The Association of Directors of Adult Social Services response to
The Department of Health consultation
‘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 (DH 2008)’

1.0 Introduction

1.1 The Association of Directors of Adult Social Services (ADASS) welcomes the
opportunity to respond to the consultation document on 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 (DH 2008).

1.2 ADASS sees the consultation and the proposals it is making as an important
milestone on a journey that will help

- ensure better outcomes for individuals who use care services
- begin to develop a more integrated approach to inspection in the context of
  the mergers of care and health inspectorates into a single Care Quality
  Commission (CQC) with a new regulatory framework by 2010
- assist the commissioning responsibilities of local care and health authorities
- develop a process of a more rounded performance assessment

1.3 ADASS agrees that people want services that are fair, personalized, effective and
safe (p2)

1.4 This ADASS response covers

- general implications from a social care perspective within this changing
  environment,
- implications for commissioning given long-standing local authority experience
  in this area and relatively recent experience of Primary Care Trusts (PCTs)
  and for providers given that many local authorities may still be playing a part
  in the provision of services within local market conditions
- specific responses to some of the consultation questions.

2.0 General Implications

2.1 The consultation proposes 18 high level requirements for registration applicable to
both health and adult social care services (see annex A of the consultation
document). The integration of health and social care into a single consistent
regulatory structure and methodology is to be welcomed and has been a long-
standing theme of the ADASS. ADASS welcomes the obvious need to link this
review and up-date of regulation to the wider systems consideration prompted by the Darzi Next Stage Review and the need to maintain dialogue across these processes will need to be kept in view.

2.2 For social care, the Transforming Social Care agenda of Putting People First is now a major driver and overall, ADASS will need a regulatory environment that assists the development of more flexible responses to individual needs that are derived from increased emphasis on self-assessment to achieve more personalised experiences as need for support to maintain or recover independence are encountered.

2.3 In fact, ADASS believes that the development which is the subject of this consultation gives the opportunity of us all to see that the contribution of social care to the well-being of people is more important than perhaps many realise in a policy arena which focuses mainly on NHS services.

2.4 As is noted in the Executive Summary (p6) of the consultation document, a regulation system already exists and ADASS believes that the process of transfer from existing arrangements will provide a management challenge across the sector and throughout the country. Our aim has to be, therefore, to ensure timely and appropriate communication throughout the process of change so as to mitigate the inevitable risks that occur in any change episode. ADASS believes that the CQC will have to work very closely both with local authorities and PCTs as commissioners but also with our local providers who – particularly in the social care sector - will vary in organisational strength and capacity as we move through the change period of a revised regulatory regime.

2.5 ADASS would be concerned if any change undermines the solid track record that has been built up over time within the social care sector between local authorities and local providers within this changing environment. We need to actively ensure that the achievements of social care are not diminished in the new constellation.

2.6 However, ADASS also recognises that at the level of local partnerships, the creation of a single inspection and regulation framework operated by the CQC may assist the way in which we work with health service colleagues as partners in response to standards. There is a clear need, nevertheless, to ensure that the diversity of what will be an incredibly wide care and health sector ranging from General Practitioner (GP) provision with associated Practice Based Commissioning (PBC) issues to small providers of social care. It is important, moreover, from the social care perspective that the performance of NHS Hospital Foundation Trusts (FTs) is well linked-in to local provision and services and there is an opportunity with a revised regulatory framework to support that need.

2.7 ADASS is unsure if the role of Strategic Health Authorities (SHA’s) in performance management of the regulation environment has been sufficiently clearly delineated in the consultation document. We fear that it is possible hat there may be potential for confusion at regional level of the influence they exercise in relation to Local Authorities and we need to be clear that Local Authorities are not accountable to the SHA.

2.8 Similarly, ADASS believes that there may be an overall democratic deficit within the consultation document as it stands. Whilst the references to the importance with engagement with people as patients or service users is noted in a welcome way, there does not appear to be a recognition of the role and responsibilities of Elected Members in terms of either their executive responsibility given whichever model of leadership is exercised locally or their role in Health Overview and Scrutiny where they will have a contribution to make with regard to the overall effectiveness of regulation within their localities.
2.9 ADASS welcomes and is committed to ensuring that issues of safeguarding and is pleased that current responsibilities of the Mental Health Act Commission will be transferred without change. Across the country, ADASS members will be at different stages of developing more integrated service arrangements for mental health and learning disabilities and it is important to acknowledge that there may be specific burdens for some who are negotiating organisational change as well responding to these proposals for regulatory change.

2.10 ADASS notes that the registration requirements are intended to ensure that services deliver an essential level of safety and quality. Performance over and above this will be assessed by the CQC during “periodic reviews” to enable quality ratings of services to be determined. The current National Minimum Standards will not form part of the new regulatory methodology and the CQC will develop “compliance criteria” for each of the registration requirements. Compliance criteria are likely to be service specific to acknowledge differences between health and adult social care sectors. ADASS believes that this will assist the social care sector to retain those things that people value in the way that we commission and deliver our services and see this as vital in the short- to medium-term phase of the transition.

2.11 ADASS also notes that the level of detail and prescription of the 18 registration requirements and compliance criteria may have implications for the content of contracts and service specifications. Contractors will need to align with CQC requirements and may need to be enhanced to compensate for any lack of specificity in the registration requirements of the CQC. Whilst ADASS appreciates that a “one-size-fits-all” approach cannot be taken, we believe that we will need to monitor this development so that unacceptable differences are avoided.

2.12 The consultation also considers the scope of regulation. Within the revised structure “regulated activities” will be registered as opposed to establishments or agencies. “Personal Care” is the registered activity that will encompass most of the current regulated services and this is consistent with the wider ADASS approach.

2.13 ADASS welcomes the fact that the current definition of the level of personal care subject to regulation has been widened to include people whose mental capacity requires them to be supervised or prompted to undertake personal care. Administration of medication and activities that restrict or deprive liberty are now also included and this is to be welcomed (see Annex B of the consultation).

2.14 The document also lists certain exclusions to regulation and ADASS is disappointed that day care remains excluded given the vulnerability and risk of some people for whom this service is a personalised solution to their need (see Annex B). The document posits that ‘local government assessment’ as a ‘regulatory system’ provides oversight of this service. ADASS would ask for clarification about what is envisaged exactly by ‘local government assessment’ i.e. is this a systems point about commissioning or a more individually focussed point about a social work assessment?

2.15 ADASS believes that there may be something of a contradiction in the point made at para 4.10 of the consultation. This justifies extending regulation to aspects of primary care on the basis of the competence of the individual professional. We take this to imply that regulation of that professional by their appropriate professional body is insufficient and this seems to be at odds with paragraph 4 of Annex B of the consultation where it is stated that “It is not our intention that organisational regulation should replace professional or any other forms of regulation, but rather that these systems should work together. With this in mind, we have excluded from the scope of registration types of care where existing regulation provides appropriate coverage.” However, day care services are then excluded and DH will know that
these services are often populated by vulnerable service users cared for by amongst
others, probably a good number of non-professionally qualified (and therefore
unregulated) care workers who provide, amongst other things the “regulated activity”
of personal care. ADASS recognises its role in ensuring minimum standards within
the whole workforce working with people who use services, but it is concerned that
there are seeds of inconsistency here that have germinated under current regulatory
methodologies which may be allowed to flourish under the new regime with
associated dangers to standards if not safeguarding vulnerable people.

2.15 Tougher sanctions and enforcement powers are proposed for the CQC to enable
direct and independent action against service providers which fail to meet essential
requirements on safety and quality (see 2.18). ADASS believes that given the
current ponderous and convoluted approaches of the Commission for Social Care
Inspection to enforcement, these tougher more direct powers are welcomed.

2.16 As far as the role of Registered Managers is concerned, ADASS believes that we
need to think further on the proposals in the consultation document. In para 3.21, it
suggests that not all areas where “regulated activities” occur require a Registered
Manager. Registered Managers are a current requirement in care and nursing
homes and domiciliary care agencies and this requirement is likely to remain with the
advent of the CQC. However, the consultation argues that Registered Managers may
not be required when “other governance and accountability structures are in place for
the supervision of managers and services”. This a point at which the consultation
document appears to grapple with the challenges of addressing such a wide sector
as the document cites NHS FT management structures as fulfilling that requirement,
yet suggests social care services are more likely to require Registered Managers “to
ensure appropriate accountability in law” (3.22). However, notwithstanding the
assumption that NHS management structures embody clear accountability,
Registered Managers of NHS hospital wards, or groups of wards, would provide an
equitable equivalent to social care Registered Managers. Such a move would clearly
define accountability at ward level for such facets of healthcare as, for example,
proposed registration requirement 3 (see Annex A) “managing cleanliness, hygiene
and infection control”, apparently lacking at ward level and further affecting the ability
to comply with other registration requirements (numbers 1, 2 and 6 for example) See
Annex A. It should be noted that regulation requirement 3 referred to above is not
subject to consultation and its inclusion as a requirement is immutable, confirming its
importance as a concern to be addressed by policy dictate. Additionally, given the
powers of the CQC, ADASS wonders who, in services where there is no Registered
Manager, would be prosecuted, for example?

2.17 Paragraph 3.25 of the consultation suggests that, “Providers of services for people
who are at greatest risk of vulnerability and that operate within frameworks with fewer
mechanisms to support the management of service delivery are most likely to be
smaller organisations, often in social care. As such, we propose that the social care
regulated activities should generally be subject to a condition for the provider to have
a registered manager ....” However, a British Association of Parenteral and Enteral
Nutrition report (Russell and Elia 2007) reveals that of admission to care homes from
hospitals, 35% were suffering from malnutrition as defined by the “Malnutrition
Universal Screening Tool”. Similarly, 31% of admissions to hospitals from other
hospitals were found to be malnourished. Though the admissions from care homes
to hospital were indeed less favourable with 43% identified as maldnourished, it
seems that the risk of vulnerability is omnipresent, irrespective of whether regulated
services are delivered in health or social care settings, suggesting Registered
Managers would best be established in both. It should be noted that allowing people
in care settings to become maldnourished amounts to neglect and is therefore,
abusive practice, linking this concern to proposed registration requirement 2
“Safeguarding people when they are vulnerable”. 
2.18 Finally, in respect of Registered Managers, ADASS is also mindful of situations where Councils need to step in to run services for a few days when a service providers has been cancelled - even though Councils have no legal right to do so and could theoretically be prosecuted for running an unregistered service. For this reason, ADASS believes that there is a need for local authorities to have the power to temporarily take over the running of registered services who are the subject of urgent cancellation processes whilst service users are found services elsewhere.

3.0 Specific Implications for Commissioning Functions

3.1 ADASS notes a number of references (paras 1.5, 1.16 –1.17, 1.19, 1.20, 1.24, para 2 Annexe A) that show the increasing responsibilities of commissioners as a recognised lever in the system to monitor and develop the performance and quality of regulated services. ADASS welcomes this and it again highlights the need for close working and understanding between the CQC and Local Authority and PCT Commissioners. ADASS believes it will be a pity and to the detriment of people using regulated services if we re-produce some of the uncertainties that have bedevilled our relationship with CSCI such as overall complaints management or sharing of information about regulated providers. As argued earlier (para 2.4,) getting the communication right is vital for all of us across the regulation, commissioning and provision continuum.

3.2 However, ADASS believes that these principles referred to in the relevant paragraphs are already operating through current commissioning activity to a certain extent, but the key question for us as Local Authorities as commissioners is are we operating to a sufficient degree to compensate for the changing emphasis of the to be formed CQC? Given that commissioning is becoming of increasing importance and this consultation perhaps represents the most recent development in that importance, not least of which is the influence on performance measurement and ratings of Councils, is the contracting and contract monitoring element of our commissioning with respect to regulated care services up to the increasing expectations? It may be that the extent to which contracts, service specifications and contract monitoring are enhanced will depend in part upon the final content and depth of the proposed 18 “registration requirements” (annex A of the consultation) and ADASS would welcome active participation in that process to ensure that the voice of Local Authority commissioning with all its experience is heard and integrated as needed.

3.3 Paragraph 2.18 of the consultation, under “Enforcement Powers” includes the “power to temporarily suspend registration for a specific period”. ADASS believes that will have implications for our contracting activity. If a provider registration were to be suspended, a local authority or PCT may legitimately suspend purchasing approval with respect to new service users. However, questions arise concerning continued contracting with a provider that has, albeit temporarily, registration suspended, with consequent implications for existing service recipients. These may be particularly profound for services of a residential nature.

4.0 Responses to specific consultation questions

Chapter 2 - Registration Requirements for Essential Safety & Quality

1. DoH 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 DoH, that are specific to the type of activity. These will be consulted upon at a later date. Do you agree with this approach?
ADASS agrees with the approach and would encourage that the 'compliance criteria' are as uniformed as possible across the service areas to avoid confusion or complicated application. However, they will need to recognise some differences in operational practicality, e.g. storage and administration of medication.

We support the 18 registration requirements and think they are appropriate.

We agree with the approach

2. 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 DoH are aiming for?

ADASS believes that the areas broadly cover everything but we wonder if they specifically address building design adequately.

Supported Housing at present are registered with CSCI and need to remain registered under the activity of personal care.

If the Registration Requirement of "Managing cleanliness, hygiene and infection control" is about premises only, we need to ensure that "managing cleanliness" of staff is included in the Registration Requirement of "Making sure people get the care and treatment that meet their needs safely and effectively."

3. Does the wording of the registration requirements in Annex A provide appropriate coverage of these areas?

Broadly - yes. There are a couple of grammatical points and points where 'care and treatment' need included and not just one or the other.

See point above regarding managing cleanliness

4. Are there any overlaps, gaps or unintended consequences that will not be picked up by other parts of the system?

Not that we can see, assuming that the existing links with Fire and Rescue, Environmental health and HSE remain part of the process.

Counselling and or advocacy services should have professional standing and some form of regulation, rather than personal opinion.

High support facilities should be regulated, with community based delivery having some guidance.

Need to ensure that there is some clarification as to what "medication management" is within the control" of Domiciliary Care providers.

If a person's own home is excluded in relation to "care being provided in safe suitable places", we need to ensure that "care and treatment by staff to promote independence ....." is included in "Making sure people get the care and treatment that meet their needs safely and effectively."
5. What are your views on the transition arrangements for existing providers to enter the new registration system?

ADASS supports the transition of service as suggested assuming that the new service will have the administrative capacity to deal with the volume. We question the natural acceptance of health care services as Registered Bodies without the application of inspection/registration process as discussed earlier.

Chapter 3 - Scope - Which Health & Adult Social Care Services Should Be Registered?

6. Do you agree with DoH proposed list of regulated activities in Annex B to be included within the scope of registration?
   a. Are there any high risk areas not covered?
   b. Have DoH proposed any inappropriate registration of lower risk services?
   c. What are your views on the exclusion of non-urgent patient transport services under the 'Emergency and urgent care' activity topic?

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?

ADASS believes that Day Care should be considered for Registration as a wide range of personal Care could be delivered within a day Care setting.

The whole Personalisation Agenda raises an unknown requirement for the protection of vulnerable people in receipt of services.

The picture of day services in Annex B Scope Personal Care is traditional and seems to qualify itself by saying that personal care needs are an additional service to enable people to access day services.

With many people this is not the case at all with Care Plans stipulating personal care needs within day services as a high priority and a continuation of other services provided.

A high percentage of people accessing current day services receive most if not all of the Personal Care Activity topics described and not just referring to people with high support needs.

Many people also receive other services from current Registered Services such as Supported Housing, Short Break and Adult Placement – their personal care needs do not change once they enter a day service.

How do we stand with people who receive 2/3 different services with the same expected and assessed standards of personal care needed, provided from the same Care Plan?

Some day services also provide a high level of personal care to people as although we promote personal independence as much as possible many of the Personal Care activities which need to take place, e.g. medication, prompting of other personal care tasks are current everyday issues.
Day services as other services often have to manage “challenging behaviours” – again highlighted in some Care Plans/Risk Management Plans.

If Day Care was to be registered than more detail would be required with regard to the provision of registered services where the building is owned by the Local Authority; or were provision is in leased/rented properties from private landlords/District Councils.

ADASS believes that in defining the scope of registration for social care would need clarification on "practical assistance" within the statement of “Social care includes all forms of personal care and other practical assistance provided for individuals who by reason of age, illness, disability, pregnancy, childbirth, dependence or alcohol or drugs, or any other similar circumstances, are in need of such care or assistance".

Query question why care in services is registered but not In Control or direct payments environments.

High risk services not covered. Direct payments, individual budgets, day care

No the DoH have not proposed any inappropriate lower risk services

Puts the onus on the organisation in receipt of the supply of agency workers to ensure appropriate standards are in place. The use of agency staff is usually in an emergency situation and the safeguards that Registration may have offered will not be there.

Agencies providing workers to registered service should be registered.

7. 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?

Yes

8. Is there a risk of inappropriately deregulating high risk activities in this approach?

Not with good criteria and monitoring

No

9. Have DoH determined the right situations in which to register a manager?

ADASS does not agree with the assumption that the NHS structure would promote the need for less Registered Managers

ADASS does not fully agree with the status of the "registered manager" we should register the responsible person

Not sure if this suggests that existing services could have a Manager that could be registered to cover more than 1 Domiciliary Care Branch or Home. If so we feel that this would be possible/feasible
Chapter 4 - Registration of Primary Care

10. Does the list of activities in Annex B (p73) appropriately capture the services where people might be at risk of harm provided in primary care settings? In particular do you agree with the proposal that ultimately all GP and primary dental services should be within the scope of registration?

ADASS suspects that the list is comprehensive but there has to be a concern about the viability of registering all such premises without significant additional resources.

There is already registration of the 'lead' practitioners with such as the General Medical Committee and General Dental Committee, and this is a key safeguard. Primary Care Trusts also have detailed contracts and specifications for General Medical Services (GMS), Personal Medical Services (PMS) and General Dental Services (GDS) as primary care commissioners, so these could be used as part of the framework.

ADASS also believes that there is an issue of delivery, in that many of the contacts are brief and episodic, and the opportunity for abuse is restricted. Perhaps there could be a focus on scenarios where vulnerability is greatest, such as with people under anaesthetic, or disabled people receiving treatment? There are already protocols around 'chaperones' for patients during examination – e.g. male doctors and invasive investigations with female patients. These could be given a stronger national framework of standards.

Finally, ADASS believes we should avoid duplication with the clinical governance frameworks which exist around safe practice.

11. Does the list of activities in Annex B (p73) inappropriately capture some services that are less likely to cause harm when provided in primary care settings?

See response to Q10

12. What information would you expect the new Commission to draw on when making decisions? How could it best do this?

All of the frameworks referred to above.
Information from complaints and the Patients Advice and Liaison Services.
The GPs Quality and Outcomes Framework operated by Primary Care Trusts.
Referrals to the GMC etc.
Referrals to the Health Ombudsman
Reports from the local Directors of Primary Care.

13. What is the scope for rationalising the existing requirements on primary care providers if a registration system is introduced?

ADASS believes that this would require significant work between the clinical/professional regulators, such as GMC, GDC, Royal Colleges etc. and the
new Care Quality Commission. There are also separate systems for primary care contracts (GMS, GDS etc.) and clinical governance which have different functions. ADASS is concerned that too much rationalisation could lead to gaps in the overall clinical safety-net.

14. When should services provided in primary care settings be required to register? Should DoH phase in registration?

ADASS wonders if registration could be dealt with on a cluster or 'polyclinic' basis. Registration should probably prioritise those primary care services based on single practitioners - GP or dentist, for example.

15. If registration is phased, how should DoH determine the Services to be captured?

See response to Q14.

16. Is DoH assessment of the costs and benefits in the accompanying impact assessment reasonable? Is there any additional information on impact that DoH could use?

ADASS advises caution on the costing and thinks that given the costs of the new CQC, it is probably an optimistic under-estimate.

David Johnstone
Chair – ADASS Standards and Performance Network

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