

# a new regulator in town

Seamus Ward reports on the Care Quality Commission, the new umbrella organisation for all health and social care bodies.

■ **Move aside, there's a new regulator in town. The Care Quality Commission (CQC) was launched on 1 April 2009, with an unprecedented reach into the assessment of commissioning and provision of health and social care in England.**

For the first time, all health and social care bodies, including those in the independent sector, the NHS and local authority social care will be regulated by one umbrella organisation, which will also have responsibility for looking after the rights of people detained under the Mental Health Act.

But this new body is not just an über-regulator: it has shiny new teeth, with powers to fine, suspend or even close down organisations that fail to meet its quality thresholds.

Not that the CQC should be seen as a menacing organisation, poised to shut down any provider with a bed pan out of place. CQC Chief Executive Cynthia Bower promises its actions will be proportionate. The agency's priorities will include ensuring CQC encourages improvement across sectors, rather than focusing exclusively on responding to failure.

"The ultimate purpose of enforcement is to bring about improvements for people who use services. We intend to take a firm but fair approach to enforcement and when we take enforcement action we will always follow up that action to make sure that improvements are made," she adds.

Gary Needle, Director of Methods at CQC, says the key difference between the new regulator and its predecessors (the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission) is that it will oversee both health and social care bodies.

"This is the first time in England a body has looked across the piece. That's important because a substantial number of people will receive both services. It gives us the opportunity to look at care on the basis of people's experiences – whether they are delivered properly and together – and reflect more the journey we take if you or I are accessing health and social care."

#### four important areas

He highlights four areas important for the new regulator, some of which it shares with its predecessors. "Our overarching role is to make sure people get the best care and there are four things we are doing – and will be seen to be doing – that will drive us towards that."

The areas are:

- driving improvement in health and social care
- putting people at the heart of its work
- acting swiftly to remove bad practice
- working in partnership with other bodies.

Improving care is not just about a tick box exercise to ensure standards are being met. "That's part of our remit but not our sole remit. We also want to see providers move beyond the minimum to much higher standards. We will support and incentivise them to do that."

#### patients come first

The Commission will champion patients' rights and include patients in its work. Needle says: "We want to have a robust relationship with providers but patients come first. We are driven by a strong rights-based approach. We want to protect people."

He adds that the Commission will also act

quickly where it uncovers poor practice. "On the back of recent notable service failures, such as the Baby P case and Mid Staffordshire, the public has a reasonable expectation that regulators will act swiftly to put bad practice right. The action will be reasonable, fair and proportionate but we will not shrink from taking action."

The action open to CQC varies. It could issue a warning or fine organisations for some failures in service (Mr Needle acknowledges the amounts involved are relatively insignificant but points out a fine will damage a provider's credibility with the public). The organisation's CQC registration could be suspended or cancelled altogether, if services are deemed to be a risk. "We hope we won't have to use that power. Our aim is to help people improve."

CQC's emphasis on partnership working demonstrates its desire not to duplicate the efforts of other bodies in what is still a relatively crowded regulatory market. The use of resources assessments produced by the Audit Commission auditors' local evaluation will be the most obvious example of this to NHS finance managers. CQC will continue to use the Audit Commission's figures, including those produced under the new use of resources assessment for PCTs (this year only the managing finances theme will be used).

CQC's assessments will initially include inputs, processes and outcomes, but Needle says over time it wants to give greater emphasis on outcomes. It also wants to make more use of patients' opinions. "We want to make more use of the intelligence provided by service users. For example, I believe one of the findings of the report on Mid Staffordshire was that patient groups and patients had been saying for



some time that the services in question were not up to scratch.”

CQC’s philosophy is to move beyond assessing governance and assuming if an organisation’s governance was fine, then the results it produces are fine.

“Governance assessments take you only so far, though that is not to say they are not useful. We want to delve into questions such as ‘What is it like to be treated here?’ and ‘What are the outcomes delivered by the professionals?’”

#### value for money

CQC is likely to examine value for money at a national, whole system, level. For example, it is interested in how commissioners (PCTs and local authorities) translate their needs assessments into their commissioning plans, how much they are spending and how they compare with similar organisations.

“With 150 PCTs there is an opportunity to look at what they are doing, the outcomes they achieve for the money they spend and how they compare with similar PCTs. It’s what an economist would call allocative efficiency,” Mr Needle explains.

However, its approach to assessing the financial performance of individual organisations will not change in the first year – 2009/10 – from the system operated by the Healthcare Commission.

“We will continue to rely on the Audit

Commission to carry out checks on providers and assess each PCT and non-foundation trust on financial management. Monitor will continue to do the same thing for us for foundation trusts,” he says.

#### health check replacement

The CQC will be publishing proposals for its replacement for the Healthcare Commission’s annual health check in June – the final health check results will be published in October. It is unlikely the new assessment will see a significant shift in the way financial performance is measured. But the overall assessment framework will look different.

It will have three components – registration, periodic reviews and thematic studies. The new registration system will be launched in 2010, requiring all providers to be registered with CQC, while the thematic studies will look at particular aspects of care, such as the care of children with severe disabilities.

The periodic review, which will initially be annual, may not give organisations a single score for their overall performance, and the results of each of the review’s elements (on, say financial management, service quality or patient experience) may not be published together in one set piece event. Needle says CQC would like to publish as soon as an assessment has been completed.

“There are dangers in hoarding information

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with the intention of pulling it all together to create a big picture,” Needle says. “We want to move away from the big set piece every year towards a more responsive model of regulation, assessing information in real time.”

Registration will also be subject to ongoing assessment, but what will CQC do if it is concerned about a trust’s financial position? “If an organisation is failing financially, we would expect the performance managers in the system to be the first people to act,” he says. “So if it’s a foundation trust, Monitor, and if it’s a PCT or NHS trust, the strategic health authority. We don’t see ourselves intervening in failures of financial management but we will intervene in failures of quality – including in foundation trusts. That’s our business.” ■

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