Care Quality Commission

Voices for power – putting people at the centre of care quality

Care Quality Commission Statement of Involvement

About the Care Quality Commission

The Care Quality Commission (CQC) was established to regulate the quality of health and adult social care and look after the interests of people detained under the Mental Health Act.

Health and social care touches everyone at some point. This gives CQC a powerful and highly responsible role in people's lives. CQC will, from 1 April 2009, bring together the work of the Commission for Social Care Inspection, the Healthcare Commission and the Mental Health Act Commission, creating for the first time an independent regulator of health, mental health and adult social care in England.

Our vision is of high-quality health and social care that supports people to live healthy and independent lives, empowers individuals, families and carers in making informed decisions about their own care, and is responsive to individual needs.

We will be a leading and innovative regulator and will:

- Focus on outcomes for people
- Harness a range of regulatory approaches to drive improvements in quality
- Prioritise on the basis of risk
- Champion a joined-up approach to care across services, centred on the individual
- Be transparent and open
- Be tough and fair
- Be independent
- Be proportionate
- Coordinate our work with other regulators.

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Foreword

The new Care Quality Commission will bring together independent regulation of health, mental health and adult social care in England for the first time. Health and social care touches everyone at some point in their lives and increasingly, people move between different services in both sectors when they need help. The Care Quality Commission therefore has the scope to break new ground and the opportunity to be a truly exceptional regulator. We will have our own distinctive style and important new powers compared to our predecessors.

We will be responsible for registering and reviewing health, adult social care and mental health services. We will work with providers to encourage them to improve the quality of their services. Where providers of services let people down, we will take action, including issuing warnings and fines and ultimately cancelling their registration. We will hold primary care trusts and councils to account for the considerable sums of money that they spend on services, checking that they are achieving the best possible outcomes for local people – especially those in vulnerable circumstances.

Our primary aim is to put the people who use services first. We will always champion their interests, particularly where services are provided to people who are less able to speak for themselves. We are committed to putting people at the centre of everything we do, and to involving people who use care services, and their friends and families, in all aspects of our work. Our involvement work will be based on human rights, equality, and valuing what people say.

Our draft Statement of Involvement sets out what we will do to put these commitments into action.

In this consultation document, we invite your views on the principles and broad approach set out in the Statement of Involvement. When the consultation is over, we will finalise and publish our policy. We will explain in more detail how we will put the Statement into operation. Our progress in implementing the Statement of Involvement will be reported on every year and we will continue to develop our ideas about involvement.

We see this as the start of an ongoing conversation about how we can all work together to help ensure better care for everyone.

Barbara Young
Chairman

Cynthia Bower
Chief Executive

Consultation

1. Introduction

The Care Quality Commission has been set up by Government to regulate health and social care services in England. (Regulation means we make sure they are following the right rules and giving people a good service.) The Care Quality Commission replaces three separate commissions, the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection. The Care Quality Commission is a public body – its board is appointed by the Secretary of State for Health.

This consultation is on the Care Quality Commission's Statement of Involvement. The Act that sets up the new Commission says it must have a Statement of Involvement.

The statement of involvement will form part of CQC's strategic plan. For our consultation on it we want to get responses both on the statement overall, and on some specific aspects of it.

To draft the statement, we started with:

- our commitment to put people first
- the legal duty that CQC has to involve people
- what we already know about good practice (from research reports and advice from other bodies)
- what people already involved in the three existing commissions told us
- what some people who had no previous involvement with the three existing commissions told us.

We now want to get views from lots more people.

For all the areas covered, we would like people to respond to two basic questions:

- **Do you support the approach?**
- **What things do you think we need to take into account to make our approach succeed? (In particular, have we left something out that needs to be included?)**

For some areas we have some additional specific questions.

2. Our values

Our involvement work will be based on human rights, equality, and valuing what people say.

What people have already told us:

That staff training in equality and diversity is important and that equality impact assessments can help to drive culture change.

- *Commissioners should understand the equality agenda and lead by example*
- *Equality to me means not making assumptions, avoiding judgements and having no negative opinions*
- *Needs REAL people to run it*
- *Understand that equality is everyone's job*
- *Need to be treated like human beings and not just a number or a disease*
- *Too much management and not enough action*
- *CQC should address people's needs – not favourable in one element only, as we are not living in a one-man island. We cannot just go to our faith place. We need to go out and share our life experiences with others*
- *We talk about empowering service users, but with lots of schemes, people can not get the right information therefore can not get these services. How could we do more and in a more effective way to let people get information?*
- *Victimisation is very common in social care! People are too scared to raise issues*

Focus groups also said that staff training in equality and diversity is important and that equality impact assessments can help to drive culture change. People already involved with existing commissions were anxious that the good work done to date should be kept and built on.

Questions

In addition to the general questions (Do you support the approach? What things do you think we need to take into account to make our approach succeed? In particular, have we left something out that needs to be included?)

What do you want to see CQC doing about equality and human rights? How will we know we are getting it right for people? How will we know we are making a real difference?

3. Governance

Governance means who is responsible in the organisation.

- Board level representation – at least one member of the board will be someone who identifies as a service user.
- Groups – all of our groups that work on improving outcomes for people will include people who use services.

What people have already told us:

- *Employ people who have gone through the systems*
- *(We need) somebody who will listen to disabled people and will make a change. It should be run by a disabled person*
- *Make sure that addresses go to the CQC so they can become board members and have a voice*
- *(I would be) worried about not understanding what to do*
- *Spending time to build confidence for people participating*
- *Knowing the subject matter*
- *Mechanism for supporting board members*
- *Expectations to be able to achieve the objectives*
- *Mentoring for people to share and support one another*
- *Supporting expert patients – there needs to be a process*
- *All people who become involved should be visited by a professional to ensure they have the correct expertise to contribute*

- *The board members or volunteers should be supported and valued by the Commission*
- *Board members are equipped with the correct skills*
- *Gaining a level of communication skills, general knowledge to input at any level*
- *Real people to be involved*
- *Commission needs to understand the cost of the commitment from individuals*

Questions

In addition to the general questions (Do you support the approach? What things do you think we need to take into account to make our approach succeed? In particular, have we left something out that needs to be included?)

Is there anything else you think we need to do to involve people in governance? What do you hope to see as a result of people who use services being involved on the board and in working groups?

4. Working together

We will maintain the use of Experts by Experience – people who use services working as part of inspection teams (including the Acting Together project from MHAC). Experts by Experience will include carers as well as people who use services directly.

Working groups – we will include people who use services and carers in groups looking at particular topics (including but not limited to discussing special studies and corporate priorities).

Regular panels – we will set up panels of people to help shape some of our work. Panels will be chosen to reflect the diversity of people who use services.

What people have already told us:

People who are already involved in one of the three commissions are very keen that the existing direct involvement should continue.

- *I hope all the work (they) have done will not be shredded and then put away in a filing cabinet in the CQC*

People also said that it is important that senior people in the Commission listen and respond to people who use services; sometimes people give a view but nothing changes as a result. Some of the Experts by Experience who had already been involved were impressed with how seriously their views are taken; they said this is different to their experience of other public bodies.

People also praised the long term approach to involvement in all three commissions – investing in the Speak Out network, or the Service User Reference Panel or Experts by Experience, building strong relationships. Not everyone wants to be involved at this level but it is good that the commissions have made the opportunity available for those who do.

People who had not previously been involved did not have many opinions on this aspect of the work. They had a lot of questions about the Commission.

Questions

In addition to the general questions (Do you support the approach? What things do you think we need to take into account to make our approach succeed? In particular, have we left something out that needs to be included?)

What are the most important things we should carry forward from previous work?

Are there other ways that you think people should be directly involved in our work?

5. Surveys and studies

We will have a regular programme of surveys and studies and will consult people on topics for surveys and studies, and involve them in the way we carry them out.

What people have already told us:

- *Commission to do perception surveys*
- *Continuous monitoring at every level*
- *Highlighting different groups and looking at problem areas*
- *Clinic/GP people do not communicate with each other and don't share information appropriately*

- *Need to identify good practices*
- *There should be a move towards independent living*

We will be carrying out specific consultation on our programme of surveys and studies.

Questions

In addition to the general questions (Do you support the approach? What things do you think we need to take into account to make our approach succeed? In particular, have we left something out that needs to be included?)

What do we need to do to make sure that our surveys and studies focus on what matters to people who use services and help to promote a rights based approach?

6. Specialist groups

In the past we have often had reference groups or panels based on specific user groups, for example one for mental health service users, one for people with learning difficulties and so on. In the future we think we will mainly have reference groups based on topics, such as communication or equal access.

What people have already told us:

- *Need to have different groups to raise different concerns*
- *There is a need for separate groups*
- *Needs to be impairment specific*
- *In order for care to be empowering it needs to be culturally sensitive*
- *If there are lots of different groups it stops people seeing the bigger picture and people fight over their own category*
- *There are many common issues which could be covered by one big group [and] people could learn from each other about the common needs*

There was no particular consensus on this topic. Some were strongly in favour of impairment specific groups, some were just as strongly against this approach.

Questions

In addition to the general questions (Do you support the approach? What things do you think we need to take into account to make our approach succeed? In particular, have we left something out that needs to be included?)

Are there particular groups you want to see set up in the new Commission?

7. Children and young people

We plan to have different involvement methods for children and young people.

We don't have feedback on this yet. But we know from other people's work that children have a lot to say, they don't like boring meetings, they often like web based ways of having a say but they also like to get together to share ideas. They often like using art or drama to share their ideas with adults. They like to get rewarded in some way for taking part but don't always want money (usually because their money is being managed by an adult in their life).

Questions

In addition to the general questions (Do you support the approach? What things do you think we need to take into account to make our approach succeed? In particular, have we left something out that needs to be included?)

What do you think are the best ways for us to involve children and young people?

8. Communication

All our communication methods will be 'user friendly'. They will be in plain English and clear formats with accessible versions readily available.

What people have already told us:

- *They should start with all documents in easy words, then make difficult versions if people ask for them*
- *We can't all use e-mail!*
- *You need to allow more time; it takes me longer to respond*

- *Language in documentation should be understood and user friendly*
- *Simple English to help people who struggle with the language*

In our focus groups, some people liked web forums because they can be anonymous but lots of people did not have access to the Internet.

- *Computers don't answer you back with clarity or compassion*

Some people mentioned the importance of face-to-face ways of giving information, especially for young people.

Lots of people have told us about the importance of tailoring accessible information for people with more complex communication needs, for example people with high support needs.

Questions

In addition to the general questions (Do you support the approach? What things do you think we need to take into account to make our approach succeed? In particular, have we left something out that needs to be included?)

- Are there particular things we can do to make our communications accessible to you?
- We plan to use electronic media (web based) for lots of our communication. What do we need to do to make this work well? Are there particular methods (for example blogs, wikis, videos) that you like to use?
- Will web based communication be accessible for you?

9. Consultation

We will hold both formal and informal public consultations, using varied methods, and make sure we include people from 'seldom heard' groups.

What people have already told us:

- *Need to be listened to if recommendations are given – professionals should not be precious and not hold onto previous methods*
- *To know you will be listened to and have a voice, feedback on your contribution*

- *Time is an issue as we are in the South West it would be difficult to travel to London for meetings – meetings need to be local*
- *Would be involved with surveys or telephone interviews providing they are booked prior to the call*
- *Yes I would love to be involved with the plans and be part of the decision making*
- *What would the service user get from the involvement?*
- *Needs to be different levels of involvement, for example local to national*
- *Need to enable people to attend meetings or workshops, for example they may have carer duties*

Questions

In addition to the general questions (Do you support the approach? What things do you think we need to take into account to make our approach succeed? In particular, have we left something out that needs to be included?)

- What sort of things do we need to take into account to make consultation really effective?
- What would make our future consultation accessible to you?

10. Involvement in policies, priorities and methods

What people have already told us:

Many of the things people said about governance also apply to getting involved in setting priorities and designing methods we use to assess services:

- *Training is vital at all levels on different things, for example what does the Commission do?*
- *Should look at the commitments of people, time, travel – these may be barriers to getting people involved*
- *People will get involved if there is an incentive and benefit for them, for example lunch paid for and their time paid for*
- *Need to empower people… people who have HIV and other illness still need to feel accepted, not excluded*

- *Volunteers can be affected by their own health issues. It can be difficult to get involved*
- *Can feel low so unable to give their support to others*

Some people talked about setting priorities, but there were differing views:

- *There needs to a move towards models of best practice frameworks which recognise different specialties – recognise the diversity of impairments in rural or city specific*
- *All points should be looked at individually instead of prioritising – should not focus on one point at a time – all should have equal levels of attention*
- *We do not know what constraints the Commission is under therefore it is difficult to comment*

Questions

In addition to the general questions (Do you support the approach? What things do you think we need to take into account to make our approach succeed? In particular, have we left something out that needs to be included?)

- What things do we need to take into account to make sure that what people tell us is really influential?

11. Assessing involvement

We will check on how well the providers and commissioners we assess involve people. We have already looked at a number of audit tools (for example from SCIE, UDSET, Involve) and we are planning to use the lessons from the Healthcare Commission's study on patient and public involvement.

What people have already told us:

People have a lot of ideas for what to look for as good practice.

- *Local committees*
- *Hands on involvement from non-administrative council members*
- *Need to have a centre of excellence for issues, regular feedback needs to be regular feedback, point of contact for complaints, knowledge of where*

problem areas are, focus groups who communicate, verbal input, incentives to get people's involvement and understanding

- *Not to have a lot of form filling*
- *Telephone interviews for feedback*
- *Make services adaptable for different needs, hearing and visual impairment*
- *Ensure clients know what information will be shared with other agencies*
- *Give appropriate timescales for response to complaints*
- *Standards need to be in place so people can be measured against them*
- *Training for the organisations ensuring they understand what both sides want, for example the Commission and the users*
- *Users have a voice*
- *Equality schemes in place*

People felt it would be useful if there is a set of standards for the organisation to work to, set up by the Commission. These can be audited against.

Questions

In addition to the general questions (Do you support the approach? What things do you think we need to take into account to make our approach succeed? In particular, have we left something out that needs to be included?)

Can you recommend any measures and audit tools that you think work particularly well?

12. Local Involvement Networks

We plan to work with LINks – how can we make this a successful working relationship? We have had meetings with lots of LINks' representatives through a series of regional meetings. LINks have the right to visit care premises and view how they are working, so they are potentially important sources of information and feedback for the Commission.

What people have already told us:

Most people were unaware of LINks:

- *Not aware of any of these. Not had any information about these groups or services*

Some people could see the potential for working with LINks but were cautious:

- *Funding, time and commitment is needed to make them useful*

Questions

In addition to the general questions (Do you support the approach? What things do you think we need to take into account to make our approach succeed? In particular, have we left something out that needs to be included?)

How can we make sure that we have a successful two way relationship with LINks?

13. Devolving functions

The Health and Social Care Act says the Commission can arrange for any of its functions to be exercised by, or with the assistance of, service users and carers. The Commission's main functions are:

- regulating health and adult social care to ensure essential quality and safety standards, by registering services and reviewing or inspecting them
- protecting the rights of people who use services
- reporting on the quality of care and providing accessible information on the quality of services for people
- providing independent public accountability on how commissioners and providers of services are improving the quality of care and providing value for money

We will look for ways of sharing our functions with people and with voluntary bodies. The Experts by Experience/Acting Together scheme are one way of doing our work with the assistance of users. We think that asking LINks to collect or review evidence or employing user-researchers for our studies could be other ways?

We don't have ideas from what people have already told us. We welcome all ideas about what ways we can share our functions with people.

Questions

In addition to the general questions (Do you support the approach? What things do you think we need to take into account to make our approach succeed? In particular, have we left something out that needs to be included?)

What ways do you think we should do this?

14. Making sure it happens

Partnership approach

- We will work in **partnership with voluntary organisations**

What people have already told us:

- *Commission not understanding the skills required – any organisation who has input must have the correct skills. This would ensure accurate information is passed through the system to the Commission and ensure facts not fiction*
- *The views of local people not always being compared with each other, for example Derby and London have different needs – the needs must fit the community*
- *Ask organisations what other internal and external links they have in other areas – the Commission should understand about this and feed into it*

Questions

In addition to the general questions (Do you support the approach? What things do you think we need to take into account to make our approach succeed? In particular, have we left something out that needs to be included?)

Are there other sorts of organisation we should be making partnerships with?

15. Staffing

- We will have a **dedicated team to lead implementation**

There will be staff with specialist knowledge in involvement in a central team, and possibly some located in four regional 'hub' offices. Other staff (for example regional directors and local area managers) will be expected to make contact with

user and carer groups in their localities. Staff will be aware of all the comments people have made about getting involved, especially the importance of listening, not judging, and of responding.

Any comments you want to make on staff?

16. Resources

- **People will get paid for some sorts of involvement.**

- Involvement activity is woven into many of the Commission's activities. Budget planning will take account of this.

What people have already told us:

We know that having expenses met and in some instances being offered a payment is important for people. Getting access needs met, including things like providing a replacement carer to enable someone to get to a meeting is also important. So we are committed to making sure people are enabled to take part as easily as possible.

- **Any comments you want to make on resources?**

17. Measuring success

In order to be sure we are succeeding in our aims of involving people and that we are really making a difference, we will have indicators for monitoring and ensuring implementation of the statement. These will include: monitoring to ensure we are achieving diverse involvement; checking to ensure all sections of the organisation are involving people; evaluating to make sure we are using the best methods. We will set detailed targets for different work areas.

We will also check on how much change there is in the organisations we inspect and assess; is involvement making a real difference in them, too?

Questions

In addition to the general questions (Do you support the approach? What things do you think we need to take into account to make our approach succeed? In particular, have we left something out that needs to be included?)

Do you have any specific suggestions for how we should check that we are succeeding in involving people?

How will you know that involvement is making a difference? What would you expect to see?

Finally...

Is there anything else you think we should be taking into account about how we involve people?

18. What happens next?

This consultation runs from 28 January 2009 and **closes on 25 March 2009**, during which time we would welcome all feedback from both individuals and organisations. Please visit our website (**www.cqc.org.uk**) for other documents related to the consultation.

You can respond to our consultation in the following ways:

- Email your response, headed 'CQC statement of involvement' to **consultationresponses@cqc.org.uk**
- Use the hard copy reply sheet inserted inside this document to send your details and comments (attach extra pages if necessary). Please detach it from the document and send it (no stamp needed) to: **CQC reviews consultation Care Quality Commission, FREEPOST LON15399, London EC1B 1QW**

Once the consultation period has ended, we will complete an analysis of the feedback we have received and carefully consider what changes we need to make to the proposals listed in this document. We will publish our response to the consultation comments.

Our Board of Commissioners will then agree our final approach to involvement. We will publish and promote the Statement of Involvement.

We will publish a report annually setting out what we have done to implement the Statement of Involvement.

If you have concerns or comments that you would like to make relating specifically to the consultation process itself, please use the same contact details as noted above.

Confidentiality of information

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, among other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information, we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding.

We will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

Summary

The **Care Quality Commission** is all about people.

We will:

- put the people who use services first
- stand up for their rights and dignity
- be guided by what people tell us
- use what has worked well in the Healthcare Commission, CSCI and the Mental Health Act Commission
- be inclusive and accessible.

The Care Quality Commission **must** involve people.

The Act setting up the Commission says it must:

- look at the needs and experience of people
- listen to what people tell them
- listen to Local Involvement Networks
- promote people's rights.

Getting involved

- People will have lots of different ways of getting involved.
- There will be someone on the board who is a service user.
- People will get paid for some sorts of involvement.
- Surveys about people's experience of services.
- Consultations, where we will make sure we include people from 'seldom heard' groups and have special consultations with children.
- There will be user-friendly communication. People will get involved in designing the website and general publications.
- Different formats including easy read will be available.
- Through taking part in Local Involvement Networks (LINks).
- Experts by Experience – working as part of inspection teams and also giving advice.

- Working groups – looking at particular topics.
- Some specialist groups – including one for detained patients and one for children.
- Policy groups that include providers, staff and users and carers, helping us plan future work.

Working with user-led organisations

The Commission will work in partnership with organisations to help it do its work (for example to support Experts by Experience or to gather information about people's experience). The Commission will talk to Local Involvement Networks (LINks) and use the information that LINks send us.

An open culture

The culture of the organisation will be based on human rights, equality, and valuing what people say. The Commission will tell its staff that they must pay attention to what people tell them. We will make sure we have systems to use what people tell us. What people say about services will guide our priorities.

An equal culture

Starting from the principle of human rights and equality we will take practical steps to make sure we include diverse voices, and use what they tell us. We will respect the different contributions people make – and make sure that all staff do this.

Specific plans

- People who use services working alongside assessors and inspectors in Experts by Experience/Acting Together programmes for all service reviews and for selected inspection activity.
- Making sure we include diverse voices – through the Speak Out Network and through an Equality Panel.
- Regular ways of involving people in development – through a well supported Service User Reference Panel.
- Making sure that we check how well services are involving people and making this an important part of our assessment.
- Making sure everything we publish is easy to read and available in different formats on request.

- Using creative ways of getting people involved – we will work with outside partners who can help with this.
- Regular ways of involving people in staff training – and making this easier by checking that our contract processes are user friendly.
- Holding regular events for local LINks' representatives and attending events run by LINks.

Making it happen

There will be a team of people in the Commission to lead the work on involvement, and to make sure that all staff listen and respond to what people tell them. They will make links with voluntary organisations, with Local Involvement Networks, user led and community organisations, to keep them in touch with the work of the Commission.

Statement of Involvement

1. Introduction

The **Care Quality Commission** is all about people.

Our vision is of high quality health and social care which:

- supports people to live healthy and independent lives
- helps individuals, families and carers make informed decisions about their care
- responds to individual needs.

As part of being a modern and innovative regulator we will focus on outcomes for people and take a rights based approach. Involving people who use health and social care services, and their carers, families and friends in what we do and how we do it is central to our plans, and essential for our success.

Our Values

Our involvement work will be based on human rights, equality, and valuing what people say.

In doing our job we will be guided by our values. This includes putting the people who use services first, being informed by what they tell us and standing up for their rights and dignity.

There are clear links between involvement and the promotion of equality and human rights. Ensuring that we engage the right people and engage them in inclusive ways is a starting point. It is essential to take account of what they tell us and to shape our priorities around activity that will secure dignity, safety, and autonomy for people. **Implementation plans on involvement will be checked against how well they are supporting and promoting equality and human rights.**

Best practice

Best practice in user involvement says that organisations should:

- **engage early and plan ahead;** find out who is likely to be affected and who is supposed to benefit
- **embed engagement in the work process** so that service users and the public are informed and involved at all key stages.

- **include all the right people** and make special efforts to reach out to those whose voices are seldom heard
- **act on what you learn** so that what matters most to service users and the public informs and shapes your work
- **remove barriers to involvement** through inclusive working methods.

Legal framework

The Health and Social Care Act 2008 (the Act creating the Care Quality Commission) sets out some requirements on involvement, which say that the Commission must (among other things):

- focus on the needs and experiences of people who use health and social services
- have regard to the views and experience of people who use services (and their families and friends)
- have regard to the views and opinions of LINks
- protect and promote the rights of people who use services, and
- publish a statement on how it will engage.

Clause 5 stipulates that the statement must include information on how the Care Quality Commission will:

- promote awareness among service users and carers of its functions
- promote and engage in discussion with service users and carers about the provision of health and social care services and about the way in which the Commission exercises its functions
- ensure that proper regard is had to the views expressed by service users and carers
- arrange for any of its functions to be exercised by, or with the assistance of, service users and carers.

This statement sets out how the Care Quality Commission intends to fulfil these obligations and aspirations.

2. What we will do

Using the best of what has been developed to date – much of what we will do has been developed by the three bodies that are coming together to form the Care Quality Commission. We will build on this and add our own ideas.

Governance

- Board level representation – at least one member of the board will be someone who identifies as a service user.
- Groups – the Commission can set up working groups to steer day-to-day business or to advise on specific projects. Most of our working groups will include public representation, including people who use services. All of our groups that work on improving outcomes for people will include people who use services.

Working together

- We will maintain the use of Experts by Experience – people who use services working as part of inspection teams (including the Acting Together project from MHAC). Experts by Experience will include carers as well as people who use services directly.
- Working groups – we will include people who use services and carers in groups looking at particular topics (including but not limited to discussing special studies and corporate priorities).
- Regular panels – we will set up panels of people to help shape some of our work. Panels will be chosen to reflect the diversity of people who use services.

Specialist groups

- We might have some specialist groups focused on one particular group of service users such as a group for detained patients (retaining the MHAC Service User Reference Panel). Most of our working groups will be topic based, rather than based on traditional ‘user groups’.
- We will have a specialist group to advise, scrutinise and challenge on our equalities, diversity and human rights policies and practice.

Children and young people

- We will have separate, child-friendly engagement methods for children (although some general engagement will include parents). We will value what

children tell us about the health services they use. (The Commission does not regulate most social care services for children, these come under the remit of Ofsted.)

Surveys and studies

- We will have a regular programme of surveys to find out about people's experience of surveys.
- We will carry out studies of different aspects of services.
- We will consult people on topics for surveys and studies, and involve them in the way we carry them out.

Communication

- All our publications will be 'user friendly' in plain English and clear format.
- We will publish information about ourselves and distribute it widely, using our regional communication teams and local media to make sure it reaches as many people as possible.
- Different formats including easy read will be available as standard.
- Our contact centre will be easy to access and staff will be trained in responding to people who communicate in different ways.
- Inspectors and assessors will be equipped with communication skills and tools.
- Our website will be easy to use and will have information about what people tell us and how people are involved, as well as information about the services we regulate.

Consultation

- We will hold both formal and informal public consultations, where we will make sure we include people from 'seldom heard' groups. To do this we will use resources developed in existing commissions such as the Speak Out network, and develop these further.
- Consultation methods will be varied, and we will make best use of electronic media to provide different consultation opportunities (for example video booths, online surveys and discussions). We will also use face-to-face methods such as public meetings, focus groups, deliberative events and interviews.

3. Using what people tell us

- **Involvement activity will be used to shape the Commission's policies, priorities and methods.** Each work area will be required to say how it has taken account of the views of users and carers.
- We will keep track of what people say about services and use it to inform our assessments.
- Programme planning methods will ensure involvement issues are integral to all elements of the work.

4. Assessing involvement

We will **check on how well the providers and commissioners we assess are involving people** and how they are responding to and using what people tell them. We will develop measures based on best practice. Methods will include:

- surveys about people's experience of services (building on but not limited to existing patient surveys)
- other tools for assessing experience (such as the 'observational framework' currently used in some care home inspections)
- developing good communication with Local Involvement Networks (LINks) so that they can share their knowledge of local services and contribute to performance assessment
- using the input of our equalities, diversity and human rights Experts by Experience (and others) to shape compliance criteria that take account of the equalities, diversity and human rights element of involvement.

5. Devolving functions

We will look for ways of sharing our functions with people and with voluntary organisations. This could include giving user and carer groups a bigger voice in the assessment of services, asking user and carer groups to carry out research on our behalf, or giving user and carer groups a role in designing new assessment tools, for example.

6. Making sure it happens

Partnership approach

- We will work in **partnership with voluntary organisations**, in particular with user and carer led organisations, for example to support Experts by Experience or to gather information about people's experience. We will make sure that our contracting processes are accessible to user-led organisations.

Staffing

- We will have a **dedicated team to lead implementation**, and we will also include involvement skills among core competencies for senior staff.
- Regional operations staff will forge relationships with LINks and with any other relevant representative bodies in their areas.
- Staff will be trained to work inclusively.

Resources

- **People will get paid for some sorts of involvement**.
- Involvement activity is woven into many of the Commission's activities. Budget planning will take account of this.

Success measures

- **We will have indicators for monitoring and ensuring implementation of the statement.** These will include monitoring how well we are involving a diverse range of people, and checking how people are given feedback about their involvement.
- We will check how efficiently we are providing the support for involvement.
- We will monitor how each work area has taken account of the views of users and carers.
- We will evaluate all our involvement activity regularly.
- We will set detailed targets for involvement for different work areas, as part of our annual planning.
- We will check on how much change there is in the organisations we inspect and assess; is involvement making a real difference in them, too?

7. Review

The statement will be reviewed at regular intervals, and will be formally reviewed at least every three years. CQC's annual report will set out what we have done to implement this statement. CQC's Commissioners will monitor progress on implementing the statement.

Note: this draft statement was prepared with the help of people who have been involved in the work of the Commission for Social Care Inspection, the Healthcare Commission and the Mental Health Act Commission, and people who were not previously involved in these organisations, who took part in eight focus groups in different parts of the country. It will be amended following further discussion with a wider range of people, and will form part of CQC's strategic plan.

Appendix: Building on how existing commissions involve people

There are numerous ways that we may use to involve people. Those listed below are all in use in one or more of the three commissions that are coming together to form the Care Quality Commission. We plan to use many of them in future.

General involvement

- Through the Commission's helpline
- National programme of surveys of NHS patients
- Surveys of people who use domiciliary agencies or live in care homes
- Online consultations

Working with local Involvement Networks (LINks)

The Government introduced Local Involvement Networks (LINks) in April 2008 to give people a stronger voice in how their local health and social care services are delivered. We have been making contact with LINks to encourage them to use their voice in CQC. As well as sending their comments to their local trusts and local authorities, the organisations that host LINks can send feedback to the Commission via our website. We think that LINks have an important role to play in helping us get a full picture of local services, and we aim to develop good relationships with them through our local teams.

Getting local feedback on services, including checking on how well services are involving people

In addition to LINks, other bodies such as scrutiny committees, the lay members of the boards of NHS foundation trusts and local safeguarding children boards, can be asked to give a view on services. For future reviews, including the Comprehensive Area Assessment, we need to make sure that views of the local voluntary sector, including user-led and carer-led organisations, are taken into account in how we build the picture of how local areas are serving different groups.

One of the Commission's responsibilities is to monitor how well service providers and service commissioners engage with their users and wider communities. Under the National Health Services Act 2006 there is a duty on NHS trusts to seek and take into account the views of patients, carers and their local community. Local authorities and care providers are also required to involve people who use their services. In 2008, the Healthcare Commission carried out a study on different approaches that health services use, the impact that this work has had on creating more patient-focused healthcare services, what helps or hinders trusts'

engagement activities, and how they engage with vulnerable or marginalised groups. We will use good practice information from this and other studies to help shape our future measures of how well trusts and other bodies are engaging with people.

Direct involvement

Experts by Experience

These are people who have personal experience of using services, as a disabled person, older person, carer, etc. They contribute to inspections or assessments as part of the team. Their report forms part of the evidence on which the Commission reaches a judgement about the service. They are currently used in all inspections of council social services functions, in joint assessments of health and social care services and in selected inspections of registered services (care homes and care agencies) and selected Mental Health Act visits.

The Experts by Experience scheme developed by CSCI is a partnership between them and a number of third sector (not for profit) organisations that recruit, train and support the Experts by Experience. They include charities, self advocacy groups and a social business. The Acting Together programme developed by MHAC is similar. It consists of Mental Health Act visits carried out jointly by a Mental Health Act Commissioner and a service user who has recent experience of being detained under the Mental Health Act, with their contributions being of equal value.

Quality boards

Quality boards are one way of making sure we follow our own processes properly. Currently used in CSCI, each board includes Experts by Experience.

Equal voices

Speak Out Network

This is a network of community groups (set up by the Healthcare Commission) to help to get the views of people who belong to minority groups, who are more likely to experience poor health and lower quality healthcare, and whose views may be overlooked. They include certain ethnic groups, people with learning difficulties or physical disabilities, and people living in poverty, including homeless people. In order to learn about how people in seldom heard groups experience care services, group leaders are trained to listen to and record the experiences of their group members, and to send these to the Commission through the Engage website. They have also worked with an arts group to design more creative ways of

gathering 'stories' from those who find it easier to express themselves through craft or music.

Equality and diversity Experts by Experience

CSCI has recruited a group of Experts by Experience who represent the range of diversity of social care users to contribute specifically to the Commission's equality and diversity strategy. They offer both advice and scrutiny on the strategy.

Mental Health service users

The Commission's remit includes helping safeguard the interests of people who are detained under the 1983 Mental Health Act. To involve this group of service users in our work we will build on the activity of the Mental Health Act Commission. It has set up a Service User Reference Panel as one important mechanism to support this.

Service User Reference Panel (SURP)

The SURP's remit is wide-ranging and includes:

- acting as a critical friend on the Commission and its activity
- providing the Commission with a service user perspective on all aspects of its current and projected activity and influencing the Commission's forward work programme
- contributing to particular projects, for example through participation in steering groups
- advising on user involvement in the way the Commission carries out its statutory duties.

People with learning difficulties

Improvement boards are regular forums bringing together users, carers, providers and commission staff to discuss policy. CSCI and the Healthcare Commission have a joint board for people with learning difficulties. This has been effective in achieving a focus on people with high support needs.

Other voices

The Commission will establish working groups on a variety of topics. There are currently improvement boards (in CSCI) covering other user groups such as carers or people with physical and sensory impairment; we will ensure that working groups include a diverse range of voices and take account of equal access for different groups.

The right tools

User friendly methods

Using a range of ways of engaging with people who use services; for example surveys of users and relatives, and communication tools, such as picture cards, for inspectors.

Communication

Accessible communications policies that ensure that all publications (including user surveys) are available in a range of formats and languages as required. This includes an 'easy read' summary report for all inspections of learning disability services. Particular efforts are being made to communicate well with people with high support needs or people who are neurodiverse (such as people with autism).

Infrastructure

A database of contacts, staff training in engagement methods; a payments policy to ensure that people are not financially disadvantaged from getting involved.

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