JDC asks...

A rating of 'inadequate' from CQC can mean the care home goes out of business, while an 'outstanding' one can do wonders for business and morale. But do CQC ratings really reflect the standards of care delivered?

In most cases Care Quality Commission (CQC) ratings do reflect the standard of care delivered in care homes. However, around the margins the ratings can be misleading and portray an inaccurate and sometimes worrying picture, particularly for residents, relatives and staff.

The CQC seeks evidence that the prescribed care is person-centred, reflects risk and has been delivered. The phrase "if it isn't written down, it hasn't happened" is well-used in care settings. But, while documentation is good evidence that staff understand individual residents' needs, it doesn't necessarily mean that if documentation is lacking that staff are not delivering safe, person-centred care.

Under its current framework the CQC takes into account the previous five years of regulatory history when considering the rating. Standards of care may have markedly improved but, should there be some aspects of care that are not consistently of a high standard, the home could still be labelled as "inadequate" or at best "requires improvement". This would not necessarily reflect fairly the progress made in that home.

The impact of such ratings can be devastating. Fear of home closure is difficult to quell and recruitment is extremely difficult. In such circumstances, some providers may see no alternative but to close the care home.

In summary, CQC ratings should be more flexible to reflect the subtlety of degrees of improvement and care standards.

Vivienne Birch is director of quality and compliance at Bupa Care Service UK.

This is an interesting question. My first response was "Yes, of course", but actually it isn't as straightforward as that.

On the face of it, the process of awarding ratings is simple. We have clear key lines of enquiry, judgement frameworks, ratings characteristics and principles. These help us to ensure that we make consistent, authoritative judgements on the quality of care.

Of course, nothing in social care is that straightforward. Within any one service, people can have very different individual experiences and perceptions of the care they receive. Our ratings show that the vast majority of staff who work in the sector are fundamentally caring. In contrast, the "safe" and "well led" key questions receive much lower ratings. People can receive a very high standard of care in a service with weak management and ineffective quality checks. This may be okay as long as nothing untoward happens. If it does, then these standards of care can unravel really quickly.

Inspectors are managing a balancing act. It is absolutely right that they listen to and report on the views of people using the service, staff and management. It is also essential that they assess the robustness of management systems and processes to ensure that, whatever happens, people receive a service that is safe, effective and responsive as well as caring.

Alison Murray is head of adult social care inspection (London) at the CQC.

The challenge faced by the sector when it comes to attaining regulatory standards is that the regulator remains inconsistent in its approach. No doubt the CQC believes that its inspectors are regulating services based on what is good, but the reality of the process is that "good" is often ignored in the zest to find fault. The experience for the majority of providers remains negative with our members telling us that they have lost staff post-inspection.

With that as the backdrop, one wonders how confident we can be that the inspection report we are reading actually reflects what the service provides. Comments in inspection reports often reflect how happy service users and their families are, but the overall rating tells us that the service requires improvement. This has an immediate impact on the provider's ability to market its service in any positive way and the fact that it then remains on the report for a period of time creates high levels of anxiety for all concerned.

On the other side, we can have a service rated as "good" which actually has some quite poor practice that was not visible on the day of the inspection because the paperwork was pristine.

Clearly, outcome-based ratings are a long way from being implemented. The truth is that ratings seldom reflect the standard of care as the regulations are being enforced in an inconsistent manner.

Nadra Ahmed is chair of the National Care Association.

CQC inspections only take a snapshot of what is going on in a care service. The role of the regulator is to look at services and, firstly, to give an assessment of whether they comply with the legislative requirements, and, secondly, to establish what level of quality the regulator believes the service is delivering.

The CQC will usually be in services for a day or possibly two, but service users experience care services for 365 days a year and it is for this reason that the real judges of whether services deliver are the people who use them. The people responsible for ensuring the quality and consistency of care services have to be the providers.

Regulation is primarily about ensuring that services

From left: Vivienne Birch, Alison Murray, Nadra Ahmed, Martin Green and David Sheard

are safe and do not fall below a minimum standard, but the vast majority of care providers work really hard to ensure that their services meet people's needs and deliver the best possible quality of life for residents.

This is particularly important when we are supporting people living with dementia, who sometimes find it difficult to communicate their needs and desires, and ultimately every care service must ensure that it delivers a life that maintains independence and has as much quality as possible. This objective is everyone's responsibility.

Professor Martin Green is chief executive of Care England.

Obsessive process inspection that largely ignored outcomes and people's quality of life did previously exist. Due to the CQC's leadership, those days have now gone and we should be thankful.

Seven of the care homes we work with in our Butterfly culture change programme have now received an "outstanding" rating from the CQC. At last I might conclude there is a correlation between the regulator's methodology and evidence of people's quality of life.

However, it boils down to five key questions - is your inspector knowledgeable, experienced, truth-seeking, reflective and outcome-focused?

Recently I was rung by a Butterfly home manager in the midst of an inspection. Apparently the inspector had never heard of the Butterfly model, nor understood the advanced communication skills being used to reach people. Was this the prerequisite knowledge for leading a safe, effective, and responsive inspection?

Certainly, CQC ratings are vastly more aligned to real care than previously. Its reports are now more incisive about what matters most. Care homes should use these reports as training tools on what good care looks, sounds and feels like.

But the CQC still needs to be clearer about the foundation that its key lines of enquiry centre on. It is still putting the cart before the horse to inspect on fundamental standards if care homes don't first grasp the source of these standards. The CQC does not make the source of these standards explicit, nor that it requires knowledge, experience and skill in how to lead a new culture of care.

We believe the only way to achieve this is by adopting a model of emotional intelligence, a linkage that the CQC does not make. Alongside this the real skill, which care homes need to develop, is knowing how to more expertly demonstrate their own core alignment and evidence to CQC lines of enquiry.

Currently, the CQC is consulting on its assessment frameworks for adult social care services so make sure you get involved in influencing the responsive, accurate and emotionally intelligent standards we all need.

David Sheard is CEO of Dementia Care Matters.

PERSPECTIVES

If training doesn't work why should we commission it?

■ Emma Hewat is co-founder and director of Support in Dementia

By Emma Hewat

At the last UK Dementia Congress in Brighton some presenters expressed the view that "training does not work". Several nods and murmurs of agreement in the audience indicated that this was a commonly held belief among delegates. And to some extent I agree.

Sending staff on training courses to "fix" a problem or change a care practice probably won't work in the long term. On the day learners are generally extremely enthusiastic about the session, praising the trainer for being so inspiring, promising to change the way they work, to use all they have learned and start working in a truly person-centred way.

Yet back on the ward, at the day centre, in the care home or on a domiciliary visit, all is forgotten as staff grapple with reality: staff shortages; time pressures; unmanaged distressed behaviours; and a culture of care that is often task-orientated, organised to meet the needs of staff rather than people living with dementia.

With a new understanding that the old way is wrong, wanting to make a change but perhaps fearing the response from colleagues, some care workers, reluctant to rock the boat, revert to well-worn furrows, the paths of least resistance. This is a picture that those of us involved in dementia education and training hear again and again.

But what kind of message does it give to commissioners and care providers, if leaders, innovators and thinkers at the forefront of excellence in dementia care promote the message that training does not work? The result is disinvestment in high quality training, leaving staff with little or no knowledge of dementia being expected to carry out a highly skilled role.

Is it any wonder, therefore, that we hear so many horror stories in the press when care has gone wrong? And often it is the individual carer who is blamed for not caring, not the provider for failing to ensure its staff are trained and supported.

As someone who has been involved in education and training the health and social care workforce for the last 10 years, I believe there is another message we should be promoting: education and training are vital to the development of a skilled and competent worker. Without it we are setting our staff (and the system) up to fail.

There needs to be a renewed commitment to invest in creative and engaging models of learning that improve on the traditional models, working alongside staff and role modelling good practice to ensure no one is expected to provide care and support without access to the knowledge and skills needed for high quality person-centred care.

We don't expect those caring for people living with cancer to provide care and support without specialist knowledge and skills. So why do we expect it of those providing care and support to people living with dementia?