

Putting quality into the Care Quality Commission in England



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Executive summary

Introduction

The Care Quality Commission (CQC) is the system regulator whose role is to reassure that all providers of adult social care and health care in England meet minimum standards for quality and safety as set out in law. Providers and individual practitioners are ultimately responsible for the care they deliver, but the CQC can play a role in identifying poor practice via regular monitoring of information on providers, and through inspections. The CQC can, in the extreme, close a provider down if it is found to be harming patients, although this is a last resort. For nurses, the CQC can also identify issues for the Nursing and Midwifery Council (NMC) to investigate about the care delivered by individual registered nurses (RN).

Given the importance of such a role, and set against a backdrop of rising pressures on staff, the NHS and health and social care, the Royal College of Nursing (RCN) wanted to find out more about what its members think about the CQC. It is the individual nurses and wider nursing family who work in providers, alongside their clinical and management teams, who need to comply with the standards and who have experienced inspection, or will in the future.

Background on the CQC

The CQC evolved from three previous commissions. It brought these together over a challenging timetable, operating in shadow form in 2008 and formally beginning work as the CQC in 2009. It has also had to do this with six per cent less funding than the three previous agencies. The CQC currently regulates over 21,000 providers, ranging from domiciliary care through to acute hospitals.

Context of regulation

The CQC is regulating at a very difficult time for the NHS and social care. The NHS in England must make efficiency savings if it is to avoid deficits, given rising demand and a lower growth rate in the NHS budget. In some providers, this drive is not leading to more efficient care, but threats of job cuts, with some 48,000 posts at risk across England (RCN, 2011a).

The NHS is also going through considerable reform, and if the Health and Social Care Bill is given Royal Assent in 2012, more reform will take place. The RCN is calling for this reform to take the opportunity to set out clearer standards for nurse staffing (skill mix and numbers) which should also mean a role for the CQC in policing against these standards.

The CQC evolving over time

The CQC has not been free from criticism. However, it has been changing in response to concerns, and to the wider changes in the system (such as a more diverse market). Recent changes have included:

- a bespoke approach to inspections including nurses from clinical practice as part of the Dignity and Nutrition Inspections (DANI)
- clarifying guidance on how CQC staff deal with whistleblowing concerns
- a move to annual inspections for some providers
- a guide for frontline staff on raising concerns with the CQC
- a re-vamped website.

RCN surveys

The RCN asked its members for their views on the CQC using two online surveys: a shorter survey for Band 5 and below nurses, and a longer survey for Band 6 and above nurses. The latter are likely to have

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more responsibilities for leading on quality of care. The survey ran between 21 August and 19 September 2011.

Key results

5,426 nurses filled in the surveys; 18 per cent Band 6 and over, the remainder Band 5 and below.

Key findings include:

- nurses are very aware of the CQC and there is support for an effective system regulator
- nurses know what drives quality care – highlighting the role of staffing in delivery of safe and quality care. But they do not feel that the CQC takes enough account of staffing in their approach
- nurses believe that the CQC can help champion staffing, supporting them in their call for appropriate staffing within their organisation
- in some areas, the CQC is already very effective and supports nurses, in achieving positive change but, this is not the case countrywide.
- The CQC needs to do more to become that effective regulator by:
 - making its guidance and approach clearer and more setting focused
 - avoiding an overly bureaucratic approach
 - focusing on unannounced inspections, including at night
 - applying balance, recognising excellence as well as problems and ensuring that this feeds into public reports
 - promptly following up
 - ensuring a more consistent approach from inspectors.

Nurses are concerned about whether the CQC has credible nursing expertise available, and want to see this applied when the CQC conducts its regulatory

activities – this will increase the relevance and credibility of the CQC overall.

Recommendations

The RCN has set out 10 recommendations for change, and we hope that these are taken forward swiftly.

Staffing within providers

1. The CQC ensures a clearer focus on staffing by:
 - a. providing further detail on staffing that inspectors see on their inspection visit, publicly reporting on: RN to non-RN ratios, use of an appropriate tool to determine staffing levels, actual versus establishment staffing levels and RN to patient ratios
 - b. revisiting the Quality and Risk Profile (QRP) to see how these metrics can be incorporated in regular monitoring.
2. The Department of Health (DH) to consider whether new data collections are required for the CQC to draw upon to support their monitoring of staffing within the QRP.

Inspections

3. The CQC ensures that all providers have an unannounced inspection once a year and ensures clear and transparent reporting of inspection and enforcement activity, including accurately publishing within their annual report all inspection and enforcement activity undertaken.
4. The CQC inspectors should talk to a range of staff when conducting inspections, including both senior and junior staff. They should also ensure that they speak to staff without managers present to allow staff to speak freely.
5. The CQC ensures a balance of unannounced inspections during the day and night.

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Whistleblowing

6. The CQC sets out a two week target for responding to those who raise concerns (if they provide their full details so that the CQC can follow up because individuals can raise concerns anonymously). The CQC should also monitor and publish their success at meeting those targets.
7. If the CQC cannot meet a two week target then they must look again at the workload of CQC staff and whether more staff are needed.

Supporting the CQC's own staff by ensuring in-house and external access to credible nursing expertise

8. The CQC must support its own staff to maintain their nursing expertise and registration, to help counter the perception of a lack of clinical expertise which undermines the credibility of inspectors and their inspection reports.
9. The CQC continues its ongoing recruitment of inspectors and reviews their training to support them in their challenging role.
10. The CQC explores more widespread work with nurses still in clinical practice as part of inspecting teams to build on the success of the DANI inspections.

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Introduction

The RCN conducted surveys of its members to ask them about the CQC. This report provides the results, alongside the background to the work of the CQC, to put them into context.

The CQC operates alongside a number of agencies from professional regulators such as the NMC to system regulators such as Monitor for foundation trusts. The CQC is the system regulator that aims to create joined up regulation for health and social care (including primary care in the future), helping to ensure better outcomes for the people who use services.

RCN members were asked for their views because the CQC has the power to intervene where care falls below an acceptable standard, and can be part of preventing harm and even mortality. For individual nurses, a CQC inspection can reveal concerns about individual practice, and lead to action by the NMC.

This report covers:

- background on the CQC
- the context in which the CQC is regulating providers of health and adult social care
- the results from the surveys
- recommendations for improvements
- further reading for those who want to know more.

Background on the CQC

The CQC replaced:

- The Commission for Healthcare, Audit and Inspection (known as the Healthcare Commission, HC)
- The Commission for Social Care Inspection (CSCI)
- The Mental Health Act Commission.

However, the CQC did not inherit the same level of funding compared to the previous commissions. The National Audit Office (2011) reported that the CQC had a six per cent reduction in recurrent funding from 2008-09 (£175million) to 2010-11 (£163.8million). However, the CQC underspent their budget in 2009-10 (£3.8 million underspend) and 2010-11 (£13.1 million).

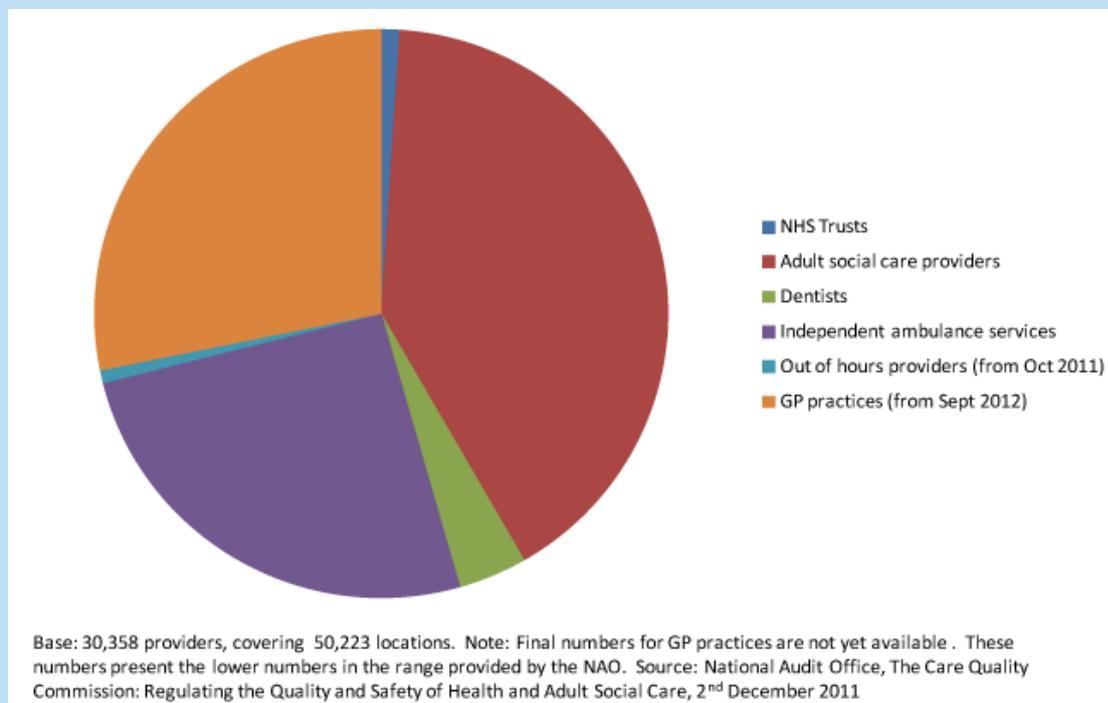
The Health and Social Care Act 2008 established the CQC and was granted Royal Assent on 21 July 2008 (Department of Health, 2008). The CQC existed in shadow form in 2008 and began operating from April 2009. The new registration system has been phased in with the majority of health care providers registered during 2010, with the exception of regulations on health care associated infections (HCAI), which came into force in April 2009. Primary care will be registered during 2013.

The CQC's functions cover (Department of Health, 2010):

- safety and quality assurance
- performance assessment of commissioners (subsequently ceased in 2010 – National Audit Office, 2011) and providers
- monitoring the operation of the Mental Health Act
- co-ordinating and managing regulation and inspection activity across health and adult social care.

The CQC currently regulates 21,600 providers and has a budget of £134million (National Audit Office, 2011). The range of providers currently regulated, or due to be regulated, is diverse, as illustrated on the following page.

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The CQC regulates against government standards. The CQC therefore cannot alter the scope of what is regulated. It can influence how it goes about regulating those activities, within the framework set out by policymakers.

The CQC has adopted a risk-based approach in order to target regulation activity where it is needed, which informs, for example, the use of inspections.

The CQC has a range of sanctions and enforcement powers ranging from:

- statutory warning notices (setting out a time limit for improvement)
- imposing a fine in lieu of prosecution
- formal caution
- suspension of services
- prosecution of organisations and/or individuals
- cancellation of registration.

Providers of regulated activities must register with the CQC and provide it with a range of information on their organisation and the services provided. Once registered, the CQC monitors providers and information is captured and analysed using the QRP and the judgement of CQC staff.

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Context of regulation

A period of considerable difficulty – Quality, Innovation, Productivity and Prevention (QIPP) and Health and Social Care Reform

The CQC is regulating at a time of considerable difficulty for providers. There are rising pressures on providers that stem from less money coming into the system (the Nicholson Challenge requiring efficiency savings of between £15 to £20 billion in England over the next four years) and from more needed from the system as people age, and as people's health suffers during the recession. The NHS in England is also facing restructuring under the new Health and Social Care Bill which is going through the House of Lords. This is leading to uncertainty for all, with some 48,000 posts at risk (RCN, 2011), many of which are in nursing. This can only be seen as a threat to the delivery of high-quality care to patients.

The CQC will remain in the new framework of the NHS, and has a crucial role to provide assurance for quality of care as the rest of the NHS changes. There are some changes to the role of the CQC if the bill goes through as currently drafted, particularly the removal of its responsibility to assess commissioners. Instead, the National Commissioning Board will undertake this task. The CQC will also host HealthWatch England, an independent agency to advocate on behalf of patients and the public. It will also work with Monitor on a co-licensing scheme.

As part of ongoing debate about the final details of the Health and Social Care Bill, the RCN has called for mandatory skill mix and staffing levels to be set (RCN, 2011b). There has been much debate surrounding this suggestion, including whether it should be for the CQC to set such standards or for others, leaving

the CQC to police against them (House of Lords, 2011). The RCN is following up with ministers and officials at the DH to understand what guidance they will be giving to local commissioners on staffing. We understand that the DH Nursing and Midwifery Professional Advisory Board will be reviewing the evidence presented as part of the ongoing discussions on staffing levels. The RCN's position is that setting the standards is not an appropriate role for the CQC. We would, however, wish to see the CQC use the standards within their regulatory model, if they are developed and implemented in the future. This would mean, for example, checking whether providers have the appropriate ratio of RNs to patients when the CQC inspects. The RCN will continue to campaign for safe staffing levels as we know that this is a key determinant of safe quality care.

CQC learning by doing

The CQC has had a challenging timetable in order to integrate three legacy organisations and design and implement a new approach to regulation. This includes both registration, and ongoing compliance, against the essential standards of quality and safety. It also has statutory requirements to consult on key elements of the approach to regulation.

The approach of the CQC has not been free from criticism, particularly in relation to:

- the **responsiveness** of the CQC. Concerns have been raised that it has been slow to respond to issues, as occurred in the case of Winterbourne View
- **missed deadlines** for registering providers (47 per cent of provider registrations not completed on time – National Audit Office, 2011)
- the way in which **change has been managed for staff working at the CQC**, with concerns expressed through the CQC staff survey (Samuel, 2010), as

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well as by trade unions (including the RCN – House of Commons Health Committee, 2011a)

- **too few inspections** (Mitchell, 2011) being undertaken around 70 per cent less during the second half of 2010-11 compared with the same period in the previous year (House of Commons Health Committee, 2011b). This is compounded by staff vacancies and a broader freeze on public sector recruitment (which did not prevent recruitment of assessors and inspectors but still the CQC took some five months to advertise the posts to limited pools of potential applicants – National Audit Office, 2011), and how far registration of providers has distracted the CQC from its core business (House of Commons Health Committee, 2011b)
- the **lack of clarity in CQC guidance** and whether it provides enough information for providers to know what they need to do to meet the essential standards for quality and safety
- the **lack of signposting by the CQC to the information, support and tools available to help providers** deliver higher-quality care
- the speed at which the CQC has updated their website and errors in **Quality Risk Profiles (QRPs)** including underlying errors in self assessment by trusts (Panorama, 2010), which forms a large part of the CQC's regulatory model. There have sometimes been errors in the CQC's performance management data (National Audit Office, 2011)
- **the need to ensure a clearer focus on staffing**, for example, by using metrics such as: RN to non-RN ratios (assessed on an ongoing basis), use of an appropriate tool to determine staffing levels (which would form part of evidence of ongoing compliance on staffing and would be a less frequent

measure), actual versus establishment staffing levels (assessed on an ongoing basis), and RN to patient ratios

- the approach to publication of reports resulting from inspections, with **reports published in batches from themed inspections which may dilute the impact** of overall findings (Age UK, 2011).

Other criticisms relate to the way that the CQC was set up including a challenging timetable for implementation and a lack of appropriate resourcing which are responsibilities of the DH. The CQC has been criticised for not making it clearly known what the implications of these would be (House of Commons Health Committee, 2011b). However, concerns about cutting funding and the impact on inspections were raised by the CQC (Gainsbury, 2009).

Leadership has also been criticised, with concerns raised about the skills of the current management team to lead such an organisation (House of Commons Health Committee, 2011b, and Campbell, 2011). Similarly, concerns have been raised about the performance management approach, including a lack of metrics to measure performance of the CQC (crucially on enforcement actions) (National Audit Office, 2011).

The National Audit Office review concluded that “although regulation is being delivered more cheaply, the commission has not so far achieved value for money in regulating the quality and safety of health and adult social care. It is not clear to us exactly where the balance of responsibility lies between the commission and the department for failing to achieve value for money, but it is clear that responsibility is shared.” (National Audit Office, 2011).

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CQC lessons being learned

The CQC has undertaken a review internally, led by one of their board members and published in September 2011 (CQC, 2011). This review highlighted that the CQC needed to improve:

- having a clear understanding of risk and a risk-based approach
- their approach to enforcement
- communication about the regulatory model and about regulatory judgements.

The CQC is also within the scope of the Francis Inquiry, due to report in 2012, and its preceding inquiry (published in February 2010) into events at Mid Staffordshire NHS Foundation Trust where there were many preventable deaths. The inquiry relates to activities of regulators which pre-date the CQC, nevertheless, lessons may apply going forward¹. CQC staff have been interviewed as part of the ongoing inquiry, however staff raised questions over the evidence being used (NHS Local, 2011). The National Audit Office reported on the CQC's value for money in December 2011 (National Audit Office, 2011). The DH is also reviewing the CQC (Calkin, 2011).

The CQC has been making changes. For example:

- a **bespoke approach to inspections**, including nurses currently in clinical practice as part of the DANI. 100 NHS trusts were inspected from March to June 2011 (before our survey was conducted). A further set of inspections are planned for April to June 2012 (personal communication, CQC, 2011)
- clarifying their guidance to call centre staff in order to **prioritise whistleblowing** concerns and speed

up action in light of the experience at Winterbourne View, where the CQC were slow to respond (before our survey was conducted). Their subsequent inspection revealed appalling care and led to Winterbourne View being closed down and residents moved to alternative providers. A further 500 inspections of care homes with nursing are planned for February to June 2012 alongside 150 inspections for organisations providing care for those with learning and disability issues (personal communication, CQC, 2011)

- a move to a minimum of **annual inspections** for some providers, rather than a planned inspection every two or three years from April 2012 (National Audit Office, 2011 – after our survey was conducted)
- a shorter **guide for frontline staff** to explain the role of the CQC and how staff can contact the CQC if they have concerns that are not being followed up by their employer (after our survey was conducted)
- a **re-vamped website** to help the public and providers access information (after our survey was conducted).

RCN surveys

The RCN has had an active interest in the CQC from its inception, working both to represent our members who work for the CQC, and on the policy and implementation of its regulatory approach, ensuring that it can have a positive impact on care, or at least help to prevent the very worst of care. This is in line with the RCN's strategic objectives for 2008 to 2013 to campaign for patients (RCN, 2008). The RCN has responded to the vast majority of CQC consultations and DH consultations on the underpinning legislation and policy

¹ The CQC has already identified lessons from the first inquiry. See Learning from the CQC from the Francis Enquiry report into Mid-Staffordshire NHS Foundation Trust paper for board meeting Wednesday 19 May 2011.

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on the underpinning legislation and policy intent. We have also worked with the CQC as a key stakeholder on the DANI steering group and on designing the dignity and nutrition tool used by inspectors when they visit providers.

The RCN wanted to find out more about the current views of its members on the CQC now that it has been operating for longer and has had a chance to settle in as the new regulator. We undertook two online surveys to find out our members views: a slightly more detailed survey for Band 6 and above nurses, and a shorter survey for Band 5 and below nurses. Band 6 and above nurses are more likely to have responsibility for leading on quality and for systems and standards of care. The surveys included a mix of questions with pre-defined answers and some open questions.

The surveys were advertised on our website, and through our member magazine, *RCN Bulletin*, which is posted to all our members. We also sent out emails to invite members to take part, including a link to the survey in their email. The surveys are necessarily high-level and do

not cover all of the work of the CQC and experiences of our members, but with over 5,000 members sharing their views, it provides a comprehensive view of what nurses, who are on the receiving end of system regulation, think.

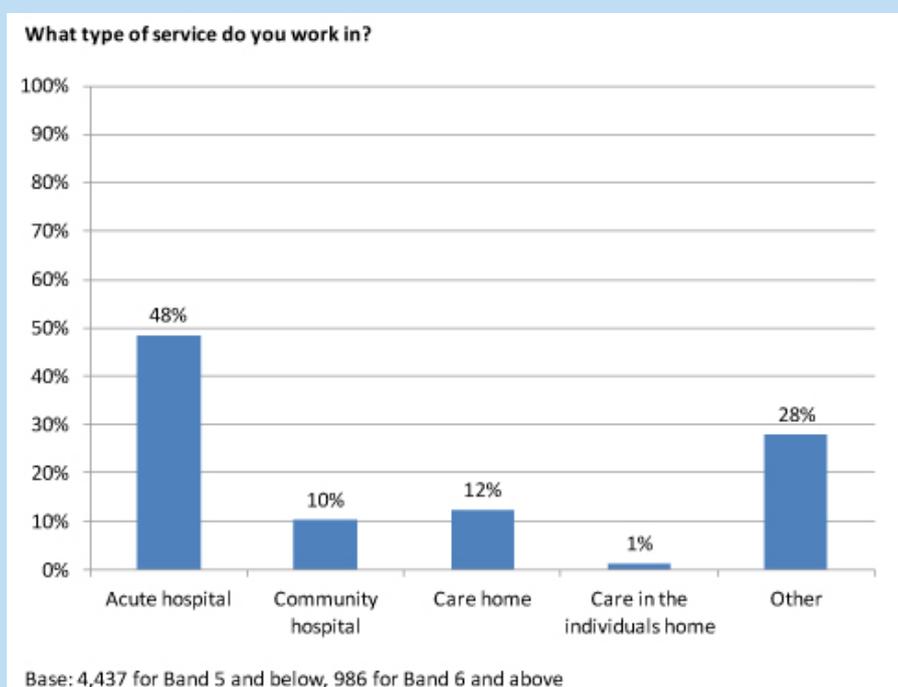
Throughout the results section we have rounded up to the nearest whole per cent.

Results

5,426 nurses filled in the online survey which was available from 21 August to 19 September 2011. Given the competing calls on nurses' time, and at a period of considerable difficulty for delivery of health and social care services, this shows the strength of feeling and level of importance RCN members attach to the CQC and its work.

Profile of respondents

Of the 5,426 nurses who responded, 989 were Band 6 and over (18 per cent) and 4,437 (82 per cent) were Band 5 nurses and below. Respondents were drawn from across both the acute and community settings as illustrated below.



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High level of awareness of the CQC

There is a high level of awareness of the CQC among nurses, with 91 per cent of Band 5 and below nurses saying that they are aware of the CQC and the role it carries out (six per cent are neither aware nor unaware of it, and three per cent are not aware).

There is also a high level of awareness (74 per cent of Band 5 and below) of what might happen if the CQC finds that a provider is not compliant with the essential standards of quality and safety. However, nearly one in ten respondents (eight per cent) did not know what could happen if a provider was found to be non-compliant.

Mixed reading of the essential standards of safety and quality

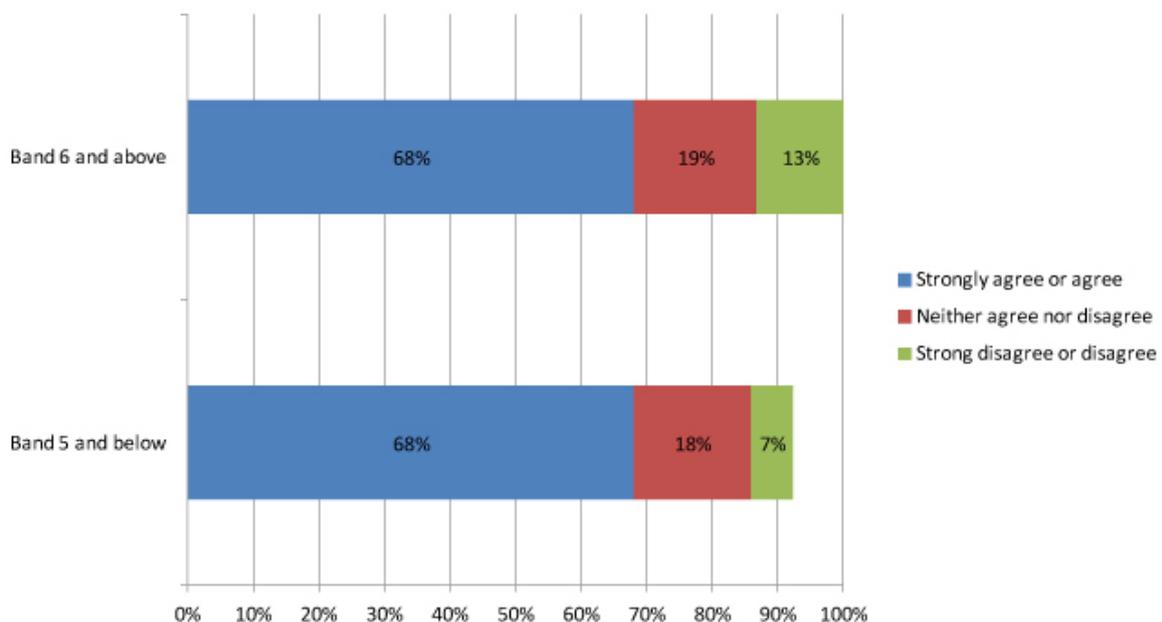
The CQC has produced guidance for providers on compliance with the essential standards of safety and quality. There was a notable difference between

respondents from Band 6 and above and respondents from Band 5 and below in relation to whether they had read the guidance on the *Essential Standards of Quality and Safety* (CQC, 2010).

While most Band 6 and above had read the guidance (74 per cent), a fifth had not read it (21 per cent), and a few were unsure if they had (five per cent). Most Band 5 and below respondents had also read the guidance (57 per cent), but over a third had not read it (34 per cent), and some do not know if they have (eight per cent).

Most respondents feel that the standards are clear about what they need to do (illustrated below), and what their employer needs to do to comply with them. However, a sizeable minority – 11 per cent of Band 5 and below, and 13 per cent of Band 6 and above – do not believe that they are clear.

The essential standards of safety and quality are clear about what I as a member of staff and my employer need to do, to comply with them



Base: 4,381 for Band 5 and below, 981 for Band 6 and above. Don't know responses explains the gap for Band 5 and below

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This also came through from open ended responses as illustrated below:

“They could do better if they can make their expectations clear. Sometimes [it] is not clear what they expect especially when it comes to indirect aspects of care.”

Member, Band 5 and below

“The Essential Standards of Quality and Safety are not clear enough as they are trying to relate to the whole range of services and are therefore too vague. This then means that individual inspectors interpret them in their own individual way, for example requiring a monthly review of a care plan, where no such guidance or regulation exists.”

Member, Band 6 and above

From free text responses of Band 5 and below, respondents also raised concerns about and/or asked for improvements in the awareness and clarity of the CQC’s role.

Some have also highlighted that they do not find the guidance accessible; both because it is very long and because practitioners need to know what it means for them in their practice, and for the specific patients and clients that they provide care for, rather than the generic approach used by the CQC (as set out by policy from the DH).

“As with all official paperwork their guidelines can sometimes be very ‘wordy’ – easy to understand versions would be helpful, especially when explaining to other colleagues in the workplace.”

Member, Band 5 and below

“The all-enveloping guidance just doesn’t make sense to people working at the sharp end – the language is their

own rather than that of the people they are regulating.”

Member, Band 5 and below

“The CQC needs to use simple English for all level staff to understand so that everyone can take responsibility.”

Member, Band 6 and above

“Their literature (essential standards etc) is largely impenetrable and not written with nurses in mind.”

Member, Band 6 and above

“[It] appears that they are non-medical/nursing people that have written them [the standards].”

Member, Band 6 and above

A number of respondents suggested that the CQC needs to produce a more user-friendly guide for practitioners about the essential standards and how they relate to the setting they work in and the care they deliver.

“A practitioner guide would be helpful, and linked with the NMC Code of Practice to emphasise, for example, the need to be able to demonstrate appropriate consent, completion of mandatory training, management of medical device training etc.”

Member, Band 5 and below

Changes needed to the approach of the CQC

There were positive and negative views expressed about the approach of the CQC. Many respondents to open-ended questions were concerned about a ‘box ticking approach’ and wanted to see the CQC minimise the amount of paperwork involved in registering and providing evidence on compliance. This was the top

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theme identified in free text answers from Band 5 and below respondents.

For example, one respondent said:

“The CQC seems to me to be a box-ticking exercise. The work they demand to be carried out has resulted in experienced nurses being tied to their computers and desks in order to fill in spreadsheets for various outcomes which quite frankly seems a waste of valuable nursing time. I know these ‘outcomes’ are supposed to benefit the patients, but higher staffing levels and nurses being allowed to get on and do their jobs would benefit the patients far more.”

Member, Band 5 and below

“Sometimes we struggle to demonstrate this in all our documentation, as we are too busy DOING it. People are much more aware of minimum standards and the CQC these days, but don’t fully appreciate that most settings were probably exceeding those standards without ever documenting the fact. The documentation takes more time to complete now, which means less time ‘hands on’ than we would prefer. I worry that actual ‘hands on’ standards could deteriorate while we try to ensure all documentation is up-to-date. Perhaps the CQC should consider devising documentation that could be rolled out to all settings so that everyone is using similar paperwork if they are being measured against the same standards.”

Member, Band 6 and above

“Nurses in the clinical area are doing their very best for patients and then pressure is added to ensure we get a good CQC report, however when this happens the patients will suffer

because there are no extra staff to prepare for the visits.”

Member, Band 6 and above

The RCN would like to see appropriate support for nurses to complete administration tasks, freeing nurses up to nurse.

However some members recognised that this was due to other factors, such as the ways in which organisations responded, for example:

“The CQC is not the problem. The childlike way that the trusts respond to being checked is the problem. This results in the trust being so fixated on passing the assessment that all staff care and consideration goes out of the window, to the point of bullying the staff!”

Member, Band 6 and above

Changes respondents were interested in include:

- greater focus on staffing levels and skill mix
- less of a focus on paperwork
- more unannounced inspections
- more inspections on weekends and during the night, and during the winter when there are particular pressures on providers and staff
- talking and/or using surveys to hear directly from those using services
- inspectors to meet with accredited representatives while visiting a trust
- inspectors to spend more time at a trust when inspecting, in order to get a fuller understanding of the context of care
- talking to staff, in private spaces where concerns can be raised confidentially
- triangulation of information, to help provide a more balanced view of a trust
- ensuring a named CQC contact if there are any issues to follow up on.

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Mixed views on fairness and proportionality of the CQC's approach

There are mixed views from respondents on whether the CQC's approach is fair and proportionate. Just under half (44 per cent) of all respondents agree that the CQC's approach is fair and proportionate, 18 per cent disagree and 31 per cent neither agree nor disagree.

Concern about consistency and balance in the CQC's approach

Many respondents highlighted a concern about the consistency of inspectors and the treatment of the NHS versus the independent sector in their open ended answers.

“CQC inspectors interpret the standards differently depending on their own preferences. [There is] no consistency to the approach of an inspection.”

Member, Band 5 and below

“Even though they have tried to make it fairer it is still too dependent on the inspector.”

Member, Band 5 and below

“Working for a private care provider for 10 years, it has become clear that there is a vast difference between the expectations placed on the NHS and the private sector. While everyone is aware that there is understaffing within the NHS, there is also understaffing and huge expectations on staff within the private sector who are just as skilled and dedicated.”

Member, Band 5 and below

“When you contact the CQC about issues, there are times when the information given is conflicting between CQC inspectors.”

Member, Band 6 and above

Some respondents are also concerned about how balanced a CQC report is when it is based on a relatively short inspection and often on inspecting only a small number of wards in a trust. In essence, that a whole trust can be ‘tarred with the same brush’ even when there are some nurses providing high quality care in other wards. A negative CQC report (particularly if perceived as unfair) can also negatively impact on morale, particularly where nurses may be working under great pressure, for example, from a lack of staff. The need to improve the CQC's impact on staff morale was cited by Band 5 and below respondents in their open text responses. These issues are highlighted with some selected quotes below:

“I do not think their reports are always a fair representation of care given in a whole trust. They tend to base their report on one or two wards that they have visited.”

Member, Band 5 and below

“The CQC needs to take into account that where there are several hospitals linked to one trust that those trusts that passed the inspection are not tarred with the same brush as those that have not.”

Member, Band 5 and below

Concern about responsiveness

Responsiveness of the CQC was also highlighted, with concerns raised about either a lack of response when a question or concern is raised or a very slow response.

“Actually investigate complaints rather than leave them in their inbox or ‘to be investigated’ pile.”

Member, Band 5 and below

“I have been surprised regarding a lack of knowledge when approaching the CQC for guidance. Often have to wait more than two weeks for a phone

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call enquiry to be returned and have been given the wrong forms twice and incorrect information.”

Member, Band 5 and below

“The feedback mechanism needs to be prompter and clearer particularly where there are major concerns.”

Member, Band 6 and above

Concern about inspectors and errors in CQC reports

Band 5 and below respondents in their free text responses also raised concerns about the manner in which CQC inspectors behave when inspecting, and also errors that can be included within reports.

“I once tried to tell a visiting inspector about concerns re a senior member of staff and she went straight to that member of staff and told her.”

Member, Band 5 and below

“I am concerned about the errors and mistakes they make and how they have failed to act when serious concerns about health care providers have been raised.”

Member, Band 5 and below

“The last inspection I experienced was extremely difficult for all members of staff. We were made to feel so uncomfortable in our work environment. We were criticised in front of our residents and the whole day turned into a nightmare experience.”

Member, Band 5 and below

Support for the CQC

However, there are also respondents who are very supportive of the CQC stating that:

“Due to the CQC visiting my trust I have seen a great improvement in hygiene

standards in my department.”

Member, Band 5 and below

“CQC involvement within care homes encourages [the] health care profession to practice in accordance to the code of conduct, hence reducing the gaps within the care delivery sector.”

Member, Band 5 and below

“I think CQC does a good job as all care homes need an external body to oversee care particularly in regard to service users who have no family or advocates.”

Member, Band 5 and below

“Trying to remain objective, it is a shame that following negative media reports the CQC have not come out as well as they should have.”

Member, Band 5 and below

“The CQC is an essential organisation ensuring high quality care throughout all nursing environments and I would hope that their input would drive up the standards of care. As a staff nurse on an elderly medical ward I understand firsthand the challenges placed upon trained and untrained nurses alike. It is a hugely demanding area and our patients have high care needs and this is not reflected in the staffing ratios even when the ward is fully staffed. Therefore we are doomed to failure despite all the hard work that goes on everyday because the expected work load is too great. It saddens me that the hard work of so many is over shadowed by the bad reports, even though I appreciate that inspection is an integral part of ensuring patients safety.”

Member, Band 5 and below

Many respondents felt that the CQCs very existence prevented complacency and that

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it offered ‘a fresh pair of eyes’. Many felt the CQC made their organisation and staff reflect on normalised practice and culture and was taken very seriously by them. For example:

“[The CQC] looks at things that ‘we’ sometimes disregard as part of our every day work pattern.”

Member, Band 6 and above

We also note that there are some very positive examples from mental health, for example, where the RCN perceives that the CQC has been able to retain a strong staff from the previous commission. This experience offers some transferable principles for CQC staff to have:

- familiarity with the clinical context
- competence in engaging with clients and their specific needs
- awareness of the broader contextual factors that impact on care delivery.

The need to pay more attention to staffing levels and skill mix

Over a third (35 per cent of all respondents) do not believe that the CQC sufficiently takes into account staffing issues such as staff numbers and skill mix.

Staffing was also a key theme in open-ended responses, and was the second main theme identified, as highlighted below, with some members having concern that staffing was not given sufficient emphasis by the CQC.

“Skill mix and staffing levels are incredibly important, yet it seems for the CQC that [these] are not a factor.”
Member, Band 5 and below

“My area is understaffed much of the time, and staff nurses spend most of their time on documentation, yet we

supposedly receive good reports from the CQC. I wonder if the criteria they use just doesn’t pick up on what is important.”

Member, Band 5 and below

“The way forward would be to ensure we had clear evidenced based staffing standards both in numbers and ratios as well as skill sets.”

Member, Band 5 and below

“[The CQC] needs to look deeper in staffing levels of organisations, don’t just accept what staffing level figures are presented. Staff nurses regularly accept responsibility for 12 to 15 acute patients with untrained staff being used to boost figures. If the staff are agency, then quality can be compromised.”

Member, Band 6 and above

It was felt that the CQC can play a part in championing staffing issues, with respondents saying that:

“The CQC needs to recognise that in most homes we strive to achieve excellent care, time for individualised care, a highly trained staff team and comprehensive record keeping. To do this effectively across the industry we must have higher staff/resident staffing levels. The CQC should take this on as a challenge and fight it at the highest levels.”

Member, Band 5 and below

“The CQC should be able to comment and recommend on poor staffing levels, if they want care and care-quality to be improved. These cannot be achieved without proper staffing, proper training and proper adequate equipment.”

Member, Band 5 and below

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“They need to look at the quality of care over a longer period of time and give a clear message to government when they see that care standards cannot be what they should without a higher number of experienced staff and reduced reliance on bank and agency staff.”

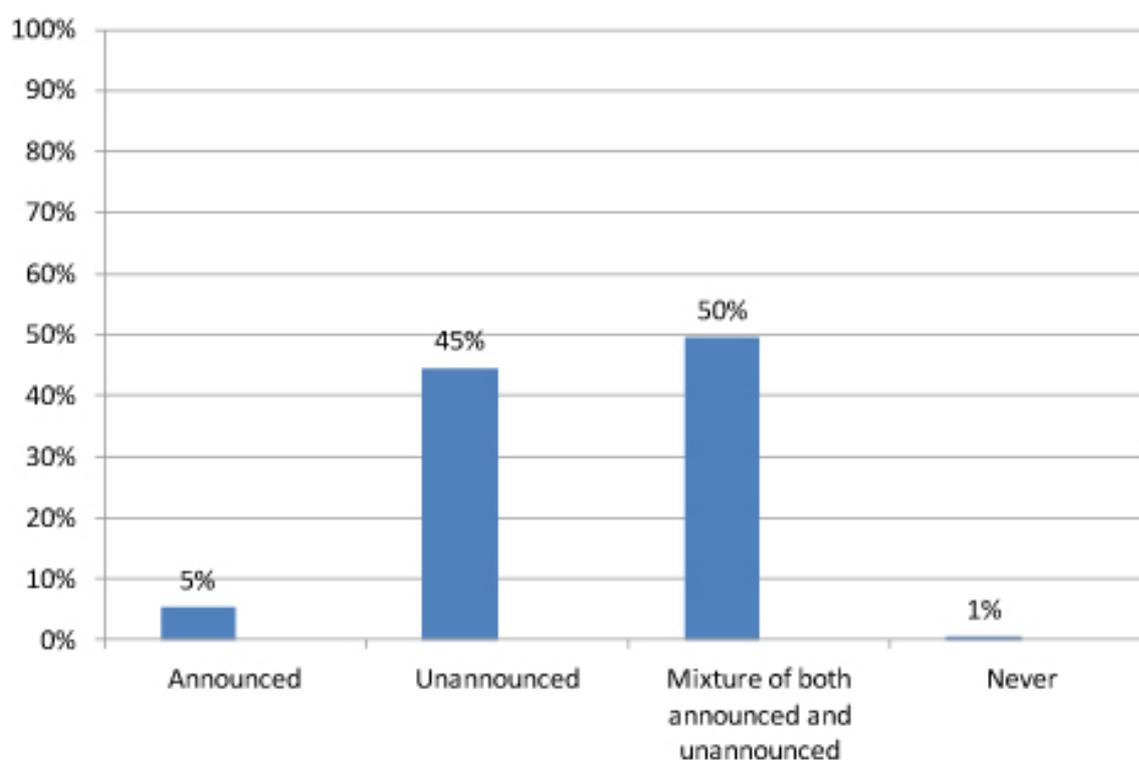
Member, Band 6 and above

Many also highlighted that there needs to be some reasonable expectations: staffing is so closely linked to the broader financing of the NHS and the lack of funding is driving lower ratios of staff to patients, despite patients having more acute health care needs.

Support for unannounced and frequent inspections

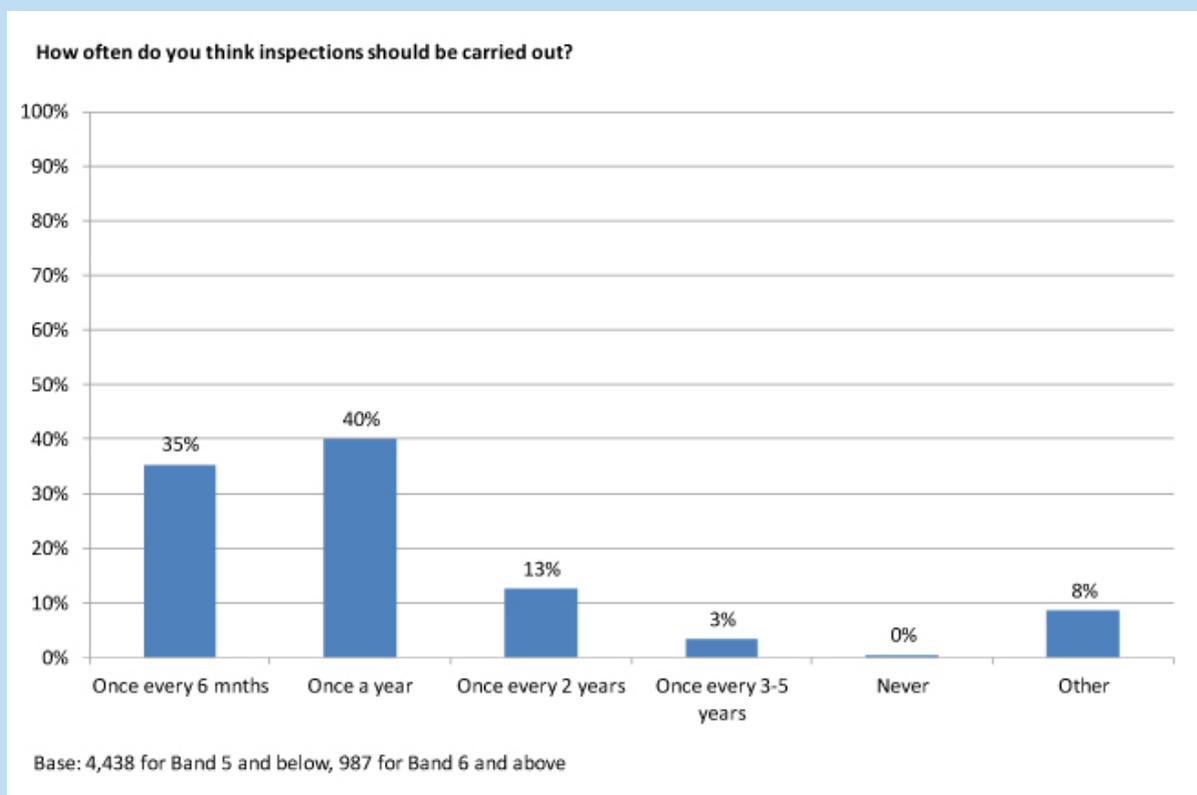
Respondents are very clearly supportive of inspections with 91 per cent of Band 6 and above respondents agreeing or strongly agreeing that inspections are needed as part of providing assurance about the safety and quality of services. Respondents are also supportive of relatively frequent inspections, as illustrated below.

How do you think inspections should be carried out, if at all?



Base 4,438 for Band 5 and below, 985 for Band 6 and above

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Mixed experience of inspections

Band 6 and above nurses have mixed experiences of inspection; 45 per cent rate it as good or very good, 41 per cent as neither good nor poor, with the remainder rating it as poor or very poor.

Concern about the CQC having enough inspectors with credible clinical expertise

More than a third (36 per cent) of Band 6 and above respondents believe that the CQC doesn't have enough inspectors. Band 5 and below respondents who provided free text responses, were also concerned about the knowledge of inspectors as illustrated from a selection of free text responses below:

"I feel that the CQC should move back to employing staff with relevant backgrounds and should use specialists when required."

Member, Band 5 and below

"Most CQC inspectors I have seen have little or no experience in working in a health care environment, and do not understand the complex needs of services."

Member, Band 5 and below

"The CQC do not always have knowledge of the different needs of different types of care – this is very obvious within mental health where the standards relating to acute care are used for the assessment – when a patient is in hospital for two years they have different needs and risks compared with someone in ITU."

Member, Band 5 and below

Many Band 6 and above respondents also felt that inspectors needed to be experts in the area, with more frontline experience and expertise, and that they required more training.

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“More informal listening to staff [is needed] to really establish their knowledge of basic needs of care rather than targets and standard’s jargon.”
Member, Band 6 and above

“The only time a service receives a fair inspection is if the inspector is experienced in the specialism they are inspecting.”
Member, Band 6 and above

Sixty-six per cent of Band 6 and above respondents have worked for a provider that has had an inspection in the last six or twelve months. Some six per cent hadn’t had an inspection at all at their current workplace. Twelve per cent didn’t know.

Band 6 and above respondents were also asked about the skills, knowledge and experience of their local CQC inspector. Just 20 per cent said it was good or very good, with 10 per cent saying it was poor, and 45 per cent who didn’t know. However, there are respondents who have a positive experience with inspectors stating that:

“I think that if you really care about caring and ensure your staff and yourself care for all of your clients your CQC inspector will recognise and acknowledge this.”
Member, Band 6 and above

Support to improve

The CQC must take a view on what action to take if they find a provider is not compliant. There are some respondents (21 per cent of Band 6 and above) who are concerned that they don’t get the support they need to achieve the improvements set out by the CQC. The same number (21 per cent) felt that they did receive the support they needed, with the remainder (58 per cent) neutral. This theme was also seen in the free text responses.

Respondents said:

“There should be a way of putting in experienced staff to help lead the facility to improve their care and standards rather than coming back at a later date to see if they’ve managed to improve.”
Member, Band 5 and below

“I am currently working in a nursing home which is under immense pressure to ensure that it gets back up to standard. I feel that we have been inspected and left to deal with the situation. Weekly monitoring for progress, even if it is just a phone call would be helpful if not motivating and remindful.”
Member, Band 5 and below

“I think the CQC should have cordial relationships with care home managers, and not make them panic or be afraid when the inspection is due, as is the case most of the time. A supportive role will be appreciated. Some managers feel quite distant to their inspectors.”
Member, Band 5 and below

“Better and more supportive assessment in which organisations are given positive as well as negative feedback. More focus on fundamental standards and awareness of the real working environment and what is ‘good enough’ safe care rather than expecting 100 per cent compliance with every standard 100 per cent of the time. This expectation can engender energies being diverted to ‘box ticking’ and away from patient care. This is demoralising for staff and counterproductive for patients.”
Member, Band 6 and above

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“[The CQC] needs to work more closely with areas that are struggling in order to prevent less occasions of patients being left at risk.”

Member, Band 6 and above

One respondent was concerned by the CQC’s approach to closing a care home and felt more time was needed:

“The CQC should give care homes time to re-house their patients before closing them down. One recent experience in a local community was such a home being closed over a weekend and patients left homeless. This should not happen even if they have been found to be below standards.”

Member, Band 6 and above

Conclusions and recommendations

There is strong support for an effective regulator. But there are some key themes which emerge about how the CQC needs to change in order to become a truly effective regulator. Our members tell us that the CQC:

- is necessary, particularly in terms of unannounced inspections to provide a much needed focus on the minimum standards that patients and users should expect
- is doing a difficult job with insufficient funding and a lack of appropriately experienced staff to inspect providers, which undermines the credibility of their inspections
- needs to support its staff and work internally to help counter the lack of consistency across inspectors, and to encourage a supportive, and not combative, approach. Some inspectors

are seen as valuable and support nurses working within providers to ensure a focus on quality nursing care, but some are not seen this way and need to improve

- needs to provide a balance in its reporting; recognising excellence as well as highlighting poor care, and they need to support providers in improving. If this is not feasible within resources, and recognising that this is not a formal role for the CQC, it must be made clear by the DH who else takes on this role. While there are agencies such as the National Institute for Health and Clinical Excellence, and the NHS Improvement and Innovation Agency (soon to be disbanded), such agencies are not well placed to take a CQC report and guide a provider through specific local actions needed to be taken to reach compliance.

The RCN recommends in relation to:

Staffing within providers

1. The CQC ensures a clearer focus on staffing by:
 - a. providing further detail on staffing that inspectors see on their inspection visit, publicly reporting on: RN to non-RN ratios, use of an appropriate tool to determine staffing levels, actual versus establishment staffing levels and RN to patient ratios
 - b. revisiting the QRP to see how these metrics can be incorporated in regular monitoring.
2. The DH to consider whether new data collections are required for the CQC to draw upon to support their monitoring of staffing within the QRP.

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Inspections

3. The CQC should ensure that all providers have an unannounced inspection once a year and ensures clear and transparent reporting of inspection and enforcement activity, including accurately publishing within their annual report all inspection and enforcement activity undertaken.
4. The CQC inspectors should talk to a range of staff when conducting inspections, including both senior and junior staff. They should also ensure that they speak to staff without managers present to allow staff to speak freely.
5. The CQC should ensure a balance of unannounced inspections during the day and night.

Whistleblowing

6. The CQC should set out a two week target for responding to those who raise concerns (if they provide their full details so that the CQC can follow up as individuals can raise concerns anonymously). The CQC should also monitor and publish their success at meeting those targets.
7. If the CQC cannot meet a two week target then they must look again at workload of CQC staff and whether more staff are needed.

Supporting the CQC's own staff by ensuring in-house and external access to credible nursing expertise

8. The CQC must support CQC staff to maintain their nursing expertise and registration, to help counter the perception of a lack of clinical expertise which undermines the credibility of inspectors and their inspection reports.

9. The CQC needs to continue its ongoing recruitment of inspectors and reviews their training to support them in their challenging role.
10. The CQC needs to explore more widespread work with nurses still in clinical practice as part of inspecting teams to build on the success of the DANI inspections.

Finally, many of our recommendations are in line with those of the National Audit Office, and we hope that these can be swiftly taken forward by the CQC and the DH.

Tell us what you think

The RCN Policy and International Department would like to receive comments and feedback from as many members as possible on this important issue – policycontacts@rcn.org.uk

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