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INPOLICY

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REGULATION SPECIAL

As the implications of CQC's *State of Adult Social Care* are slowly digested, we look at its findings, repeat a **Care**Markets interview with Andrea Sutcliffe, present an exclusive opinion on inspection from Lancashire Care Association and deliver legal advice on the topic of failure

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Care Quality Commission
State of Social Care 2017

Stephen Dorrell, Chair of Public Policy Projects, shares his view on the latest report from the social care quality watchdog

After months of public discussion about the funding of social care the recent CQC State of Care report raises serious questions about the quality of care provided to older people. The CQC is careful to say that most social care provision passes what Andrea Sutcliffe calls 'the mum test', but it is deeply concerning that nearly a fifth of services are reported to 'require improvement' and an additional 2% are described as 'inadequate'. It is also concerning that over a third of those found to require improvement do not improve their rating on re-inspection and 5% deteriorated in quality – despite clear explanations from the CQC about what needs to change.

Overall over a quarter of services saw their rating deteriorate when they were re-inspected and the CQC reports it was surprised that such a small number of services were rated as 'outstanding'. There are also significant regional differences in performance – for example the East of England shows 10% more locations rated as 'good' or 'outstanding' than the North West.

Nine months ago the CQC reported that adult social care in England was 'approaching a tipping point'; now it says that safety levels in social care are 'fragile'. These failures in care are not just an issue of providing better quality of life – for some receiving inadequate care is, in CQC's words, 'having extremely serious consequences...leading to actual harm to people using services'.

The CQC is clear this is not merely a question of money. It points to the role of strong leaders in successful organisations, both at registered manager and provider level, who communicate strong vision and values to all staff; it also emphasises the importance of a culture of openness and transparency within the organisation.

It also points to the importance of staffing issues. Staff levels are an issue, but so too is ensuring that staff are well trained and developed to provide good care, focused on positive outcomes for people. It sets out very clear practical respects in which training often falls short and points to examples of staff who lack the necessary in terms of infection control, risk assessments and medicines. It also emphasises the importance of ensuring that staff have the necessary skills to deal with people with complex needs.

In response to the public discussion of social care funding, the Chancellor provided some relief in his Spring Budget but he did not offer a solution to the structural problems facing the sector. Expectations that the Social Care Green Paper may offer more fundamental solutions have been severely dampened in the aftermath of the General Election, but it remains true - as the Chancellor acknowledged - that the sector needs a sustainable solution to the funding and structural dilemmas posed by rising numbers of older people living with, often multiple, long term conditions. In addition to those who currently receive the care of mixed quality reported by the CQC, this sustainable solution also needs to address social care needs for a further 1.2 million older people whose needs are currently not acknowledged by the system, and which Age UK estimates would require an additional £4.8 billion a year, rising to £5.75 billion by 2020/21.

Our conclusion must be that the picture of social care is mixed – the majority of services are good or outstanding and the majority of those services previously assessed as 'inadequate' have improved.

Yet at the same time in nearly a quarter initially rated as 'inadequate' remain so, and over a quarter of those rated as 'good' have deteriorated. Even outstanding services can experience a decline in their care – of the eight services originally rated as outstanding, half have deteriorated by two ratings to requires improvement. As CQC states in its report, the sector remains 'fragile'.

The need for fundamental reform is critical to ensure that the social care sector is sustainable in the longer term. The government must follow through its stated objective to fully integrate health and social care, to its fullest extent.

Without such a commitment adults and older people in need of social care will have to rely on a sector which hovers close to crisis point.

Stephen Dorrell, chair, Public Policy Projects and former Health Secretary

When CM met Andrea Sutcliffe

In November 2016, LaingBuisson's social care news magazine CareMarkets met with the Chief Inspector of Adult Social Care, she talked about what good quality looks like and whether providers can improve in the current climate...

CM How did you come to work in social care?

AS I have worked in health and social care since 1986 so 2016 was my 30-year anniversary. I guess the reason why I came to work in this sector is, and I know this may sound cheesy, but it truly is about the people and it is about making a difference.

Having had both my own family's experience and knowing how others are experiencing the system and it not necessarily going as we would have liked, I want to know people using services do get the right and proper care and support. That is what drives me.

CM What has been the biggest development at CQC in the past 12 months?

AS There are probably two or three things that would fit into this timeframe.

The first is really embedding the new approach to the way we monitor, inspect and rate services. We introduced it in October 2014 but I think really over the last 12 months it is getting really embedded, really understood by providers and is producing the information that gives us a really good insight into the quality of care across the adult social care sector.

We also took on new responsibilities in terms of prosecution powers, which were transferred to us from the Health and Safety Executive in April 2015. So that has been a very significant development for us and has generated a lot of work. We've had two successful prosecutions from that this year.

Last but not least is, despite the fact that we changed everything a couple of years ago in terms of a new way of inspecting and rating services, we also launched our five-year strategy in 2016. That was the product of an awful lot of work, talking with people within the sector, people who are using services, their carers and families, as well as our own staff to say 'What has worked up till now' and 'What's changing in the sectors that we are regulating and therefore what do we need to do differently going forward?'. It means really focusing our efforts on becoming more efficient and effective in what we do, really using intelligence and information about services in an much, much better way. But also trying to make sure we are encouraging the innovation, sustainability and quality in care so that we are not seen as a barrier to those things.

> WE ARE SEEING A NUMBER OF INDICATORS WHICH WORRY US ABOUT MARKET RESILIENCE

And trying to make sure that we have got what we have called a shared view of quality so that people using services, providers and commissioners alongside ourselves as the regulator really understand what good care looks like and we are all working to that same end.

CM What are your inspectors reporting back are in main issues among providers who are failing to meet the standards?

AS We ask five questions when we go into care services, if they are safe, caring, effective, responsive to people's needs and is it well-led.

The two questions that are the most problematic are 'Is it safe?' and 'Is it well-led?'. What we are seeing is on the safety side of things is do we have sufficient numbers of capable and competent staff to deliver care in a safe way, are the processes and procedures embedded within services so that people are able to be safe, to be supported to have independent and meaningful lives in terms of what they can do?

The other side is around leadership and we can see how important leadership is in establishing the right culture – a person-centred culture which is transparent and inclusive. If that leadership isn't there, services can quickly deteriorate, staff are not supported so you have higher levels of turnover so are more reliant on agency staff which means that people don't get continuity of care.

I think the role of the registered manager is one of the most important jobs that anyone can do. It's a job that has to cross a whole range of different capabilities and skills.

They are managing a staff team, they are managing the environment, they are looking after people and they are setting the tone and the culture of the organisation.

If they have got it right and they are really caring about the people who are

using the services, doing the right things for them, enthusing their staff, providing the right training and support, and working positively with the people who use their services and their families, we can absolutely see that makes a difference.

CM How is the implementation of the market oversight regime going? Are you satisfied that the market is stable?

AS What we are seeing across the board is a number of indicators which are worrying us about the resilience of the market.

When we rate services as Inadequate, three quarters of them improve, which is positive but that means that a quarter of them are not improving.

And when we rate services as Requires Improvement, only half of them improve.

The two aspects of that, the ones that don't improve, that really worries me because I think that is demonstrating a lack of resilience amongst the social care providers to actually be able to improve what they are doing

CM meets...
Andrea Sutcliffe
Chief Inspector of Adult Social Care, Care Quality Commission

Education
London School of Economics

Career
Chief Inspector of Adult Social Care, CQC (2013 -)

Chief executive of the Social Care Institute for Excellence (2012 - 2013)
Chief executive of the Appointments Commission (2008 - 2012)

Executive director at the National Institute for Health and Clinical Excellence (2001 - 2008)

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and move into being a good quality service.

The market oversight team is up and running having good and constructive relationships with the providers that are within the scheme. I think it is working well.

CM What is the biggest challenge CQC is facing?

AS The biggest challenge for us is making sure that we are responding appropriately to risk. So that we are using the information and insight that we are getting from services, from healthcare professionals and other professionals who are on the ground and may be aware of things that are going on.

So we can get that information and respond appropriately to risk so that we are protecting people. Just making sure we are constantly on top of that, we are able to respond to that and demonstrate to people that we are taking the action that's required.

That is really important that people see that happening.

CM This summer CQC carried out its first successful prosecution of a care provider (St Anne's Community Services). Does CQC plan to use the full extent of its powers against providers who fail to offer the required standard of care?

AS The health and safety prosecution powers are specifically concerned with what the Health and Safety Executive did before.

We've had two successful prosecutions and it is likely there will be more as we go forward, sadly. It is happening when someone has been seriously harmed or we think there is a potential for that.

In terms of our other enforcement powers, when providers are not able to improve, we will be using those. I would much rather that we were going into services finding that they were good, telling people that that was the case, and we were going into services that were not good but they were able to improve.

But if they can't or won't then we will use our powers that will either force them to do so or may mean that they will no longer operate.

CM In your opinion has government austerity measures impacted on the quality of care some providers offer?

AS We haven't been able to demonstrate that correlation, partly because our assessment of quality started in October 2014.

To be fair over 70% of services that we are rating are Good and another 1% is Outstanding so there is still quite a lot of good quality care out there which I think we should be very positive about.

We are concerned about is there are certain signs, for example, those services that are not improving and the fact some providers are handing back contracts to local authorities because they don't think they can deliver a good quality of care on the basis of the resources that are available.

I am worrying as that goes on, we may see providers tempted to cut corners in terms of quality, which would obviously have a devastating impact on the people using services and we all need to make sure we are avoiding this.

THERE ARE A NUMBER OF CHARACTERISTIC FEATURES OF AN OUTSTANDING SERVICE...

CM How are some providers managing to achieve 'Outstanding' status in the face of local authority cuts?

AS There are a number of characteristics that are features of an Outstanding service. They absolutely focus on the people who are using the service. They are not providing a great service because they want to get an Outstanding rating from CQC. They are doing it because they know it's the right thing and they are doing it for the people using the service.

It is the cultural thing of that dripping out of the DNA of the people who are running the service and working there to do that.

The other thing is the outstanding services I've seen, spoken to and some of them I've visited, is they are not standing still. They all want to continuously improve. So, although we've said they are outstanding, they are still looking at 'What more can we do?' and 'How can we improve what we do for the benefit of the people who are using the service?'

I think that is just fantastic.

CM You have just launched your second consultation proposing a further rise in the fees providers pay?

AS The expectation that we move towards full funding through fees is an expectation which is set by HM Treasury and we consulted on that over a year ago in terms of moving towards that in these two years.

I can understand the concerns of people within the sector but at the end of the day it is government policy that the budget that funds what we do comes from fees from providers.

CM If you could change one thing in care, what would it be?

AS I would say that for everybody involved in adult social care, that they focus on the needs of people, their carers and families. If we all start from that premise, we won't go far wrong.

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For further details on how to subscribe call +44 (0)20 7841 0045

A handful of 'inadequate' CQC ratings have sent shockwaves through the independent hospital sector. The numbers may be small but in a market where quality is a key differentiator, **Healthcare**Markets' **Emma Dent** asks what impact anything less than 'good' might have on the choices made by patients and commissioners

The ratings game

The emergence of a rigorous new regime for the inspection of independent hospitals has meant that over the last 18 months, they have been scrutinised as never before. While the majority have received satisfactory, good and outstanding ratings, the handful found to be 'inadequate' have been the subject of attention-grabbing headlines about lack of cleanliness and inadequate safety procedures.

However, it is not just inadequate ratings that can be detrimental to providers' health. A number of independent hospitals have also been deemed as 'requiring improvement', while others have been found 'inadequate' in one of the individual domains rated by the CQC: safety, effectiveness, caring, responsiveness and whether they are well led.

Although, on the whole independent sector providers have performed favourably in inspections compared to their NHS counterparts, they do operate in a smaller market – and one where there is not only a high degree of competitive tension but also consumer expectation.

Understandably, a number of providers contacted declined to comment.

One, Ramsay Health Care UK, whose Oaklands hospital in Salford recently received an inadequate rating, said a 'robust action plan' is in place to 'ensure all the issues identified by the CQC [at the hospital] are fixed'.

Another, which preferred not to be named, said: 'A CQC inspection is an intense experience that shows up everything; there is no point in brushing anything under the carpet as it will be found out. Providers really do realise the implications to their reputation and commercial position and as such should be prepared.

'It is not so much about the number of incidents, for example, but about what type of incidents they are, how they are dealt with and how you learn from them.'

Partner in the healthcare regulatory team at law firm DAC Beachcroft Corinne Slingo says it is understandable why a commercial organisation would be reluctant to discuss poor inspection ratings publicly.

'We advise a lot of independent hospital operators on preparing for and managing the CQC experience and expectations around it, including managing if [an inspection] does not go as well as hoped,' she said.

One source said: 'Different providers are at different stages in their awareness of the inspection regime and take different approaches to it, much as the NHS has done. But managers feel a poor rating very keenly and all social care and health managers, regardless of the sector they work in, take it personally.'

A question of survival

Reputational risk is a major concern for any healthcare provider but in a market where consumers are paying for what they perceive as superior quality, it is a question of survival. As one sector stakeholder pointed out, 'after all an NHS hospital is often serving something of a

closed market.'

Association of Independent Healthcare Operators chief executive officer Fiona Booth acknowledges that there are some concerns in the sector that a small number of poor ratings could negatively impact on the reputation of the sector as a whole.

And with the competition among providers – particularly in London and the south east – fierce, the reputational and commercial risks of a poor rating to an individual independent hospital setting are enormous.

Many sector observers believe that as patients increasingly use online comparison tools to help choose a private hospital rather than be governed purely by the opinions of their GP or consultant, CQC ratings will massively influence their decisions.

However, one thing the independent sector does have on its side is that it has the ability to act swiftly to make improvements.

According to Booth, the relative small size of private hospitals, compared to their NHS counterparts, means they are 'small and flexible enough' to address problems and turn them around quickly.

However, there will inevitably be questions over how a private provider got to the position of being rated inadequate or requiring improvement in the first place.

One sector stakeholder said: 'What I think is happening is that in some larger [hospital] groups, there can be a facility that gets left behind, is getting less input from head office or, alternatively, is too reliant on head office giving them direction to take control over local issues. It should also be noted that if the CQC thinks the board does not get on, or thinks board level messages do not get down to ward level, it will affect a hospital's rating.'

Another source said: 'Inadequate ratings come down to funding, margins, pressure on capital. The culture and mind-set that develop as a result leads to managers squeezing the pips. Facilities get tired and inadequate behaviour is allowed to slide.'

Scores on the doors

It is thought that the impact of poor ratings is already being felt, with reports that some private health insurers are beginning to decline sending their members to hospitals that haven't received high enough ratings.

All of the major insurers declined to comment but one sector stakeholder said: 'Being delisted [by an insurer] will have an immediate impact. Typically, other insurers will follow. And when around [half] of your work is privately funded and of that 50% is insured by one insurer, to put it bluntly, an inadequate rating could be horrific, commercially. I believe [the delisting] is purely down to an inadequate rating.'

However, managing partner at Candesic Dr Leonid Shapiro believes that many patients will continue to trust the word of their consultant on where to have treatment, and that a poor rating will not necessarily be enough to put clinicians off recommending a particular hospital.

'Many doctors are likely to give a setting the benefit of the doubt, after working somewhere for a long time and having a long-term relationship between the consultant and the provider,' he said.

'Patients might vote with their feet but to an extent it would depend on if there is another provider in the same location.'

Dr Shapiro acknowledges, however, that there is a risk such outcomes could affect an NHS commissioners' use of a provider.

It will soon be seen if such scenarios develop around more facilities, as the remaining uninspected independent facilities are due to be inspected by the end of the year. A review of the CQC inspection regime of the sector to date is currently in its second phase of development and is due to be published in the Autumn.

> DIFFERENT PROVIDERS ARE AT DIFFERENT STAGES OF AWARENESS OF THE INSPECTION REGIME

Largest independent sector hospital groups

% of facilities ranked 'good' or 'outstanding'

*ratings do not reflect full portfolios

Priory Group	80%
BMI Healthcare	49%
Cygnet Health Care	88%
Spire Healthcare	71%
Nuffield Health	91%

Article first published in LaingBuisson's **Healthcare**Markets in June 2017.
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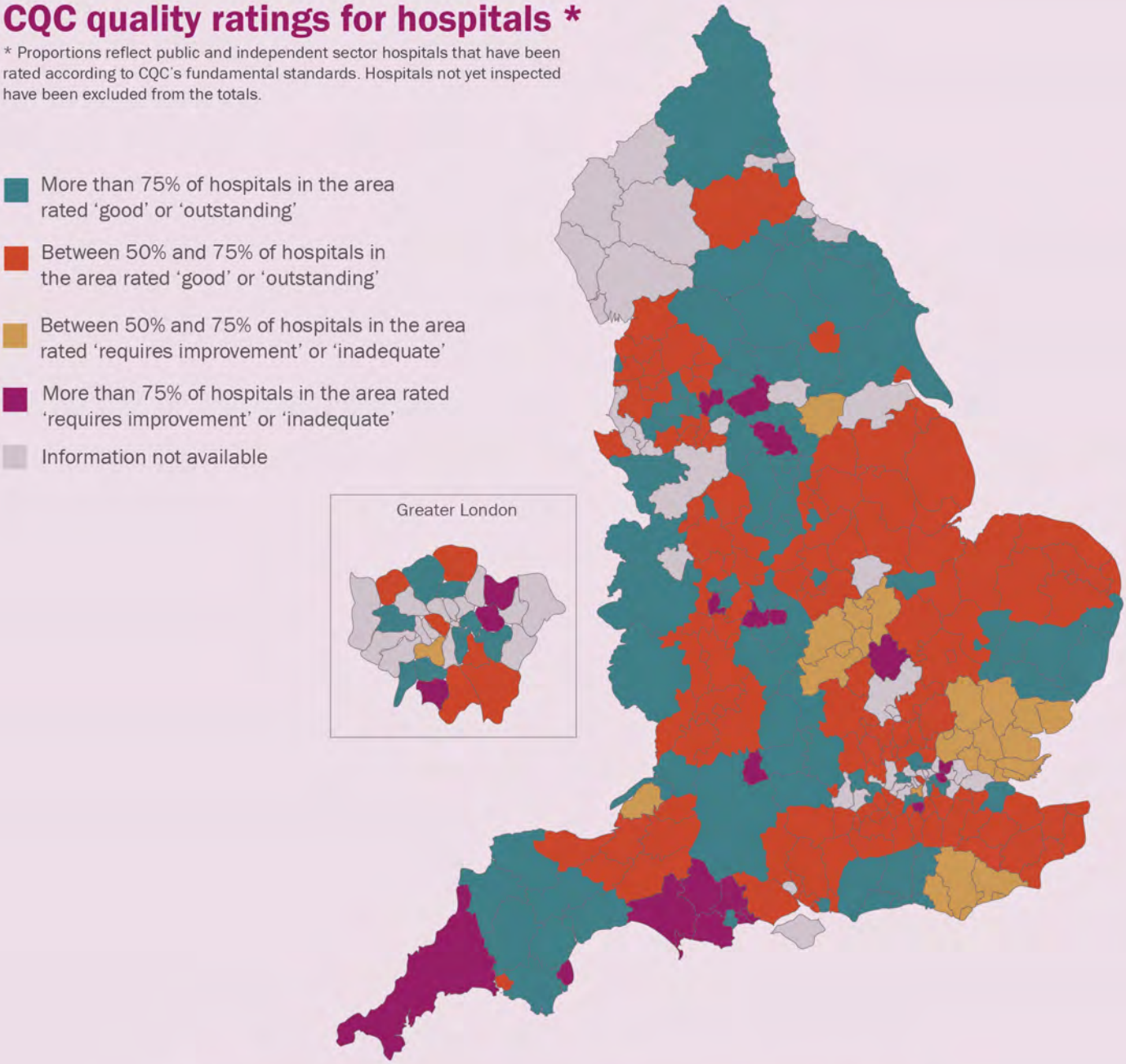
CQC quality ratings for hospitals *

* Proportions reflect public and independent sector hospitals that have been rated according to CQC's fundamental standards. Hospitals not yet inspected have been excluded from the totals.



Performance of largest independent sector groups

	Rated 'Good' or 'Outstanding' (a)	Number of hospitals rated	Total number of hospitals (b)
Priory Group	80%	49	54
BMI Healthcare Ltd	49%	45	49
Cygnet Health Care Ltd	88%	42	45
Spire Healthcare Group plc	71%	24	35
Nuffield Health	91%	23	29
Ramsay Health Care UK	61%	28	29
Elysium Healthcare	78%	9	18
Four Seasons Health Care	50%	10	11
HCA Healthcare UK	80%	5	10
Danshell Group	78%	9	9

(a) The proportions reflect inspected hospitals in the area that have been rated 'outstanding' or 'good' according to CQC's fundamental standards.
(b) The total number of hospitals is representative of those that belong to the independent sector and are located within England. They do not reflect the total number of facilities the group owns/manages in the UK.

CareMarkets' editor **Eleanore Robinson** looks at the Care Quality Commission's anaylsis of its inspections carried out between 2014 and 2017 under the fundamental standards

Good services slipping in quality

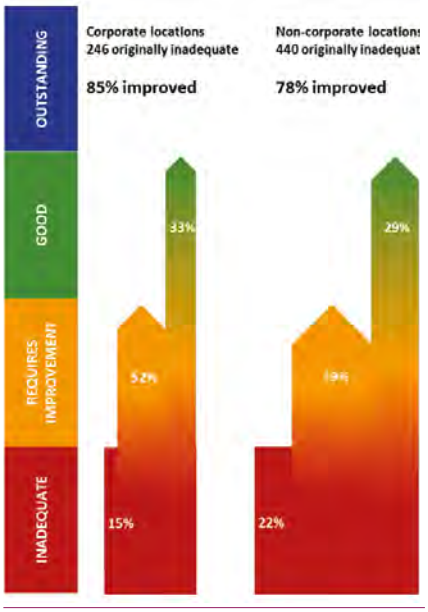
More than a quarter of services originally rated 'good' by the Care Quality Commission (CQC) have deteriorated in quality the regulator's analysis of its inspection programme between 2014 and 2017 has found.

CQC's *The State of Adult Social Care Services 2014-2017* stated this shows that 'providers cannot always sustain this level of good practice within their services and that, as a whole, the sector continues to be fragile at a time when more people are expected to need its services.'

Launching the analysis, Andrea Sutcliffe, chief inspector of adult social care, said she was concerned that some homes 'were struggling to maintain high quality care'. 'Good quality care was particularly precarious', she added. 'We are probably seeing less outstanding care than we hoped or wished to see when we set out on this journey.'

She added that the danger of adult social care approaching its tipping point had not disappeared.

RE-INSPECTION OF SERVICES RATED AS INADEQUATE
CORPORATE AND NON-CORPORATE FACILITIES



SOURCE THE STATE OF ADULT SOCIAL CARE 2014-2017, CQC

GOOD QUALITY CARE WAS PARTICULARLY PRECARIOUS

This is most apparent in the nursing home sector where 3% of facilities were rated as 'inadequate', 29% as 'requires improvement', 67% were 'good' and 1% 'outstanding'. This compared to 1% 'inadequate', 18% 'requires improvement', 80% rated as 'good' and 1% 'outstanding' in other residential homes. Ratings for homecare services were similar to those of residential care homes but 2% of agencies were rated as 'outstanding'. The quality of care, however, in all three types of setting tended to deteriorate as the number of beds or agencies increased.

Sutcliffe said: 'Nursing homes continue to be the worry area from an adult social care point of view. That is something we are going to have to think about going forward. We know they are struggling to recruit and retain good quality nurses.'

The analysis, based on 33,000 inspections of 24,000 services since the introduction of the fundamental standards, also found significant variations when it came to quality with the north west of England and Yorkshire and the Humber both having the highest number of services that were 'inadequate' (3% and 2% respectively) and 'requires improvement' (24% and 23% respectively). However, 2% of providers in the north were rated as 'outstanding'. The South East and South West had the highest proportion of 'outstanding' providers at 3%.

The report states that: 'We continue to observe these geographical differences in quality and, while the differences on average between the poorest fifth and best fifth of areas is not enormous, we are seeing that there are parts of the country where good quality adult social care may be harder to access.

Sutcliffe added that: 'Commissioners and funders need to think about quality as part of their role in shaping the market. There is an issue for commissioners and the shaping of the local market and how they are ensuring this is happening with the basis of good quality care.'

Responding to the report, Caroline Abrahams, charity director of Age UK said its contents would 'stiffen government sinews' particularly as 'it is proving very difficult for providers to sustain the quality they want to offer'.

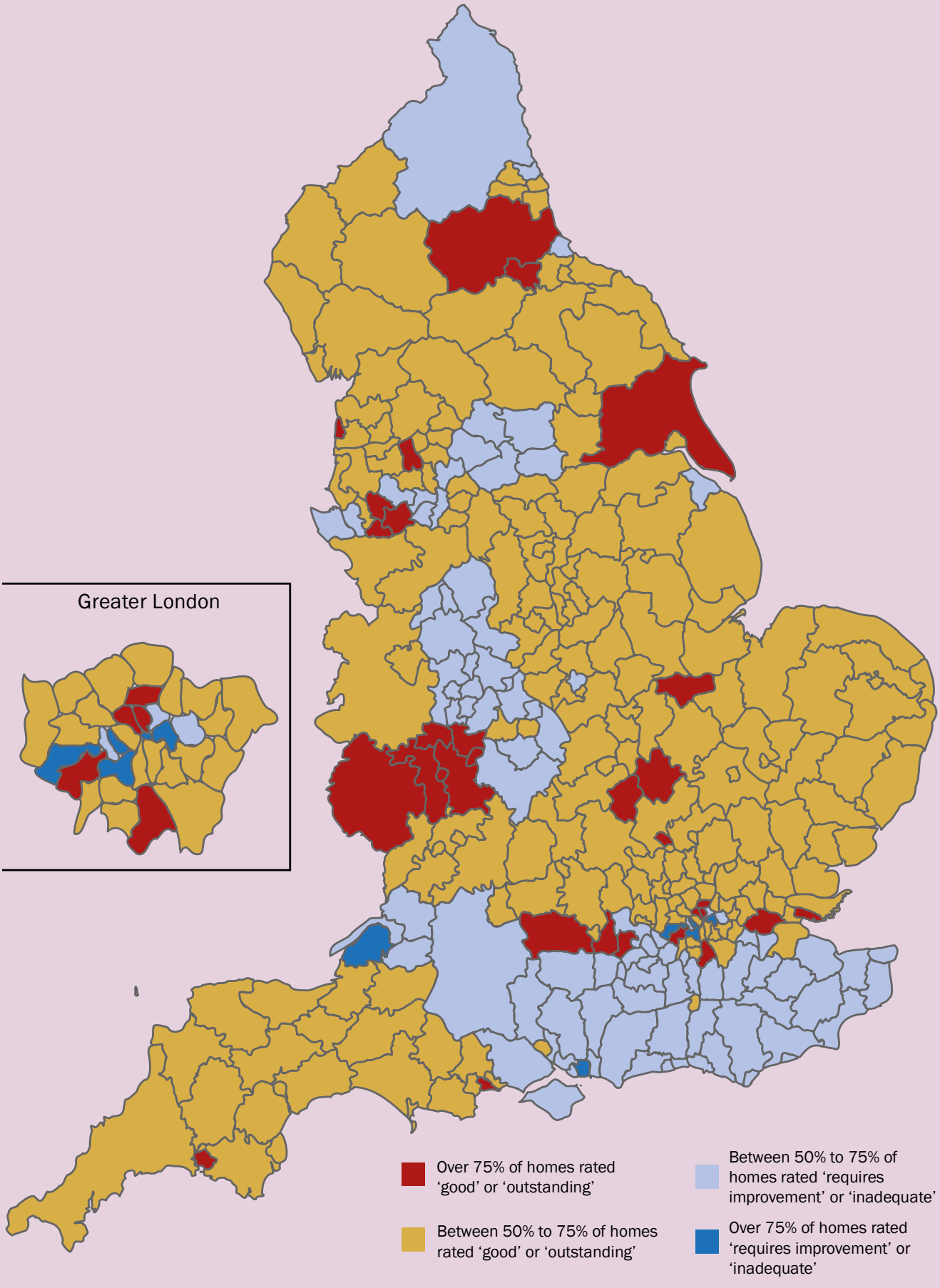
Martin Green, chief executive of Care England, said, while the report indicates that progress has occurred, there is much to be done in order to ensure that all providers are in a position to provide the best quality care and getting to grips with the fees from local authorities and CCGs is key to this objective.

Green said: 'This sector is still at a tipping point. In order for this to be alleviated the resource, including the newly pledged money from the Government, needs to be delivered to the front line. This is not always happening and action must be taken to address this by government.'

Janet Morrison, chief executive of Independent Age, added: 'While it is reassuring that the overall majority of social care services continue to be rated as good, it is extremely concerning that nearly 4,500 care services are under-performing.

'This poses serious questions to government about the crisis in the social care system. A cross-party approach is needed to put in place a sustainable and long-term funding solution that delivers high-quality social care services now and in the future.

CQC quality ratings for care homes



SOURCE LaingBuisson Care Monitor

Paul Simic, chief executive of Lancashire Care Association, shares the views of his members on Care Quality Commission inspections

An Inspector Calls

The providers' view on CQC inspection experiences

"Sed quis custodiet ipsos custodes", Juvenal.

Who guards the guards?

How do care providers view their CQC inspection experience? What protections should be in place for providers and what rights do they have – through, for example, right of reply, corrections and complaints – that help ensure that inspection is done rigorously but fairly?

The issue of inspection and its fitness-for-purpose is important and pertinent and the provider voice in that discourse an important one particularly when looking at inspection and its relationship with service outcomes and care market sustainability.

Concern about CQC fitness-for-purpose and the scale of the challenge is something recognised by CQC itself: 'We do not have an impact and are unable to encourage improvement (SR3)...We do not have the skills and capability we need to be able to regulate effectively (SR6).' (CQC, Paper no: CM/05/16/07, Public Board Meeting 18 May 2016).

So, Juvenal's question - 'Who guards the guards?' - is a fundamental one for anyone looking at care with a 'whole system' perspective and one with a rather keener edge to it for providers who daily may hear the (unannounced, if you are a care home) knock on the door as an inspector calls.

While providers are regulated and monitored by numerous functionaries in the system (CQC as the regulator, local authority and health commissioners, safeguarding staff, Healthwatch and others) there is no such independent oversight checking their competence.

How do we know if inspection is outstanding or inadequate? One way is to give the proper profile to 'user views'.

Providers should be able to raise questions about fairness and competence in the oversight and scrutiny processes as part of a bigger, shared, process to learn lessons for better inspection and service improvement and that is the aim of this ongoing survey we report on here.

Interviews with 80 providers in the LCC area who had had a recent CQC inspection (up to three months prior) in four surveys between October 2015 and December 2016, found that 24 respondents had amendments or complaints they wished to see addressed in the final report. Of these 13 said there was either no change or response and two were told the data was missing.

The role of CQC in the whole system delivering care and support to vulnerable adults is crucial. No one has argued in the surveys we have conducted or the case studies or other data gathering we have conducted for this piece that care should not be subject to proper and fair regulation.

However, concern over duplication and replication of roles across CQC and a range of other bodies doing things which looks very like regulation but are called other things – to do with safeguarding, quality monitoring, contract monitoring, patient voice, et al – has been a major issue (in terms of overlapping roles and burden on providers) in our dialogue with providers up to and including this survey as well as inspection culture, text and subtext, the competence of inspectors, reliability of inspector judgements and the lack of independent scrutiny or avenues of appeal.

It is a whole system which delivers care outcomes but the spotlight is only on providers. The provider case is that we need a more balanced approach which ensures manifest standards in commissioning and inspection, both of which impact on provider quality and viability and market fragility.

If there was one complaint above all others that is the key provider-side message it is the perceived disjunction between CQC's duty to inspect on the one hand and the obligation there should be to treat providers being inspected in a "just manner" and for them to have rights recognised within a set of system checks and balances that are absent from the current processes.

A major statement from this research is that the culture of inspection would benefit from a shift towards more appreciative inquiry approaches and more of a 'balanced scorecard'/ rich picture approach to reporting. This would tilt the system towards service improvement and towards a more balanced and fairer narrative on care.

We are exploring, as we move into our fifth survey, how we might collate inspector performance data to be available in the public domain in the same way that consultant outcome data is.

No part of the system should evade scrutiny.

Paul Simic, Lancashire Care Association

Sarah Knight, senior associate at Anthony Collins Solicitors, examines the merit of challenging CQC inspections

Inspecting the damage from poor CQC ratings

A recent report into its own effectiveness by the CQC paints a largely positive picture of the organisation's enforcement action. By the end of 2016, 79% (492 out of 622) of adult social care services originally rated inadequate had improved their overall rating and the number of enforcement actions rose from 1,073 in 2015 to 1,462 in 2016.

However, look deeper into inspection protocol and a more worrying picture begins to emerge. In many cases providers will accept inspection outcomes, recognising that the service in question needs to change. However, too often providers report inspection outcomes which differ from their own assessment of a service. Many care providers, disarmed by the lengthy inspection process and existing financial pressures choose not to challenge reports, undertake ratings reviews and in terms of enforcement action prefer to accept fixed penalty notices rather than choosing to challenge questionable outcomes.

This is especially worrying when there appears to be an increase in concerns regarding incomplete or inadequately gathered evidence. While the CQC may consider the threshold for a criminal conviction has been reached, the evidence is not tested and acceptance of a caution is acceptance of criminal liability. The CQC does not have to issue a warning notice before issuing a caution and acceptance can be seen as an easy option.

In an industry that is facing heightened external and financial pressures, it is easy to see how a reluctance to challenge inaccuracies within a CQC inspection report could be harmful to both the commercial interests and reputation of any care provider. In fact, 14% of adult social care providers have lost custom due to CQC ratings.

Why then, are so many providers accepting the findings of the CQC without challenge?

Is CQC acting fairly?

A lack of consistency, transparency and a failing review mechanism have all contributed to a feeling amongst some care providers that the CQC is working against them, not with them.

It is widely recognised that there is a lack of flexibility in the CQC inspection process (despite its own guidance to the contrary). This is especially evident with regard to challenges, and despite the various handbooks published, there is still no real understanding of how guidelines or criteria are applied by inspectors. This is before you consider the differences between individual inspectors and the impact it can have on ratings across different sectors and geographical areas.

In particular, the Ratings Review process remains grossly unfair, as demonstrated by the CQC's own figures; by the end of November 2016, less than 7% of rating reviews for adult social care providers resulted in the rating(s) being increased.

This arbitrary review system is not only inflexible (providers have a 500 word limit to set out their challenge, even if they challenge all five ratings) but it is veiled in mystery. Further, the CQC fails to make clear that there is a 'triage' stage before a Ratings Review even gets to someone who can make an objective decision – and we, as an industry, do not know the criteria for that triage. The pressure is on from the outset as the CQC gives the provider only 14 days from the date of publication of the report to file the application for review.

However, the CQC imposes a time limit of 50 days on itself. The CQC is an organisation that is supposed to promote transparency, but for a service provider it can feel anything but a transparent process.

Information disclosure

There is a lack of clarity surrounding disclosure of information gathered during the inspection process. Providers often face difficulty when challenging the findings of a report because they are not given access to inspection notes from CQC.

CQC guidance notes for inspectors published earlier this year, state: 'As more and more providers have begun to seek access to inspection notes, and as the size of our inspection teams has increased to deliver more robust inspections, this has begun to pose a significant challenge to the resources of CQC. CQC has a duty to the public to ensure we use our limited resources in an efficient way.' If systematic disclosure was once acceptable it seems odd that proportionality should be given as the excuse to withhold information.

The key for providers is to act now and be prepared in advance of any unscheduled inspection. Work with your professional advisers proactively, not reactively, to make sure that you are in a position to generate your own record of the inspection process in the best way possible.

This could mean making a note of the questions asked, using pre-defined templates and making a record of all plans, strategies and documents that were presented to the inspector. In 2015, one GPC member even went as far as saying GPs should 'voice record' their CQC inspections to back up any complaints they have about the process.

Tactical approach

Above all else, don't be put off where the CQC outcome doesn't match you own view of a service. It can't be said that a challenge will always be successful in getting significant changes to the report or the ratings given, but despite the complexities and frustrations of the process and the somewhat poor rate of success, challenges are often worth pursuing – for tactical reasons, if nothing else.

Remember that by presenting your challenge up front you are registering your disagreement with the original findings - something which could potentially be used strategically in future proceedings, for example if a case goes to regulatory tribunal or inquest.

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Healthcare intelligence

Care Monitor Top 20 Operator Tables

Ranked by % of services rated **good** or **outstanding** by CQC

Excludes services that have not yet been inspected or where ratings have not been published

CQC compliance of top 20 care home providers by beds (older people inc. dementia)[1]

Operator	%
Sunrise Senior Living	100
Minster Care	92
Avery Healthcare	88
Excelcare	88
Sanctuary Care	82
Methodist Homes	81
Abbeyfield Society	78
Runwood Homes	76
Caring Homes	74
Barchester Healthcare	74
Care UK	74
Orders of St John Care Trust	72
Anchor	71
HC-One	71
Bupa Care Homes	68
Maria Mallaband & Countrywide	66
Four Seasons Health Care	66
Larchwood Care (Healthcare Management Solutions)	48
Orchard Care Homes	48
Priory Adult Care (fka Amore)	46

CQC compliance of top 20 care home providers by beds (adult learning disability)[2]

Operator	%
Four Seasons Health Care	100
MacIntyre Care	97
Voyage Care	96
Care Management	96
Hft	95
Mencap	93
Dimensions	93
Caring Homes	92
Lifeways	92
Potens	92
Cygnet Health Care	91
Regard	90
Sussex Health Care	90
Choice Care	89
The National Autistic Society	85
Community Integrated Care	83
Allied Care	82
Heathcotes	81
Priory Adult Care (fka Craegmoor)	80
CareTech Community Services	79

CQC compliance of top 20 homecare providers **by establishments**[3]

Operator	%
Hft	100
Home Instead Senior Care	98
Your Life Management Services	97
Mencap	97
Creative Support	94
Voyage Care	93
Lifeways	93
Bluebird Care	92
Methodist Homes	91
Carers Trust	90
Prestige Nursing + Care	88
Caremark	87
United Response	87
Housing & Care 21	85
Sanctuary Care	79
City & County Healthcare	76
Mears Care	73
Carewatch Care Services	70
Allied Healthcare	69
Sevacare	67

1 PROVIDER GROUPS WITH MORE THAN 500 BEDS
2 PROVIDER GROUPS WITH MORE THAN 200 BEDS
3 PROVIDER GROUPS FIRST RANKED BY BRANCH NUMBER, THEN BY CQC STANDARDS
SOURCE: CARE*MONITOR*, LAINGBUISSON - 23 JUNE 2017. CARE QUALITY COMMISSION INSPECTION REPORTS

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LaingBuisson, the leading healthcare market intelligence provider, has been serving clients for over 30 years with insights, data and analysis of health and social care market structures, policy and strategy. Our products and services are based on proprietary primary data and we are the only non-government data source cited by the Office for National Statistics (ONS) for the UK independent healthcare market. We help healthcare providers, commissioners, payors, investors and regulators to understand their markets, access their customers, increase profitability and deliver better quality care through market intelligence, consulting and data solutions

Market Intelligence

Sector knowledge is at the heart of what we do. We inform clients about their markets with sector reports, news delivered online and in print from our two market news magazines, policy updates from our policy forum Public Policy Projects, conferences and events

- Market reports - in depth analysis of key markets in health and social care
- Market news - Care Markets and Healthcare Markets magazines
- Policy - insights from our Westminster think tank, Public Policy Projects
- Events - conferences covering individual markets, investing and real estate
- Awards - recognising the leading providers and advisors

Consulting

We advise leading healthcare clients on the full spectrum of market analysis, covering quality, policy, data, markets, strategy and operations. We provide knowledgeable, fact-based insight to make the right choices and implement strategies successfully

- Inspections - mock CQC and OFSTED type inspections
- Data - market and marketing data
- Policy - thought leadership projects, policy insights
- Consulting - market, strategic and operational consulting and commercial due diligence
- Human capital - market talent mapping, pay benchmarking, management referencing, board compensation reports

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Our data solutions are based on extensive proprietary databases accessed via a suite of unique cloud based solutions delivering sophisticated insights to clients. We continue to invest in data analytics, data mining, Bayesian analysis and machine learning

- Care*Search* - search and export all provider data
- HEPS - marketing database for Healthcare, Education and Public Sector
- CareHomeAdvisor.com - consumer portal
- Care*Directory* - online list of providers
- Care*Monitor* - benchmark CQC quality data
- Care*CostBenchmarks* - model the cost of care
- Care*Finance* - Company House financials online

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