive Function and Ageing Study Investigators (2006). Dementia before Death in Ageing Societies—The Promise of Prevention and the Reality. PIoS Med 3(10):e397.doi.1371/journal.pmed.0030397.

[5] King's Fund (2008). *Paying the Price: The Cost of Mental Health Care in England to 2026*. King's Fund: London; and Alzheimer's Society (2007) *Dementia UK*, a report to the Alzheimer's Society by King's College London and the London School of Economics. Alzheimer's Society: London.

[6] National Audit Office (2007). *Improving services and support for people with dementia*. The Stationery Office: London.

[7] Alzheimer's Society (2008). *Home from Home*. Alzheimer's Society: London.

[8] Commission for Social Care Inspection (2008). *See me, not just the dementia: understanding people's experiences of living in a care home.* CSCI: London

[9] All Party Parliamentary Group on Dementia (2008). *Always a last resort: Inquiry into the prescription of antipsychotic drugs to people with dementia living in care homes.* Alzheimer's Society: London.

[10] Alzheimer's Society (2009). *Counting the cost: caring for people with dementia on hospital wards.* Alzheimer's Society: London.

[11] Department of Health (2009). *Living well with dementia: A National Dementia Strategy.* Department of Health: Leeds.

[12] Department of Health (2010). *Quality outcomes for people with dementia: building on the work of the National Dementia Strategy.* Department of Health: Leeds

— The Government is committed to ensuring there is greater focus on accelerating the pace of improvement in dementia care.

— Local organisations are expected to publish how they are delivering quality outcomes so that local people can hold them to account.

3.2 Following the publication of the NDSE, A Department of Health report into the use of antipsychotics for people with dementia (2010)[13] found that 180,000 people with dementia are being treated with these drugs, yet of these, only 36,000 are appropriate. In response, the Government committed to reducing the use of these drugs by two thirds by November 2011.

3.3 The revised Operating Framework for the NHS[14] included dementia as one of only two items added as requiring increased emphasis. The revised plan states that NHS organisations should be working with partners on implementing the NDSE.

4. The Role of CQC in Improving Dementia Care

4.1 CQC must not tolerate inferior standards of dementia care. The growing number of people with dementia, the seriousness of the condition, the cost it imposes and the widespread poor standards of care has led Government to state that it is a priority area. CQC must recognise this and be supported to work to improve quality of care across the board. Providers must also understand that they could do much better in terms of the quality of dementia care they provide. CQC must prioritise the following:

(a) *Work to drive up the quality of dementia care in care homes*

4.2 In the last 20 years there has been a significant shift in the profile of people in care homes, which means that now over two thirds of people in care homes have a form of dementia. The role of care homes has now become the provision of late stage dementia care and the primary task of the care home sector is providing good quality care to people living with dementia.

4.3 Yet despite dementia being the core work of care homes, the provision of dementia care continues to be of poor quality. Currently, CQC is not providing an adequate response to the state of dementia care in care homes, and does not have the resource or powers to work effectively. The need to urgently drive up the quality of dementia care requires a specific approach to inspection and regulation. In particular, regulation in care homes must focus on enabling people with dementia to live their lives well and achieve outcomes that matter to them.

4.4 CQC must be supported to ensure that there is:

— A system of frequent inspection by trained inspectors, including unannounced inspection—see paragraphs 4.4 to 4.8.

— A focus on the outcomes that matter to people with dementia during the inspection process. Care homes are about living ones life, and there should be an emphasis on activities and social interaction. The services that CQC register should do all they can to support people to live rewarding lives as well as maintain abilities and independence.

— A focus on antipsychotic drugs, with CQC supporting the Government's aim to reduce use of these drugs for people with dementia. CQC must set core requirements around preventing the inappropriate use of antipsychotic medication. Alzheimer's Society welcomed the acknowledgement of antipsychotic medication in the "managing medicines safely" registration requirement. It is vital that CQC guidance is produced on how this will be regulated, using core recommendations from the NDSE and the DH report (2009).

— Employers should have to demonstrate that their staff has had appropriate dementia training.

(b) *Ensure inspection is an integral part of the regulation system*

4.5 The role of CQC inspectors is central to improving dementia care. Previously the Society has expressed concerns about the frequency of inspections and this concern increased with the proposal that CQC will carry out triggered inspections. Indeed, in recent times, there has been increasing concern about the low numbers of inspections being undertaken.[15] It seems there are now fewer inspectors carrying out fewer inspections.

4.6 Inspection is a vital part of understanding the care provided to people with dementia, particularly in a care home setting where two thirds of residents will have dementia and reports have shown the quality of care to be particularly poor. The NSDE places an emphasis on understanding the real-life experience of people with dementia, particularly through use of the SOFI observational process, and on care home inspections that must include an assessment of the quality of care that people with dementia experience.

[13] Department of Health (2009). *The use of antipsychotic medication for people with dementia: A time for action.* DH: London.

[14] Department of Health (2010). *Revision to The Operating Framework for the NHS in England 2010–11.* Department of Health: London.

[15] For example, in May 2011. *Community Care* reported that the number of on-site inspections of adult care services being conducted by the Care Quality Commission fell 70% in the first six months of the new regulatory regime (www.communitycare.co.uk/blogs/adult-care-blog/2011/05/)

4.7 Inspection therefore must be an integral part of any review system if we are to drive forward improvements in dementia care. At this time, as the number of inspections drops, Alzheimer's Society does not have confidence that CQC can effectively understand, monitor and improve the dementia care being provided in care homes. CQC must be enabled to carry out this vital part of its work through the provision of adequate resource to allow for frequent inspections, including the use of unannounced inspections.

4.8 In addition, if inspection is to understand outcomes that are important to people with dementia, training for inspectors in best practice in dementia care is vital. Previously Alzheimer's Society has had concerns about the consistency of knowledge about dementia care amongst inspectors. CQC inspectors must be kept up to date on best practice in dementia care so they can provide the right support to services to ensure the best outcomes for people with dementia.

(c) *Assess how well health and social care are working together*

4.9 CQC is well placed to monitor how well health and social care services are working together. This is particularly important for people with dementia, as they will often be receiving a range of services from both sectors. Currently, few people receive the seamless service that health and social care services should be aiming for.

4.10 In cases where an inspection of one service reveals problems with another, Alzheimer's Society believes that it is important that CQC use their ability to inspect across health and social care. For example, an inspection of a care home may reveal that the local NHS services for people with dementia are not providing adequate support to the care home. This information should be used by CQC to support the NHS to improve its services.

4.11 Given the current priority attached to joint working, within the context of dementia and within the wider health and social care context,[16] it is vital that CQC place an emphasis on this area.

(d) *Provide a robust system for assessing and reporting the standard of social care*

4.12 We know the current quality of services for people with dementia varies considerably. Alzheimer's Society has serious concerns with the replacement of the quality ratings system with a simple description of the essential standards of quality and safety and whether a provider has met them. This system will not allow a service user to understand the differences between the quality of care provided by different services. It therefore does not support effective choice. Whilst the Society acknowledges that the recognising excellence in adult social care award is in development, there are concerns that the current proposals will not provide a standardised excellence rating and is not an adequate replacement for the ratings.

4.13 In addition, the Society has concerns that any rating system will not allow people with dementia and carers to assess the quality of the dementia care being provided. This is particularly important in care homes, where two thirds of residents have dementia and the quality of care overall is not representative of the quality of dementia care (for example, as shown by the findings of the CSCI report *See me, not just the dementia*). It is vital that this is addressed to support effective choice and control. Alzheimer's Society would like to see a system where service users can clearly understand the quality of care each service provides, and for care homes, the quality of dementia care that is provided.

(e) *Use enforcement powers, with a particular focus on early intervention in care homes*

4.14 Alzheimer's Society strongly supported the expanded powers at CQC's disposal (in Alzheimer's Society's response to the consultation on CQC enforcement policy). There remains unacceptable variation in the quality of services available to people with dementia and a robust enforcement policy is vital to improving quality and outcomes for people with dementia.

4.15 It was a widely held view that CQC's predecessor social care regulator, CSCI, did not have sufficient powers needed to drive up standards and quality. The Society reiterates its view that earlier intervention, through the use of penalty notices and suspension of registration, can be effective in driving up the quality of dementia services and avoiding crisis situations, such as emergency admissions to hospital or into long term care. CQC must have the capacity and resources to intervene earlier. The Society also reiterates the need for CQC to report to the public information on enforcement, which is integral to building faith in the regulatory system.

(f) *Involve people with dementia and carers in the work of CQC*

4.16 The Society was very pleased to see the Care Quality Commission's development of a Statement of Involvement. The Society's response to the consultation on the statement of involvement highlighted that it must provide for people with dementia, or it will fail a significant group of service users. People with dementia are significant users of health and social care services and yet the care offered is frequently of unacceptably poor quality. If quality is to be improved, and care is to truly focus on the outcomes that matter to people with dementia, they must be involved in CQC's work.

[16] For example, the Government's response to the Future Forum's recommendations notes that integration of care means seamless care for all, and that there is the need to get all parts of the system working towards that goal.

4.17 CQC must actively support people with dementia to have a voice. The Society expects CQC to enable people with dementia to offer their opinions and share their experiences. Simply including people with dementia in studies and surveys will not be enough—people with impaired capacity require extra support to be involved and CQC must provide this.

July 2012

Written evidence from the Joint trade unions (CQC 08)

Introduction

1. This memorandum is submitted on behalf of UNISON, RCN, Unite, PCS and Prospect—the five recognised unions representing staff in CQC.

2. Since the Health Committee last reported staff have continued to work hard to try to fulfil CQC's obligations in the face of a major staffing deficit and of new demands on the organisation such as government-ordered snap inspections of abortion clinics, learning disability facilities and domiciliary care providers.

3. The joint trade unions have continued to raise our members concerns with CQC management through our joint consultative arrangements. To inform this activity we have compiled a set of recommendations—suggested by members at CQC in a recent union survey—which staff believe will help them to work more effectively.

4. As part of CQC's improvement planning resulting from the Department of Health capability review, we are working through these suggestions with CQC and seeking to address as many of them as possible.

5. We consider it would therefore be useful to share the recommendations with the Committee as a "shop-floor" perspective on what needs to happen to improve CQC's performance in the future.

6. Recommendations from Members' Survey

Inspection Methodology

(a) Prioritise a period of stability where methodologies and ways of working are allowed to bed in.

(b) Strengthen the registration function.

(c) Devote more attention to ensuring inspection methodology for domiciliary care agencies is fit for purpose.

(d) Reintroduce service user/carer surveys.

(e) Improve the enforcement function through more training, better guidance and advice, less time-consuming processes and protected time for inspectors to work on enforcement.

Comment—recommendation a) also requires Government to avoid placing requirements on CQC which require frequent methodology revisions.

Staffing

(f) Devise an action plan to improve damaged staff morale.

(g) Employ more staff and increase first line manager capacity.

(h) Devise a fair and workable workload management and caseload weighting system.

(i) Provide better and regular training for managers.

(j) Employ more administrative support staff.

(k) Implement consistent policies for face-to-face supervision and support for staff.

(l) Provide support for homeworkers to combat isolation and share ideas.

(m) Re-establish leads for safeguarding, enforcement, infection control and central investigations.

(n) Place more emphasis on professional/service/clinical background and expertise.

(o) Move away from generic caseloads and encourage specialisation mapped to individual skills and expertise.

Comment—in relation to recommendation g): more staff are currently being recruited and inducted which in time will ease some of the pressure on inspectors. However, we remain concerned about whether the planned staffing complement will be sufficient to meet all the requirements. We are also concerned about whether spans of control for first line managers are realistic.

Tools to do the job

(p) Provide a simplified, streamlined case management system which is fit for purpose and does what staff need it to do.

(q) Invest in better ICT equipment eg tablets to make notes during inspections, voice technology etc.

(r) Improve training and learning programmes with better delivery and less e-learning.

(s) Support training and learning activities to enable staff to maintain their nursing/pharmacy/social work registration.

Leadership and Management

(t) Be candid with government about where the limits to capacity are and what can, and cannot, be delivered. Strengthen CQC's ability to argue for and secure the staff and resources it needs.

(u) Set realistic objectives and targets for numbers of inspections and other activities.

(v) Demonstrate to staff how CQC plans to deliver all the additional service areas and minimum inspection schedule it has committed to within expected staffing and resources.

(w) Change a blame and bullying culture among some senior managers and move to a more open and supportive management style.

(x) Reform the performance development review process to make it more meaningful with agreed individual objectives not corporate targets unilaterally written in.

(y) Ensure greater transparency in recruitment to senior posts.

(z) Make senior managers more visible and more in touch with the reality of the work—encourage them to undertake "back-to-the-floor" activities.

July 2012

Written evidence from the Royal College of Nursing (CQC 09)

Introduction

1.1 With a membership of more than 410,000 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 UK Governments, the UK Parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

1.2 The RCN welcomes this opportunity to make a submission to the Health Select Committee in advance of the Care Quality Commission's (CQC) Annual Accountability Hearing.

The Work of the CQC

1.3 The NHS in England is currently undergoing significant reform, which could see an increase in the number and types of providers of health and adult social care. It is vital that all providers, whether NHS, charitable or commercial, are providing safe and high quality care. This requires a regulator that is able to identify when care is compromised and the pre-cursors to care failures in order to prevent it happening altogether. The regulation of health and social care services is therefore a part of the broader system to support safe high quality care.

1.4 The RCN believes that system regulation starts from a recognition that the health care system must have appropriate checks and balances to prevent harm and to support high quality care for patients. We have consistently called for a regulator with "teeth", which takes swift action when there are real concerns about harm, including preventable harm and even the deaths of patients and service users. We have called for more inspections (both announced and unannounced) and a greater focus on staffing levels by the CQC, as staffing is a key determinant of the safety and quality of services.

1.5 We therefore welcome the CQC's efforts to bring in more clinical expertise via their "specialist bank" of clinical and professional experts, who can provide advice as well as accompany inspectors on visits to regulated organisations throughout England. However, the CQC needs to keep refining its operational model to ensure that they can act swiftly when patient safety and quality of care is at risk. For example, the CQC should regularly review how often they undertake an unannounced inspection, what times of day they inspect (early morning, day, evening, night time), what enforcement powers they use, and how their staff are supported to deliver that challenging remit. The CQC also needs to ensure that it is continuing to engage providers in understanding how they can use the results of inspections to make improvements in the care that they provide. This could be supported by inspection reports being written in a way that seeks to help facilitate a "learning organisation" to respond appropriately to comments.

1.6 We also have a number of concerns regarding pressures on the CQC workforce. The RCN has approximately 200 members employed in frontline and national roles across the CQC, representing 10% of the total workforce. We are one of the recognised trade unions within the CQC and representatives continue to meet regularly with the CQC to discuss issues within the workforce.

1.7 Despite the additional resource and lifting of the recruitment freeze for CQC inspectors agreed with the Department of Health in mid-2011, RCN members continue to report concerns about workload pressures. RCN members report dealing with caseloads of well in excess of 50 organisations each and also providing cover for

vacant post or absent colleagues regularly adding a further 40 organisations to this workload. Members still report a sense of "fire-fighting" and worry about "what will be missed" due to workload pressures.

1.8 The RCN urges the CQC to work with us and other trade unions to enhance workforce planning and workload allocation to ensure that inspectors can deliver their role effectively, including the appropriate level of announced and unannounced inspections as well as appropriate responses to safeguarding alerts. At the time of this submission, the CQC is completing its first staff survey for two years. The RCN looks forward to working with the CQC to review the results of the staff survey as well as preparing and engaging in the delivery of a plan to move the organisation forward.

1.9 The CQC's recent "Market Report", which was published on 28th June 2012, was extremely helpful and highlighted the importance of having a strong, independent regulator. The RCN welcomes that, for the first time, this type of report has focused on staffing levels and the effect of inadequate staffing on patient care. For the past two years the RCN's Frontline First campaign has been highlighting job cuts and the direct risk this poses to patient safety. Alongside this we have been making persistent calls for a system that provides guaranteed safe staffing levels. Now that the CQC has highlighted these issues, it is important that steps are taken to ensure that trusts employ enough nurses and health care assistants to provide patients with the level and quality of care they deserve.

July 2012

Written evidence from The Royal College of Radiologists (CQC 11)

SUMMARY

— This evidence raises the issue of the regulation of teleradiology.

— Whilst many of the matters that follow relate to the regulatory functions of the General Medical Council (GMC), the College has raised the issues in the past both with the GMC and the Care Quality Commission (CQC) and considers that both regulators could do more and in particular could work more closely together in addressing these issues from a proper regulatory basis.

— The College has submitted similar evidence on this issue to the Health Committee's accountability hearing in respect of the General Medical Council.

1. The Royal College of Radiologists has been concerned for a few years that there is a gap to the detriment of patients and the public in regard to the regulation of teleradiology. Teleradiology is the remote reporting of imaging investigations used to diagnose patients. Increasingly, teleradiologists based outside the UK are being engaged to report the images of UK patients.

2. This has created a two tier system of regulation. Unlike doctors practising in the UK, doctors based outside the UK are not required to be on the specialist register of the General Medical Council (GMC) or to have a licence to practise, even though they are practising on patients based in the UK. The GMC can only regulate doctors who it registers and only those practising in the UK are required to have a licence to practise. Whilst some overseas-based radiologists delivering teleradiology services may voluntarily choose to register with the GMC (or maybe required to do so by their employer), it is not a statutory requirement. Therefore they will not be required to revalidate as they do not have a licence to practise in the UK.

3. For example, a teleradiology company reporting images of UK patients may use GMC-licensed UK-based radiologists some of the time, and offshore non-GMC licensed radiologists at other times. Thus, should a fitness to practise question arise in the care given to a UK-based patient, the means to resolve that will depend on whether the radiologist concerned has a licence to practise with the GMC. Hence the protection for patients, in terms of holding the doctor to account for their fitness to practise, may depend on which day of the week or time of day their images were reported.

4. UK patients have the right to expect that all doctors involved in their care will be regulated to the same standard, and that in the case of substandard care, patients will have the right of redress. This would involve action either in the UK legal system, or referral to the doctor's regulator, so that their fitness to practise may be assessed. If the doctor is not regulated by the GMC, such regulatory referral would have to be made to the doctor's regulatory body in another country, with standards which may differ from those of the GMC, and where complaints systems may be completely different, and in a different language. This is neither practical nor reasonable.

5. The College considers that the same standards of care must apply to all UK patients, irrespective of where their radiologist is based. This is stated in the RCR's publication: *Standards and recommendations for the reporting and interpretation of imaging investigations by non-radiologist medically qualified practitioners and teleradiologists* (1) (standards 9 and 10): https://www.rcr.ac.uk/docs/radiology/pdf/BFCR(11)2_reporting.pdf

6. The College has discussed this issue over years with the GMC and the Care Quality Commission (CQC). It has been brought to the attention of the Department of Health (DH). The RCR is pleased that both regulators have acknowledged the problem and have set out steps to address the position. However, that must be regarded as a stopgap solution. We have seen no enthusiasm or willingness on the part of either regulator to address the situation through a proper regulatory mechanism, neither have we seen clear evidence of the two regulators

wanting to work together in this regard. Clearly, with the CQC only having a remit in England, it would also be necessary to involve the equivalent regulators in Wales, Scotland and Northern Ireland to ensure coverage throughout the UK.

7. The RCR is of the view that further steps are needed to protect patients and that action is needed because:

   (a) further technological advances are almost certain to enable the further and rapid growth in teleradiology/telemedicine;

   (b) the prospects for multiple supplier delivery of radiology services in England under the changes envisaged by the Health and Social Care Act could well see much greater use of teleradiology; and

   (c) patient care and protection could be compromised.

8. The RCR issued a statement in May 2012:

   http://www.rcr.ac.uk/docs/newsroom/pdf/Telerad_PS_May2012.pdf and has written to the chief executives of all trusts or equivalent bodies in the NHS throughout the UK and to the chairs of the emerging clinical commissioning groups in England drawing to their attention this issue and recommending how they can minimise the risks to their patients.

9. We *recommend* as follows:

   Short term

   — *GMC:*

   (1) the GMC should ensure that those doctors who it registers and who are actively involved in providing or commissioning teleradiology services are aware of their duties in regard to telemedicine. This is set out in paragraphs 54 and 55 of the core GMC document *Good Medical Practice* (2) as follows:

   > **54** Delegation involves asking a colleague to provide treatment or care on your behalf. Although you will not be accountable for the decisions and actions of those to whom you delegate, you will still be responsible for the overall management of the patient, and accountable for your decision to delegate. **When you delegate care or treatment you must be satisfied that the person to whom you delegate has the qualifications, experience, knowledge and skills to provide the care or treatment involved.** You must always pass on enough information about the patient and the treatment they need.
   >
   > **55** Referral involves transferring some or all of the responsibility for the patient's care, usually temporarily and for a particular purpose, such as additional investigation, care or treatment that is outside your competence. **You must be satisfied that any healthcare professional to whom you refer a patient is accountable to a statutory regulatory body or employed within a managed environment. If they are not, the transfer of care will be regarded as delegation, not referral. This means you remain responsible for the overall management of the patient, and accountable for your decision to delegate.**
   >
   > [Please note that words which are particularly important in this context have been emboldened]

   The GMC publication *Leadership and management for all doctors* (3) also has relevant guidance as set out in paragraph 82:

   > **82.** If you are responsible for managing resources, or commissioning or delivering health services, you should have detailed knowledge of how management processes work and how they affect the delivery of patient care.

   (2) the next edition of *Good Medical Practice (GMP)* (2) and any related guidance issued by the GMC should state that patients who are being cared for in the UK should be able to rely on the same standards of and requirements for regulation by a doctor, irrespective of whether that doctor is located within or outside the UK. All doctors involved in the care of UK patients should also be subject to the same requirements for the regular review of their practice. We have made this point fully in our comments in response to the GMC's consultation on GMP.

   — *CQC*—The CQC should require any doctor providing medical services to patients in England to hold a licence to practise with the GMC as a contractual condition. The appropriate regulatory bodies in the other three home countries should do likewise.

   — *GMC and CQC* should, as a matter of urgency, enter into a joint statement along similar lines to those the GMC has entered into with equivalent system regulators in other UK countries. The same approach to regulation should apply across the whole of the UK in the interests of patients.

Longer term

— The Department of Health acting across the whole UK should enable the GMC to regulate all doctors who practise on UK patients through legislative change.

10. As noted above, similar written evidence is being submitted for the Health Committee's annual accountability hearing in respect of the General Medical Council.

July 2012

Written evidence from The Priory (CQC 13)

About The Priory Group

Established in 1980, The Priory Group *("the* Priory") has become the UK's largest independent sector provider of mental health, learning disability and specialist education services. The Group is also one of the top three independent providers of secure and rehabilitation services. As of 1 December 2011, the Priory has 272 facilities and approximately 7,200 available places across the UK. 84% of the Priory's care is publicly-funded.

1. Summary

1.1 The CQC is undergoing a period of review and significant change. This period presents clear opportunities to focus on improving the quality of the regulatory environment for health and social care services.

1.2 As part of the Health Select Committee's annual accountability hearing into the actions of the regulator the Committee may wish to consider the future plans the regulator has to address recent failings and how it can deliver a high quality regulatory environment in the future which reduces risk and raises standards, particularly in relation to its assessment and inspection processes which underpin its core duties.

1.3 The Priory has identified three areas where potential improvements could be made to the *CQC's* approach to sector regulation, these include:

- Improvements to the assessment process, including:
  - Allowing the CQC to develop robust safety and quality standards.
  - Working with providers in developing service-appropriate standards.
  - Allowing inspectors to take greater account of provider risk management procedures.
- Improvements to the inspection process, including:
  - Ensuring inspectors have sufficient and appropriate sector-relevant expertise.
  - Making clear the need to take account of a range of available data on patient outcomes and management processes at the sites inspected.
- Ensuring that regulation is proportionate:
  - Regulation should allow the CQC to exercise its expanded responsibilities effectively.
  - Regulation should encourage a partnership approach with providers to ensure safety and promote quality.

1.4 The Priory has welcomed developments already announced in these areas which have been set out in response to parliamentary questions, namely that:

- The CQC will be developing sector specific standards for particular types of providers it is inspecting.
- The CQC will be targeting inspections of providers so that they are focused and proportionate.
- The CQC plans to work with "specialist advisors" in particular fields when inspecting specialist facilities.

1.5 The challenge now for the regulator is to deliver these improvements and this should be a key focus of the forthcoming CQC strategy due to be published before the end of the year.

1.6 In addition there are a few areas where the regulator should go further to promote greater transparency in its work, ensure a greater focus on driving quality in the delivery of health and social care services and create a more open culture in regard to its working practices.

2. Assessment

2.1 The current generic inspection model is no longer fit for purpose and needs updating. A "one-size fits all" policy will not provide the best indicators against which different providers should be assessed.

2.2 The CQC needs to develop robust safety and quality standards for different types of providers. The quality and safety metrics for providing high quality dementia care, for example, will differ greatly from those

needed to provide safe and high class dentistry care. The CQC needs to address this by developing subgroups of metrics for the different types of organisations and patients in its remit to supplement the generic framework.

2.3 In developing these metrics the CQC should consider working with groups of providers to ascertain which metrics would be most effective.

2.4 In addition when conducting inspections of specialist facilities the CQC should draw on the expertise of "specialist advisors" as much as possible to ensure that assessments are thorough and of a high quality. The CQC should publish information on the number of inspections conducted with "specialist advisors" on an annual basis to demonstrate how such advisors are being used.

2.5 In addition assessments should not only consider the metrics against which providers are assessed but also ensure they are undertaken with a broader review of provider risk management processes and procedures.

3. Inspection

3.1 Whilst this is likely to be a difficult undertaking in the current economic climate, it is essential that the CQC has an adequate mix of inspectors who have the suitable training and experience to make the necessary judgements in relation to compliance, judgement and enforcement. Without sufficient sector specific specialist expertise, it is highly unlikely that a single common set of standards across different types of providers will protect quality, as inspectors will not be able to interpret the standards sufficiently with regard to the type of provider being inspected. Recent moves by the CQC have recognised this issue by increasing specialist clinical advice to its inspectors to assist with making regulatory judgements, and revising specialist guidance to inspectors on inspecting mental health services.

3.2 Whilst these steps are welcome, there is scope for the level of expertise to be improved further and for measures to be taken to "up-skill" existing inspectors in particular areas through better training. Additional funds earmarked for the CQC should be used for this purpose and the CQC should set out in its strategic plan how any recruitment of additional inspectors will meet the need to increase expertise.

4. Enforcement

4.1 The existing generic regulatory model does not allow the CQC to deploy enforcement resources effectively. The problem with the broad definition of, for example, the term "safety", is that it can include poor documentation of care plans right through to active abuse of patients. This is another reason for the regulatory framework to encourage the use of service-specific standards alongside generic standards as set out above.

4.2 With a regulatory model underpinned by effective assessment and inspection, the CQC should have the tools at its disposal to carry out necessary enforcement actions against providers who are non compliant.

4.3 In addition; the current regulatory system of declaring a service compliant or non-compliant with an outcome does not give patients a clear idea of whether the breach is a serious one, or a technical breach which will have no impact on patient outcomes. When publishing its findings on a particular provider the CQC should set out the nature of the breach identified, the actions agreed by the provider to address it and once the CQC is satisfied that the provider has addressed the issue, it should provide clarity for patients and service users that the issue has been addressed.

July 2012

Written evidence from Patients First UK (CQC 14)

Introduction

Patients First welcomes the invitation by Mr Dorrell to give evidence to the Health Select Committee concerning the Care Quality Commission's failure to listen and act on concerns raised by whistleblowers.

Patients First represents health professionals and patient groups pressing for an open culture in the health service.

We do this by working to support those who raise concerns and expose cover up of failings and fraud and who in so doing expose themselves to great risk to protect patients.

We challenge the culture which creates fear among staff which makes them reluctant to speak out and challenge bad practice.

We campaign to raise public awareness of the duty to whistle blow when all normal routes to remedy failings have been exhausted.

We campaign to expose bullying, intimidation and oppression of whistle blowers which happens too readily and too frequently for the good of the NHS and the safety of patients.

Our Concerns

Patients First provides support and advice to medical and nursing staff who whistle blow as a last resort. We have many case examples and in this submission we provide to the Health Select Committee information about a sample of incidents which have been reported to us.

The evidence we provide will show that CQC has failed to respond to expressions of concern from whistle blowers, has colluded with weak NHS management in their mistreatment and has actively suppressed expressions of concern about its own standards of performance. It is on the basis of this evidence and the considerable and growing body if information in the public domain that Patients First expresses its concerns to the Health Select Committee that CQC is failing in its function to ensure that health and social care services are safe for the public.

CQC summarises its role as:

> *"Our job is to make sure that care provided by hospitals, dentists, ambulances, care homes and services in people's own homes and elsewhere meets government standards of quality and safety."*
>
> *"…we protect people's health, wellbeing and human rights, and make sure that they are not harmed, abused or neglected."*

We question whether CQC is fulfilling these responsibilities given the body of evidence about failings in care, failings in regulation and failings by CQC to take heed of whistle-blowers' expressions of concern.

A Summary of Evidence known to Patients First

We are limiting the submission of evidence about CQCs failings to respond to whistle blowers to a small number of examples. Patients First would be pleased to present this information in person, or to prepare a more detailed submission to a later inquiry if the Health Select Committee so wished.

We do not comment on the increasing number of organisations given a "good" rating by CQC and which have subsequently been revealed to have been failing when deemed to be performing well.

Nor do we comment on the evidence already in the public domain relating to CQC failings to identify or respond to serious failings in care. This information is well documented in an earlier Health Select Committee report, in the findings of the Public Accounts Committee and in evidence given to Mid Staffs Inquiry as well as in the failing of CQC demonstrated by the exposure of abuse at Winterbourne and other institutions.

We do, however, submit that these failings are a consequence of systemic weaknesses in CQC and an inappropriate culture within its leadership.

In illustration we refer the HSC to the treatment by CQC of two of its Directors and some of its staff. The first instance is the treatment of Kay Sheldon, a CQC non-executive Director, after she gave evidence to the Mid Staffs Inquiry about the poor performance and leadership of the organisations. CQC tried to have her dismissed and alleged she was mentally ill. This is a common strategy within the health service against whistleblowers. We can provide you with additional examples of such tactics. For the CQC to adopt this strategy is unacceptable and must be challenged if they are to have any credibility with regard to their role in supporting whistleblowers.

The second example is of a former CQC Executive Director, David Johnstone who was appointed to the post of Director of Operations with responsibility for the regulatory and inspections functions when CQC was established in 2009. He gave evidence to the Inquiry of the same failings described by Kay Sheldon, describing how CQC regulation was not fit for purpose and that management systems within CQC were weak. He was dismissed by Cynthia Bower as Director of Operations after only 13 weeks in post having made it clear within CQC that the regulatory process needed fundamental overhaul and that CQC could not make sound decisions about NHS performance based on its flawed processes. His evidence to the Mid Staffs Inquiry corroborated that of Kay Sheldon and is consistent with other evidence which we will submit that there were fundamental failings in a management culture which was separated from operational reality.

In addition to two CQC Directors there were other CQC members of staff who gave evidence to the Mid Staffs Inquiry. The HSC should be aware that their evidence was not given lightly, and that CQC had used "gagging clauses" to prevent former members of staff talking about their experience, resulting in the Inquiry having to resort to sub-poena some witnesses in order to get around the gagging imposed by CQC. A report in the Guardian has exposed the gagging of CQC staff by the organisation.

http://www.guardian.co.uk/society/2012/jan/24/care-quality-commission-ga

We submit that scandals such as Winterbourne and Mid Staffs could have been avoided by acting on concerns raised by employees, patients and their carers.

In summary we would characterise the approach taken by the CQC as one of defensiveness both of itself and on behalf of the organisation to which the complaint is directed. The complainant is often treated with distain, disinterest, or is ignored.

In our sample of examples we will show that CQC does not investigate concerns consistently or in some cases at all, and sometimes does not even interview the whistleblower. These examples can be replicated in many other instances. Our concerns are such that we consider that serious failings in care are currently going undetected across the health and social care sector. These failings are often only exposed when staff or relatives blow the whistle having exhausted all attempts to get management and the organisation to respond.

We provide you with four examples by way of illustration. This is by no means an exhaustive list but reflects a sample failings brought to our attention by NHS staff and by relatives.

David Hands

David Hands is a retired Health Authority Chief Executive and Visiting Professor in Health Policy and Management.

From 2006 onwards, he progressively became aware of an apparently institutionalised bullying culture in the management of Northamptonshire Healthcare NHS Trust, where, in 1996–97, he had been interim Chief Executive and where his wife was a Consultant and Clinical Director of the Psychotherapy Service. He eventually documented more than 70 instances of apparent management malpractice, many of which involved harm, or potential harm, to patients.

Professor Hands reported his concerns to East Midlands SHA. When they were summarily dismissed by the Chief Executive, Dr Barbara Hakin, he asked the Chief Executive of the NHS, David Nicholson, and the CQC to intervene. Several Clinicians, including Consultant Medical Staff, also complained to the CQC. The CQC accepted management denials of malpractice at face value and refused to investigate.

Eventually, in 2009, following persistent requests to Mr Nicholson by Professor Hands (who had, by then, been elected a Governor of the Trust), to establish an independent inquiry, the SHA reluctantly established a "Review" by management consultants. This was superficial and flawed. It concluded, without investigation, that whilst Professor Hands had acted in good faith by reporting his concerns, there was insufficient evidence to justify an investigation. This exercise was subsequently claimed by the Trust, the SHA and the DoH to have been a complete and independent investigation. Professor Hands was dismissed as "the husband of a clinician".

Subsequent complaints by Professor Hands to the Secretary of State and the CQC were ignored. Responses to a series of evidence-based letters to the Chief Executive of CQC became progressively more evasive and disingenuous. Further evidence of apparent bullying and management malpractice in the Trust has subsequently emerged.

Professor Hands has since compiled further evidence about similar situations in other parts of the NHS in England, particularly the apparently frequent practice of using "Reviews" to avoid investigations and suppress valid concerns by professional staff. In 2011 he presented an analysis of his conclusions in evidence to the Francis Inquiry on Mid Staffordshire. He would be willing to make these papers available to the Committee if required.

Kim Holt

Dr Holt is a Consultant Community Paediatrician and the Designated Doctor for Children in Care Haringey.

She and three other paediatricians had reported concerns about failings in basic good practice in paediatric care in Haringey on a number of occasions in the years preceding the killing of Peter Connelley, "Baby P". Dr Holt informed the CQC investigator charged with looking at the organisations involved in the Peter Connelley case of these system health failings, institutional bullying and a blame culture and that these concerns had first been raised in 2006.

The response from the CQC was to ignore the documentation sent to them even though it was of direct relevance to concerns raised over one year before Peter Connelley was seen at St Anns. This protected disclosure letter was reported in the press around the time of the CQC report and has been the source of much discussion regarding the case. This letter was not included in the CQC report of the involvement of the relevant health bodies into baby P. Given the fact that the warning letter from 2006 mirrored the findings of the CQC this raises a serious question as to why the CQC chose to ignore this key piece of information. Dr Holt was never formally interviewed by the CQC despite the importance of this case for national child protection procedures and the national outcry over the failings which resulted in this child's death.

Following the publication of the report in May 2009 Dr Holt contacted the CQC regarding factual inaccuracies in their report. Dr Holt had documentary evidence that the crucially important post of the "named doctor for child protection" had been cut in 2006, and that this had been supported by senior management at GOSH. The loss of this post was subsequently one of the heavily criticised decisions within the NHS L report that followed later that year. Yet the CQC failed to correctly establish this fact and failed to follow up on Dr Holt's information.

Subsequently Dr Holt reported again to the CQC lead investigator on 27 September 2009 ongoing concerns about harassment and bullying, and threats of dismissal by Great Ormond Street. In the context of her being a whistleblower this should have raised alarm bells within the CQC.

The response from the CQC was an email dated 9th November 2009 that referred to actions taken post Peter Connelley case, but not mentioning whistleblowing In the CQC email it stated that harassment and bullying issues did not fall within their remit but that these were the responsibility of the SHA under their performance management arm.

Patients First experience is that bullying and whistleblowing are closely linked and Dr Holts case is an example. There is more evidence related to this that could be shared with the HSC under parliamentary privilege.

The Committee will also want to be aware of the significant sums from the public purse which were wasted in attempting to intimidate and dismiss Dr Holt for taking her stand.

Considerable sums of money leach out of the NHS every year in suppressing, bullying, intimidating and gagging highly qualified and expensively trained staff, because they have challenged and exposed bad practice.

No one knows how much is lost in this way. Patients First recommends to the HSC that it initiates an Inquiry into this misuse of public funds to cover up bad management and bad care standards. Patients First can provide a body of evidence to expose the extent of this abuse of power.

Joshua Titcombe

The Titcombe family lost their new born son Joshua in November 2008, due to failures in care at Furness General Hospital in Cumbria. Unsatisfied with the Trust's response and its own investigations into the case, Mr Titcombe referred his son's death to the Parliamentary and Health Service Ombudsman (PHSO). After a year of deliberations, the PHSO refused to investigate on the basis that discussion with the CQC had taken place in which "robust action" to ensure standards of care in maternity services at the trust would be taken by the regulator.

In December 2009, the regional director of the CQC, Alan Jefferson wrote to Mr Titcombe to say that the CQC were aware of serious concerns in maternity services at the Trust. The letter warned of "future tragedies" unless the quality of care improved. Internal documents obtained under the Data Protection Act from the PSHO, demonstrate that the CQC were aware of serious systemic risks at the trust, not just in maternity services but relating to the Trust's management as a whole.

Despite these concerns, just four months later, in April 2010 the CQC registered the trust "without conditions" and without any planned investigations. In June 2010, the CQC carried out a one day "unannounced visit" at the maternity unit at FGH which identified no concerns.

In June 2011, an inquest into Joshua's death was undertaken, following which the Coroner wrote to the Trust under rule 43 as it was felt ongoing issues still represented a risk to other users of the service. This resulted in a range of regulatory actions, eventually cumulating in Monitor commissioning a full diagnostic review of maternity services at the trust which reported in February 2012. This review concluded that mothers and babies at Furness General Hospital remained under "significant risk".

The maternity unit which failed Joshua is currently subject to 37 legal actions following death or serious harm to mothers and babies. The majority of the incidents leading to these claims occurred after Joshua's death in 2008.

This is a brief summary of a tragic case in which there is evidence of multiple failings in good care standards within a poorly performing organisation. The regulators failed to recognise this, even in the face of a body of evidence collected and presented by the bereaved parents. It also illustrates the gap between the operational knowledge of poor practice within CQC at regional level and the judgements of CQC emanating from an out of touch and ineffective centre based on a deficient model of regulation.

Gary Walker

We are aware of the case of Mr Walker who is prevented from giving evidence to the committee. What we understand of Mr Walker's case prior to him being gagged is that he approached the CQC with six concerns from doctors, managers and directors at United Lincolnshire NHS Trust concerning patients either actuality coming to harm and premature death, or at risk of coming to harm.

We understand that the CQC took more than three months to start an investigation. When the investigation was complete the CQC found minor issues. However, we understand that none of those raising concerns were spoken to and no relevant patient records were examined.

Mr Walker is a recognised whistleblower and it is our belief that because of this he was effectively ignored by the CQC which appears to be common practice.

As Mr Walker and others had predicted, a year after the concerns were raised the CQC discovered significant failings at ULHT and it has been given formal warnings and threatened with closure of services. It has been actively monitored for the past two years.

To our knowledge, the CQC has still not looked into the deaths and harm raised by Mr Walker *et al* and ULHT continues to have one of the highest mortality rates in the UK along with many other elements that are reminiscent of Mid Staffordshire.

Dr David Drew

Dr Drew is a founder member of Patients First. Dr Drew has submitted information separately to the Health Select Committee and so we will not repeat his example here.

August 2012

Written evidence from Professor J J Scarisbrick (CQC 16)

On behalf of the national charity LIFE I ask that the following question be put to the Care Quality Commission at the forthcoming Accountability hearing:

In view the fact that:

1. 98% of abortions are done on the ground that continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, to the mental health of the woman; and
2. the review entitled "Induced Abortion and Mental Health" (December 2011) developed for the Academy of Medical Royal Colleges by the National Collaborating Centre for Mental Health concluded that "the most reliable predictor of post-abortion mental health problems was a history of mental health problems before the abortion", and that other stressful factors and/or negative attitudes may lead to poorer mental health outcomes.

Should not the Care Quality Commission require that doctors who authorise abortions shall have adequate training in psychiatry and shall make a full assessment of the mental health and other relevant personal factors of every woman presenting for an abortion?

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