Care Quality Commission

insights

HEALTHY REGULATORS

Regulating for quality requires trust and independence

The Care Quality Commission

The Care Quality Commission is the independent regulator of health and adult social care in England.

Our purpose:

We make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role:

We monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and we publish what we find, including performance ratings to help people choose care

We ask five key questions of all services to inform our judgements and ratings:

- Are they safe?
- Are they effective?
- Are they caring?
- Are the responsive to people's needs?
- Are they well-led?

David Behan
Chief Executive

This booklet accompanies the speech that David Behan, Chief Executive of the Care Quality Commission, gave at the 'Healthy Regulators' discussion, hosted by the Institute for Government, on 29 July 2014.

INTRODUCTION

The landscape of regulation and of regulators is constantly shifting.

We are evolving to meet new demands on us as regulators, and new public expectations on the services we regulate. However, regulation and regulators often seem confusing and bureaucratic to the public and people who depend on us. Rightly, the way regulators operate is continuously under scrutiny, but we also need to be trusted by the public to do the job we are here to do. As the world changes around us we must change to keep up, to be relevant and effective.

Public scrutiny is evolving too. People are using new and more sophisticated ways of expressing their views and expectations, as service users but also as taxpayers and consumers. Earlier this year, the media reported that public complaints to the energy sector's ombudsman had broken all previous records, with the explicit expectation being that those regulating the industry would have to listen and act. Just this month, academics at Plymouth University published a report looking at the drivers behind increased complaints to doctors, citing the role social media has played in encouraging people to discuss their experiences in public forums and share information more easily.

CQC, as the regulator of the health and social care sector, makes judgements of the quality delivered by the 44,000 health and social care services in England. From this perspective, during this period of unprecedented change, it is clear that our fundamental goal is to be a regulator that has the trust of the public, that is effective in meeting its purpose and is an organisation we can be proud of. To do this, our independence and impartiality is important. That is why the Health Secretary, Jeremy Hunt, said:

"We will … give the CQC statutory independence, rather like the Bank of England has over interest rates. The welfare of patients is too important for political meddling and our new legislation will make sure ministers always put patients first."

With Royal Assent of the Care Act 2014 earlier this summer, we have been given greater independence from Government. It is the right time to explore how our increased independence in law can help us

become trusted to fulfil our role as a strong and effective health and social care sector regulator.

As the regulator, we have a responsibility to make fair, consistent and robust judgements of quality. But that's only half the picture. We all also have a responsibility to use these judgements to drive improvements as commissioners and system leaders, as providers and professionals, as media commentators, as politicians, and also as patients, service users and carers.

This in turn relies on having a strong, independent and impartial regulator.

These issues are not exclusive to health and social care. It is also about the broader role of regulation, public bodies and, ultimately, public trust. This is the start of a conversation about what it means to have independent yet accountable regulators, about what it means on the side of people who use services whatever those services might be, and about encouraging improvement in quality through regulation.

UNDERSTANDING AND INFLUENCING QUALITY

In healthcare, what we mean by quality has shifted over time and continues to evolve.

From the father of quality assurance, Avedis Donabedian, setting out his seven pillars of quality in 1966 and during the 1980s, to Lord Darzi's *High Quality Care for All* in 2008, describing a health service where quality is "at the heart of everything we do", and now CQC's new approach where we now measure quality in terms of safety, effectiveness, caring, responsiveness and being well-led. Although it may be particular to health and social care, there are similar attempts to define how we understand quality in other sectors.

Our view of quality in the health and social care sector:

- **Safety** – are people protected from abuse and avoidable harm?
- **Effectiveness** – does people's care, treatment and support achieve good outcomes, promote a good quality of life and is it based on the best available evidence?
- **Caring** – do staff involve and treat people with compassion, kindness, dignity and respect?
- **Responsiveness** – are services organised so that they meet people's needs?
- **Well-led** – does the leadership, management and governance of the organisation deliver high-quality, person-centred care, support learning and innovation, and promote an open and fair culture?

The idea of quality, in most regulated sectors, is complex; it is particularly complex in health and social care. We need to find simpler ways to articulate and communicate what is good quality and what is bad quality. Regulators can determine whether a service is compliant with regulations, but a different yet insightful question for a regulator is whether you would place a loved one of your own in the care of that hospital, care home, or GP practice. This can be distilled down to something that our Chief Inspector of Adult Social Care calls the 'Mum's Test' – Would you want your mum to be cared for here? Making the judgement of quality real and personal may be a way to cut through the complexity.

If quality is a complex concept in health and social care, then so too are the mechanisms for influencing it. There are broadly five groups who influence quality:

1. Commissioners
2. Providers
3. Professionals
4. Regulators
5. Public voice, directly or through representatives.

The impact of these groups may rise or fall over time. Their direction may shift; they may be competing against each other or complementing one another at different times. The focus here is on the role and impact of regulators in influencing quality, and how that enables others to influence quality.

Influencing quality through regulation

Through discussions with providers and people who use services, we are now clear about our purpose and role in the health and social care system:

"Our purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve. Our role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety and to publish what we find, including performance ratings, to help people choose care."

CQC Strategy 2013

In order to deliver this, like other regulators we deliver three important functions: we protect people who use services, we have a whole system overview, and we reduce information asymmetry.

Protect people who use services from harm

This is part of the fundamental role of the state as a 'protector'. It has shaped the history of government, regulation, taxation, and even architecture. From protecting citizens from violence and protecting workers from exploitation, right the way through to the establishment of the welfare state and protection from poor quality – for example through consumer rights – the state had, and has, a role to protect.

The evolution of regulation is therefore intimately linked to our development as a society and through specific events that

have struck a particular political, social, economic, ethical or emotional chord with the public. This was particularly the case for the deinstitutionalisation of mental health care in England and the development of mental health protections.

While the aim of 'protection' has developed and become more embedded, the move to rights and standards – and thus regulation – is also partly a response to the changing nature of state provision. Where once the state set expectations and delivered them in closed monopolistic systems, the plurality of the market now means that regulators, like CQC, set standards for everyone who provides services, whether they are public or private.

We have seen a similar development in energy, education and healthcare. Regulation is now a preferential mechanism through which state protection is given.

Whole system overview

Regulators also have an overview of the whole system through consistent and exhaustive coverage of the sector. That means the ability to see across providers and across sectors, to spot patterns, trends and outliers. This view is built from both the bottom up and the top down, through understanding each provider individually, and also understanding the context or market in which the sector operates.

Our aim is to develop a confident voice on the things that matter to people who use services. That means speaking up with courage when we see something that is unacceptable, to raise a challenge to the system to respond on behalf of people using services now and in the future. CQC is in a privileged position of having a remit across health and social care, which gives it a unique sector overview. This is important because people usually don't experience these services in isolation from each other but as a connected whole, especially those people who are most vulnerable.

"OUR AIM IS TO DEVELOP A CONFIDENT VOICE ON THE THINGS THAT MATTER TO PEOPLE WHO USE SERVICES."

Reduce information asymmetry

Where quality is hard to judge, there is a role in developing an impartial and expert view of quality and helping others to understand it. This is about levelling the playing field on information and knowledge. Here we have a role in opening up the 'secret garden' of medical and social care knowledge to the public. Although typically it is knowledge for the consumers about the providers, often it is also about providers understanding their own performance, and about the people paying for services (whether commissioner in the NHS, local authority, people funding their own care or on behalf of a loved one) understanding what they are buying.

As a regulator helping to reduce this asymmetry, we are trying to hold up a mirror to the whole spectrum of quality. We use our expert inspectors, our clinical experts and our Experts by Experience (people who use these services who take part in our inspections) to describe and identify 'outstanding' and 'good' care, as well as care that 'requires improvement' or is 'inadequate' . We don't do this in isolation, but with accredited partners

and through extensive consultation with the public, providers and professionals. Defining what 'good' looks like will have the effect of setting a standard across the sector that is higher than the minimum threshold required by law, and will better reflect the level of quality that would pass the 'Mum's Test'.

…And thereby encouraging improvement

Improvement is not part of the functions listed above. However, we have an important role in encouraging improvement through performing these three functions and by doing them well. CQC is not an improvement agency, but is an agent of improvement. While we should encourage improvement, we cannot take responsibility for delivering it. To do so would compromise our independence and undermine our ability to deliver impartial judgements of quality. This distinguishes CQC as a quality regulator, and not an improvement agency.

Health and social care is an especially complex case

No other sector has the same particular mix of complexity, consequence and market distortion as health and social care. This increases the importance of sector regulation across all three of the functions above.

It is not a perfect market. In some areas it is not really a market at all. It is not like buying a TV or a car where you have lots of choice of products, manufacturers, and retailers.

There is a sharp power asymmetry between the people who use health and social care services, and the providers in 'the system'. The size, complexity and specialism of the services means the system can have significant power over the individual, no matter how much 'Googling' they have done beforehand.

There are very real consequences when it goes wrong. This is an industry that can be life or death. It is an industry that affects everyone; it touches the heart of what it means to be a compassionate and caring society. Getting it wrong can be degrading, undignified and deadly.

All this makes it even more important for the regulator to be involved in defining what good quality looks like, and describing it expertly in a language that directly speaks to the public.

"CQC IS NOT AN IMPROVEMENT AGENCY, BUT IS AN AGENT OF IMPROVEMENT"

REGULATORS ARE UNIQUE, BUT NOT ALONE

As a quality regulator we have unique powers to register, inspect and enforce the rules in the health and adult social care sector in England.

We have the power over market entrance and exit, and the power to physically enter every service to inspect. We have independence of judgement in a way that others in the system mostly cannot provide because of other incentives or even conflicts of interest. And we have a role in setting expectations of what good quality actually looks like.

Although this makes our role as regulator unique, we are not alone. We share the space we operate in with others, for example:

- The Health and Safety Executive and the Police who also have strong powers to protect people from harm.
- The Parliamentary and Health Service Ombudsman and Local Government Ombudsman who have a role in investigating, encouraging improvement and disseminating learning, and hold providers to account when they have been responsible for harm.
- Think tanks like the Health Foundation, Kings Fund or the Nuffield Trust, who offer an impartial system overview, and consumer organisations like Which?, Dr Foster and Iwantgreatcare.org, work to reduce the information asymmetry.
- Monitor, who shares the regulatory space over NHS providers on leadership and sustainability in terms of finances and quality.
- Professional regulators who define and test the rights and guidelines for professionals to practice.

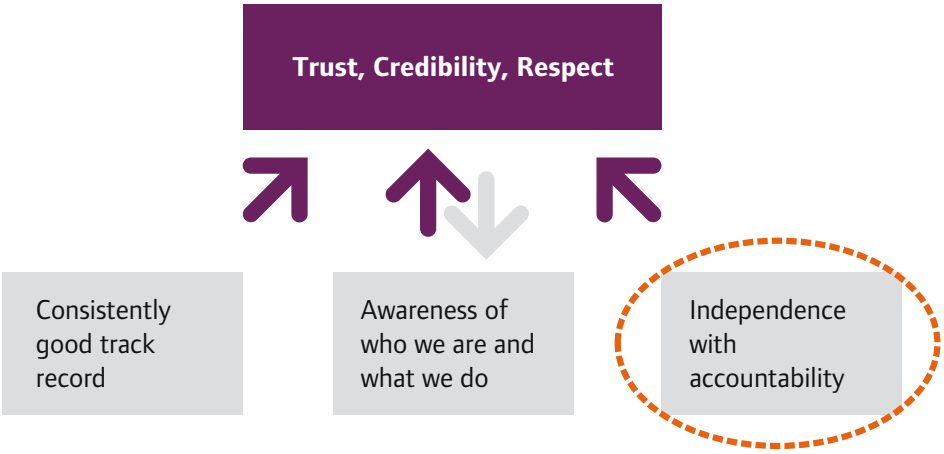
As a public body and system regulator, we regularly collaborate and cooperate with these other bodies. We need to be confident in how we interact with them and recognise what they can do that we cannot. With their help we should embrace new technologies and channels for listening to how people experience services, for example, the quantity and richness of data from the new NHS 'Friends and Family test' feedback survey. Social media offers greater speed, frankness, and more continuous scrutiny than any inspection method could, even though it cannot give an expert view, or a consistent, comparable view.

Perhaps the challenge for regulators is in complementing rather than competing with others in the same space, particularly by focusing on what we are uniquely placed to do – and then doing that bit really well.

BUILDING TRUST IN REGULATORS

To effectively protect people from harm, provide a system overview and reduce the inherent information asymmetry, we need to build trust, credibility and ultimately respect for what we do.

We need to build trust with the providers we regulate, the people who use services, the policy makers and decision makers, with MPs and ministers, and also with the public. This is hard. It is probably the greatest challenge we face as a quality regulator, and as CQC. It is even harder in a climate of declining trust in public bodies. The challenge is to be more open, transparent and honest about areas of weakness in a way that doesn't further erode this public trust. This is a much broader issue than just for CQC, or even regulators in general. Rebuilding trust will take time and will require a collective drive across arms-length bodies, government departments and regulators. To be trusted and credible we need to have a track record of delivering, and of meeting, the expectations set of us.



A good track record

At CQC we are taking this challenge seriously. We have made mistakes in the past, but are now working hard at building a new track record of doing the right thing and living up to the high expectations placed on us. We are turning ourselves upside down and inside out to develop a new approach to inspection to be consistent, comparable, robust, expert and trusted by people. Our extrinsic measures of quality need to align with the intrinsic motivations of those who deliver services (for example, to provide good quality, compassionate care) and need to align with public expectations – otherwise

regulation will be seen as a distraction or a bureaucracy. As the regulator, we should want what the people who use the services we regulate want – good quality care.

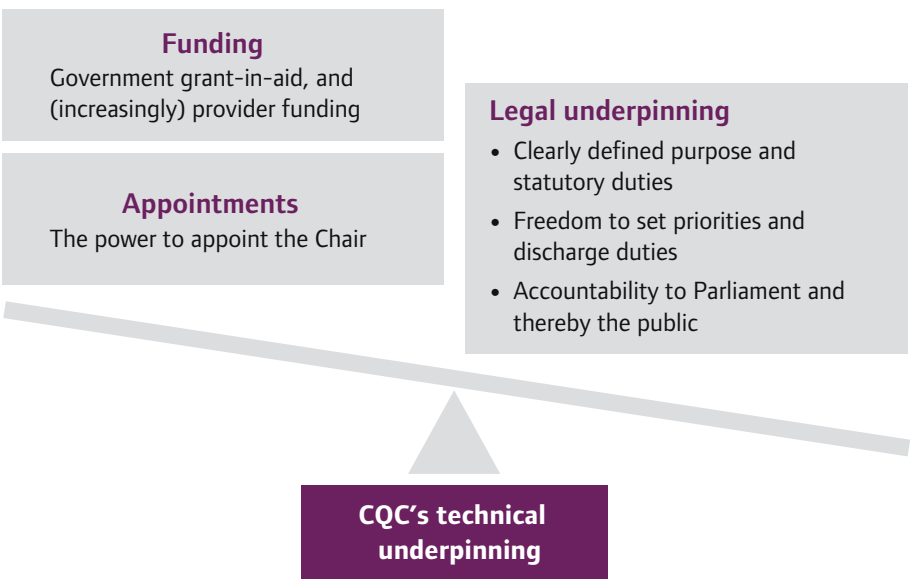
Awareness of who we are and what we do

To have a credible track record, people also need to be aware that we exist, know what we stand for and have a high-level understanding of what we are trying to do. It is empty rhetoric to say that 'the public's voice is at the centre of what we do' if the public do not know who we are.

Walk down the street and ask someone if they have heard of Ofsted and you're very likely to hear a 'yes'. Ask if they are even aware that that health and social care is regulated or monitored, a third of people would say 'no'. Ask if they know who the Care Quality Commission is, less than 1 in 10 would say 'yes'. Over time, we'd like that to change. As we build trust and credibility, there will be greater awareness of us and our role for the right reasons.

INDEPENDENCE *WITH* ACCOUNTABILITY

Alongside this credible track record and awareness sits an essential building block of trust – independence with accountability. All regulators need to be accountable for the way they operate and make judgements, yet independent in making those judgements themselves, no matter how inconvenient or unwelcome they may be.



On a technical level – legally and financially – understanding the balance between independence and accountability is important. Each regulator is surprisingly different in this respect. Who has the power to appoint, who can tell you what to do or how to do it, who do you report back to each year, who pays your salary? There is huge scope for difference between all regulators across all sectors.

"AS THE REGULATOR, WE SHOULD WANT WHAT THE PEOPLE WHO USE THE SERVICES WE REGULATE WANT – GOOD QUALITY CARE."

For CQC, there are two technical factors that could detract from our independence: funding and appointments. We are funded in part by grant-in-aid from the Government and, in an increasing part, by the providers we regulate through the fees we charge them. This means we have a responsibility in how we use resources to both providers and the Government. And as a public body with statutory powers, the Secretary of State appoints our Chair. This power of appointment matters, and is often the focus of the public debate about independence, as we saw earlier this year with Ofsted.

Although these factors need to be considered, our purpose and independence is clearly defined in law and has been further embedded through the introduction of the Care Act earlier this summer. With the new Care Act in place, the scales have now tipped in favour of technical independence for CQC. We have a clearly defined purpose, and freedom to set our priorities and how to discharge our duties.

However, beyond the legal dimension of our independence lies a much more complex web of relationships and accountabilities. This web of relationships holds CQC in the right balance between independence and accountability, beyond what is technically defined in law.

First, we are formally independent from Parliament, Government Ministers and the Department of Health (DH), and yet we are accountable to DH for the budget, dependent on Ministers for appointments, and held to account through the Health Select Committee to Parliament in their capacity as a democratic representative of the public.

Second, we are independent of others who have a role in the system, but do not directly provide services, like NHS England, Public Health England, Health Education England, Monitor, the professional regulators, and trade bodies. Here, we can be collaborative and responsive, but we will remain independent and will not be accountable. Our joint work focuses on understanding the context we operate in, but as the independent regulator with a whole system overview, we are able to challenge these bodies when they fall short in performing their role in improving quality.

Finally, we have the relationships where we are formally independent and yet we want to be accountable. Perhaps the best expression for this sort of accountability is 'moral accountability'. We want the providers we regulate and the people who use services to hold us to account. We want

to listen, to be responsive, to be relevant, to be trusted.

- Being independent yet accountable to providers would mean listening to understand where we might not have followed the right process, but standing firm on our well-made judgements.
- Being on the side of people who use services and being accountable to them requires us to think about care from their perspective. We also need to be open and humble – speaking directly to people in any case where we got it wrong. Ultimately, the answer to "who is regulating the regulators?" is you, as a member of the public. You are holding us to account for the way we regulate and the resources we use to do it. We should never forget that.

Think of us as the referee on the pitch. We enforce the rules, and hold to account those who break the rules. We are not the players on the pitch, we are not the spectators in the stands and we are not the coach in the dugout. The referee has the ability to influence the players to play a good game. How the referee enforces the rules and encourages players to play changes influences the way the game is played. We, like the referee, are impartial, expert, and held to account for our judgements. We influence the quality of the game without being a part of it.

Demonstrating our independence and accountability

Our words

Obviously we need to speak the truth about what we find, as best we can know it. This means developing an authoritative voice through commentary on the issues that matter, in a tone that is challenging yet constructive, not full of jargon. We need to be talking in a proportionate way about both good and bad services so that our view is not distorted to the negative. What we say also needs to be personal and real, built on real examples and understand the people behind the statistics. For us, that means speaking on behalf of people who use health and social care services by ensuring we do so fairly, impartially and truthfully. This is what we do, particularly through our thematic reviews that are focused on issues that matter for a particular group of people or type of service.

The audience matters too. We need to understand how to talk with people on their terms, not ours, while speaking to the public at large, as well as to individuals, to the system, and to providers. Understanding how people want to engage with the sort of information we provide sometimes means also working with others, such as Dr Foster, NHS Choices or Netmums, where that dialogue is already established.

Whether we can develop an authoritative voice on quality will ultimately depend on what we say, and to whom. Words alone are not enough; our words need to be backed up by actions.

Our actions

We need to be clearly demonstrating the independence of our judgements and the consequences of the actions we take. Through our registration of services, enforcement of fundamental standards, inspections and ratings, we should be fair,

impartial, open, consistent, and justified. This is especially important given our unique position as the regulator across health and social care. We should be listening and be responsive without being swayed, by politicians, governments or lobby groups. Our independence should mean that people can be confident that we are doing the right thing.

"WE WILL WORK HARD TO DEMONSTRATE OUR INDEPENDENCE AND BUILD A GOOD TRACK RECORD SO THAT OUR JUDGEMENTS CAN BE TRUSTED … AND, IMPORTANTLY, USED TO DRIVE IMPROVEMENT IN THE QUALITY OF SERVICES FOR THE PEOPLE WHO USE THEM"

FOR CQC THIS MEANS CHANGE

We are one year into a three-year strategy, *Raising Standards, Putting People First*, which will see us develop a new approach to regulation and inspection. Central to the changes we have been making is a commitment to regulate and inspect services differently by sector, led by our Chief Inspectors and more specialist inspection teams, including members of the public. This is being supported by a new system of Intelligent Monitoring that helps us decide when and what to inspect. It also includes listening to people's experiences of care and using information from across the system. We are working hard to develop our track record and build trust in the organisation we are becoming.

There is still a lot more to do, but we are committed to this journey. We will take responsibility for providing sound judgements of quality for the services we regulate. This task should not be underestimated. It is a huge responsibility for CQC to get right.

Sound judgements of quality alone will only get us so far. To improve the quality of services, these judgements also need to be respected, and used.

Providers and professionals should use our judgements to help them improve the quality of the services they provide. Often, the most important step for improvement to happen is the acknowledgement that improvement is required. Our judgments should help providers understand the quality of services they provide, and help them focus their improvement efforts.

Commissioners and system leaders should use our judgements to take action in the areas where care is not good enough, and celebrate good and outstanding care where we find it as an example for others across the system.

The media and politicians should take our judgements in context and appreciate the complexity of quality in health and social care, yet use them to champion change and highlight where care is inadequate or is failing to improve.

And finally the patients, service users and the public – that is, everyone – should use our judgements to become savvy consumers, make informed decisions and better choices, and voice their expectations about the care that they want for themselves and their loved ones.

Our argument is that for regulation to encourage improvements in the quality of health and social care, CQC needs to be independent, accountable and trusted. This is what people who use services and their families want us to be. By putting people at the heart of what we do, that is what we are hoping to achieve.

"Think of us as the referee on the pitch. We enforce the rules, and hold to account those who break the rules. We are not the players on the pitch, we are not the spectators in the stands and we are not the coach in the dugout. The referee has the ability to influence the players to play a good game. How the referee enforces the rules and encourages players to play changes influences the way the game is played. We, like the referee, are impartial, expert, and held to account for our judgements. We influence the quality of the game without being a part of it."

STARTING A WIDER CONVERSATION ON REGULATION AND PUBLIC TRUST

This paper is not trying to give the answers, merely raise some interesting and constructive questions about how we regulate in health and social care, and perhaps in other sectors too:

- Is 'quality' a useful measure? What does it mean outside of health and social care?
- Should regulators see themselves on the side of people who use the services they regulate? How can they demonstrate this?
- Is the oscillation between deregulation and regulation that we have seen in the past inevitable, or is there a way of developing a more stable model of regulation?
- How do regulators take a system overview and what impact does their voice have in identifying and galvanising improvement on issues that matter for people who use services?
- How can, or should, regulators embrace the new types of data and feedback from social media and consumer organisations to help them to be more responsive and proportionate?
- Is getting the balance right between independence and accountability the way to build public trust in regulators?

Care Quality Commission

HOW TO CONTACT US

Call us on: **03000 616161**

Email us at: **enquiries@cqc.org.uk**

Look at our website: **www.cqc.org.uk**

Write to us at: **Care Quality Commission**
Citygate
Gallowgate
NE1 4PA

Follow us on Twitter: **@CareQualityComm**

Please contact us if you would like this booklet in another language or format.