The future regulation of health and adult social care in England: A consultation on the framework for the registration of health and adult social care providers

Response by Chartered Institute of Environmental Health to the Department of Health consultation paper.

17 June 2008

The Chartered Institute of Environmental Health

As a **professional body**, we set standards and accredit courses and qualifications for the education of our professional members and other environmental health practitioners.

As a **knowledge centre**, we provide information, evidence and policy advice to local and national government, environmental and public health practitioners, industry and other stakeholders. We publish books and magazines, run educational events and commission research.

As an **awarding body**, we provide qualifications, events, and trainer and candidate support materials on topics relevant to health, wellbeing and safety to develop workplace skills and best practice in volunteers, employees, business managers and business owners.

As a **campaigning organisation**, we work to push environmental health further up the public agenda and to promote improvements in environmental and public health policy.

We are a **registered charity** with over 10,500 members across England, Wales and Northern Ireland.

Any enquiries about this response should be directed in the first instance to:

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Our initial statement

1.0 The CIEH supports the establishment of the proposed Care Quality Commission as the new integrated health and adult social care regulator, taking over the functions of the Healthcare Commission, the Commission for Social Care Inspection (CSCI) and the Mental Health Act Commission (MHAC).

1.1 We therefore welcome this opportunity to provide our comments on the registration requirements, on the scope of registration and the safety and quality assurance function within the overall regulatory framework and also to provide our views and suggestions which we trust will be of assistance.

1.2 We wish to state at the outset our agreement with the intended role, function and framework of the proposed regulatory body. In particular:

1.3 We recognise that the differing systems, regulations, standards and approaches in the existing regulatory framework have meant inconsistency in the type of enforcement used and the way it works across the different sectors and organisations. We therefore strongly support the intention that the new Commission will provide a consistent approach to regulation for providers from all sectors across health and adult social care, reflecting the fact that services are increasingly integrated and continually developing.

1.4 We also recognise that in moving to a regulatory system which is based on essential safety and quality requirements rather than desirable best practice standards, it is intended to put a greater regulatory focus on essential outcomes and on addressing the risks. This is entirely in accordance with regulatory principles operating in other areas of public safety.

1.5 We support the need for the existing functions and powers of the three current commissions to be supplemented by tougher sanctions and enforcement powers that will enable the new Commission to take direct and independent action against service providers which fail to provide care that meets essential requirements on safety and quality. This is entirely in accordance with the established principles of health and safety requirements, that individuals as well as the owners and managers of provider organisations can be held to be liable for failures which compromise public and employee safety.

Our comments on the consultation document

Chapter 1: Introduction and context

2.0 Enforcement decisions

It is intended that decisions on enforcement measures will be informed by the results of site visits and inspections, information on the provider's performance held by third parties (such as commissioners) and evidence of good governance and management systems.

2.1 We strongly support the intention that, when deciding whether to take enforcement action, the Care Quality Commission will be able to take account of the provider's compliance with other relevant legislation (for example on health and safety, fire

regulations or equality). We believe that this is sufficiently important to be made a statutory requirement for the Commission to obtain and take account of information from key agencies, including the Health & Safety Executive and the local authority environmental health services.

2.2 Development of the regulatory framework
The proposed approach to the revised regulatory framework is to be one of evolution and it is intended that the Care Quality Commission will be able to draw upon the views and experiences of others. The CIEH and its members have considerable experience of the successful implementation of regulatory regimes and the appropriate and effective use of enforcement measures. We would be most willing to provide our assistance.

2.3 Assessment of compliance
It is intended that the Care Quality Commission will take a proportionate approach to assessing compliance with the registration requirements, wherever possible using existing data sources, self-assessment methods and feedback from people using the services. However, it is accepted that for some services, on-site inspections will always be necessary to assure compliance, but their frequency will be set by the Commission.

2.4 We believe that there is a need to consider the contributions that could be made by local authority officers to assuring compliance and informing the decision making of the Care Quality Commission on the need for its on-site inspections.

2.5 For example, where serious pest infestations or food hygiene concerns are discovered then these alone might be sufficient to trigger on-site inspections by the Care Quality Commission.

2.6 There may also be activities where the basic health and safety and hygiene inspections routinely carried out by local authority and other regulatory officers would be sufficient for the purposes of the Care Quality Commission if combined with its other sources of information on compliance with its standards.

2.7 There is also the possibility of employing joint inspections which can draw upon the knowledge and skills of other regulatory officers, such as environmental health officers, and provide a comprehensive assessment of compliance with standards.

2.8 Periodic Reviews
It is intended that the Care Quality Commission will carry out wider performance assessments (known as 'periodic reviews') that will provide assessments of the general quality of services both of commissioning organisations and provider organisations, as well as authoritative and independent information to the public and the organisations themselves.

2.9 We also note that the Care Quality Commission itself will be only one of several parts of the health and adult social care systems with a responsibility to promote ongoing improvements in the quality of services.

2.10 Members of the CIEH have participated in the work of the Department of Health National Support Teams (NSTs) and we wish to commend this approach.

2.11 The NSTs carry out intensive support inputs in the 'most challenged' areas of England as well as building a picture of successful holistic models of strategic planning, professional practice and service delivery at a local level whilst reflecting the national standards. These intensive support visits involve interviews with a wide range of stakeholders and other relevant agencies to assess scope for strengthening performance, followed by immediate recommendations for enhancements.

2.12 The insight gained from the work of the NSTs can be further utilised in identifying priority areas and key actions for improvement such as are contained in documents including High Impact Changes for health and social care, prepared by the Care Services Improvement Partnership (March 2008) and Excellence in tobacco control: 10 High Impact Changes to achieve tobacco control, prepared by the Tobacco Control National Support Team (May 2008).

Chapter 2: Registration requirements for essential safety and quality

3.0 *Question: We propose to introduce a generic set of registration requirements (set out in regulations) for all providers offering services that are within scope. These requirements will be supplemented by compliance criteria, to be developed by the Care Quality Commission, that are specific to the type of activity. These will be consulted on at a later date. Do you agree with this approach?*

3.1 In order to be granted registration with the Care Quality Commission, care providers will need to demonstrate that they can meet, or are already meeting, the registration requirements. The registration requirements are intended to cover those activities and functions of service provision that, if not well managed, pose most risk of harm to people. To maintain their registration the provider will need to demonstrate an ongoing ability to meet the requirements.

3.2 We believe that in reaching these decisions it will be important for the Care Quality Commission to be made aware of relevant information from other agencies concerned with the activities of the proposed provider and the premises and in which their activities take place. This information would include the compliance history of the provider in matters such as health and safety and food safety and the suitability of the premises as regards housing legislation and means of escape from fire. To this end, the relevant agencies, including the local authority, should be a statutory consultee.

3.3 *Question: Are the areas covered by the registration requirements (set out in Annex A) the right ones to provide the assurance of the essential levels of safety and quality that we are aiming for?*

3.4 *Question: Does the wording of the registration requirements in Annex A provide appropriate coverage of these areas?*

3.5 We note that the proposed registration requirements have been deliberately set out in summary form at this stage.

3.6 However, we agree the intended coverage of these areas and we anticipate that our areas of concern will be largely covered in the development of standards in relation to:

- Managing cleanliness, hygiene and infection control

- Having arrangements for risk management
- Checking that workers are safe and competent to give people the care and treatment they need
- Having enough competent staff to give people the care and treatment they need
- Supporting workers to give people the care and treatment they need

3.7 *Question: Are there any overlaps, gaps or unintended consequences that will not be picked up by other parts of the system?*

3.8 The need for strong professional regulatory systems to be in place for clinicians and professional care workers is fully supported. We believe that standards of competence are also needed for care and ancillary staff to ensure that people know that the staff caring for them and maintaining the care environment are appropriately trained, qualified and supervised.

3.9 We understand that the registration or regulation of care workers is the responsibility of the General Social Care Council and that the organisation *Skills for Care* already works with social care employers and training providers to establish the necessary standards and qualifications that equip social care workers with the skills needed to deliver an acceptable standard of care.

3.10 The case can be made that all workers in health and care services need to have a basic level of training to ensure that they can operate safely and are aware of significant risks. The CIEH has previously proposed this in the case of all workers involved in preparing and serving food and we would support this for health and care workers for similar reasons.

3.11 *Question: What are your views on the transition arrangements for existing providers to enter the new registration system?*

3.12 No comments.

Chapter 3: Scope – which health and adult social care services should be registered?

4.0 *Question: Do you agree with our proposed list of regulated activities in Annex B to be included within the scope of registration?*

4.1 We note that the criteria for inclusion in the registration system are whether a service has the potential to cause significant harm, or is provided for those at risk of being vulnerable.

4.2 We believe that consideration should be given to the inclusion of the carrying out of male circumcision. This procedure is frequently carried out for non-medical reasons and by persons who are without medical training and who operate outside of hospital facilities and the accepted governance arrangements. Setting aside any religious or cultural concerns, the recipients of circumcision and their families and carers are entitled to the protection and assurance that the registration scheme provides.

4.3 We are also concerned that there are potentially hazardous procedures, commonly described as ‘cosmetic’, such as the use of lazars and sub-cutaneous injections but

which are also promoted as health procedures eg Botox injections for the prevention of sweating. We recommend that there is a detailed examination of these and similar procedures to determine which can be brought within the registration system and we would wish to make separate detailed representations for such consideration.

4.4 *Question: Are there any high-risk services not covered?*

4.5 See our response above.

4.6 *Question: Have we proposed any inappropriate registration of lower risk services?*

4.7 None that we are aware of.

4.8 *Question: What are your views on the exclusion of non-urgent patient transport services under the 'Emergency and urgent care' activity topic?*

4.9 We wish to oppose the exclusion of non-urgent patient transport services under the 'Emergency and urgent care' activity topic.

4.10 It is stated in the consultation document that a key and overall concern as to whether an activity should be included is whether it poses the inherent risk of spreading disease. This must be true of patient transport, especially if proper hygiene standards and infection control measures are not understood and routinely employed. There can therefore be no justification for excluding these. It is understood that many of these transport services are contracted out or operate on voluntary arrangements and in such circumstances the exemption of 'non-urgent' patients may be misunderstood or simply ignored.

4.11 Responsibility for assessing and registering such transport and any ancillary premises and activities could be assigned to local authorities, through their environmental health services, an agency basis, or by service level agreement.

4.12 *Question: What are your views on the proposals for the registration of agencies who supply workers to other registered providers, under the 'Personal care' and 'Nursing care' activity topics?*

4.13 None

4.14 *Question: Are the activities for registration described at the right level of detail, given that they will be underpinned by more specific and legally enforceable regulations?*

4.15 We agree.

4.16 *Question: Is there a risk of inappropriately deregulating high-risk activities in this approach?*

4.17 Not as far as we are aware.

4.18 *Question: Have we determined the right situations in which to register a manager?*

4.19 We support the proposal that if a provider wants to deliver any regulated activity that the Care Quality Commission decides requires the appointment of a registered

manager, it will be the provider's responsibility to ensure that the manager applies for and obtains registration. This duty should extend to requiring the provider to notify any changes of management and any relevant changes in the circumstances of the manager that could have a relevance to their suitability for registration.

4.20 A registered manager will be required where the provider is not in day-to-day control of the service. In dealing with emergency situations and enforcement measures, experience demonstrates the importance of being able to identify the 'person in control'. Whether or not there is a requirement for a registered manager, there is still a need to be able identify the 'person in control' of the remises or regulated activity at any particular time, including when the registered manager is unavailable.

4.21 Where should therefore be a requirement on the provider or the registered manager to identify 'the person in control' who will have responsibility when the registered manager is not present or where there is no requirement for a registered manager.

Chapter 4: Registration of primary care

5.0 We have no comments to make on these proposals.