“Our next phase of regulation”
CQC consultation
Joint ADASS and LGA Response

Background

The **Association of Directors of Adults Social Services** (ADASS) is a charity. Our objectives include:

- Furthering comprehensive, equitable, social policies and plans which reflect and shape the economic and social environment of the time
- Furthering the interests of those who need social care services regardless of their backgrounds and status and
- Promoting high standards of social care services

Our members are current and former directors of adult care or social services and their senior staff.

The **Local Government Association** (LGA) is the national voice of local government, working with councils to support, promote and improve local government. The LGA is a politically-led, cross-party organisation that works on behalf of councils to ensure local government has a strong, credible voice with national government. We aim to influence and set the political agenda on the issues that matter to councils so they are able to deliver local solutions to national problems.

The context

We have welcomed CQC recognition of the challenges that increased needs for care and support for older and disabled people bring, in the context of reducing budgets. CQC is well placed to monitor the impact on care providers and the threat to their viability as businesses.

We share CQC’s concerns on the impact of economic difficulties on the sector. This is important to our shared interest in raising standards and promoting awareness and choice and is all the more important as the sector is challenged both financially and in relation to workforce and market sustainability.

The ADASS response to CQC’s State of Care report outlined that this provided “good evidence that both the Commission and social care services are heading in the right direction despite growing financial pressures placing the sustainability of the sector at ever greater risk.”.

These pressures are outlined further in:

- Adult social care funding: state of the nation report
- ADASS budget survey 2016
- ADASS Autumn Statement submission
- LGA briefing on the provisional 2017/18 local government finance settlement

Working together

We welcome the chance to comment on the next phase of regulation. We share the priorities of good quality, safety, safeguarding and sustainability and look forward to continuing to work even more closely with CQC and providers on this.

ADASS recently have recognised CQC for its:

- **Commitment** to meaningful coproduction and authentic, values-based leadership,
- **More robust** inspection findings that we can increasingly rely on, and
- **Growing numbers** of dedicated staff now proud to say they work for the Commission.

As noted in our joint responses to other CQC consultations, we support opportunities to draw together a fuller picture from all the sources of data and information available to assist providers, regulators, commissioners and the public understand the quality of care and health provision. We are aware that many local areas and regions already have mechanisms for sharing data and intelligence. There is a need to identify and build on existing good practice of this collaborative work at local, regional and national level.

There is too much in the care and health sector that requires improvement and that is something that will require providers, councils and the regulators to work together to tackle. Providers have a key responsibility in relation to the quality of the care and support they deliver - but we are very conscious that providers, commissioners and regulators are completely interdependent in relation to ensuring quality, particularly in a very challenging financial environment. From previous experience, it is only when the CQC, providers and commissioners work together, with a shared view of quality, that service failures, pressures on capacity and improvements can be addressed effectively.

We are aware of the importance of good commissioning decisions. Increasingly, councils are developing innovative programmes of pro-active support for care providers, in order to ensure a diverse and sustainable supply in fragile markets, informed by intelligence, which goes beyond simple contract monitoring and looks at the multiple characteristics of each business. The joint Care and Health Improvement programme is building on the existing route map and peer challenge on commissioning for better outcomes, as developed jointly with providers and people that use services. The ADASS Commissioning network is engaged in a raft of activity both regionally and with national partners including CQC and NHS England to support the sustainability of the market, enhance quality of provision and plan for the event of provider failure.

This will support councils' responsibilities under the Care Act for information and advice for all and for market overview. All key partners also need to have an awareness of, and agreement around, each other's roles and responsibilities in the event of market failure, including who could offer what assistance in the event of occurrence, including leadership responsibilities at a local, regional and national level.

The information CQC holds can also play a very useful role in safeguarding arrangements. We welcome ongoing work with CQC, the NHS and providers to address the overlap between poor care and abuse and neglect. We will be keen to discuss how contract failures, safeguarding concerns and complaints to councils can also be assimilated into the findings from CQC regulatory activity. The rising number of safeguarding incidents may in some part be a reflection of concerns over poor quality of care as well as abuse and neglect, and financial failure is in many instances preceded by a decline in quality.

Consultation questions

1a: Do you think our set of principles will enable the development of new models of care and complex providers? 1b: Please tell us the reasons for your answer.

In the 2015 Autumn Statement, the government announced a requirement that all local areas integrate health and care services by 2020. The concept of better co-ordinated care has developed over many years. We have called for a radical transformation of services in order to meet the needs of people within a society with increasingly chronic and complex needs.

We welcome CQC's recognition that it needs to react to a changing environment in health and care in a way that facilitates and supports improvement and sustainability, and that continues to make sure people have access to safe, effective, compassionate, high-quality care.

We therefore welcome the flexibilities around new models of care, and support the proposed principles. An additional principle that centres on engaging with people who use services, their families and carers would be welcomed.

2a Do you agree with our proposal that we should have only two assessment frameworks: one for health care and one for adult social care (with sector-specific material where necessary)? 2b Please tell us the reasons for your answer.

CQC's effectiveness is vital to councils, the NHS and the health and care sector as a whole for older and disabled people. We have continued to welcome CQC's determination to address some fundamental concerns held by people using services, carers and the public about how to understand and interpret its findings on the services it regulates. We therefore agree with the move to two frameworks as being simpler to understand for people who will use services and those that care for them.

We would also would support consistency in approach across the two frameworks given the move to more integrated services, particularly in aspects which are relevant to both health and social care. Some further examples of where this could be further explored in the answer to question 3 below.

3a What do you think about our proposed changes to the key lines of enquiry, prompts and ratings characteristics. 3b What impact do you think these changes will have (for example the impact of moving the key line of enquiry on consent and the Mental Capacity Act from the effective to the responsive key question)?

In our joint response to CQC's consultation on its *Strategy 2016 to 2021: Shaping the future* we urged CQC to retain a clear focus on its core regulatory function:

- given its potential to help both the system and the many individual care people using care, carers and families who relied on CQC ratings to help them make choices,
- as a key driver in leading to improvements in care.
- to help local authorities to target and focus on the any problems with providers in local areas.

We welcome the proposals that continue to enshrine 'fundamentals of care' as both simple and relevant to people that will use the services, and the people that care for them. Reports that outline performance clearly in relation to *safe, effective, caring, responsive and well-led* care will inform people's decisions and understanding.

How CQC sets out its own values and reflects those of the sector is important. We note that in using these principles, CQC is still putting the individual and their families and carers at the centre of their regulatory activity. This focus on people's overall experience of care and health provides structure and clarity going forward. The inclusion of end of life care therefore is an important inclusion to the new framework. As part of this, references to 'care' could be renamed 'care and support' to reflect a more empowering approach to the support of people. We also welcome the continued focus on leadership and governance as a means to enable improvement.
We continue to welcome CQC's focus on including people's experience and views, and in particular, looking at innovative ways of collecting these. We encourage the commitment to co-produce the future regulatory framework with users, carers and patients.

We also recognise the need for simplicity and relevance in expectations of regulated providers. Providers need to understand their own story of quality, safety and performance and that should be validated by a well-conducted inspection to form the main basis for judgement (and of course, triangulated with views from people using their services and their families, commissioners and safeguarding staff).

We are aware however that the current inspection framework requires substantial resources to prepare and participate in an inspection - and small providers may struggle to cope with the demands of a complex system, so simplification should be welcomed.

ADASS and LGA are keen to contribute to the development of the new framework, building upon their own expertise and experience of sector led improvement. We look forward to working with CQC in the run up to its further consultation in Spring 2017.

An effective framework is crucial to improving quality of services. It may be helpful to provide further clarity on specific KLOES as part of this development:

Safe

- **S5.4** (adult social care framework) about alerting the right agencies to concerns about people's health and wellbeing: greater clarity is needed on whether this refers to managing risk or being more positive about people's or care homes' links with their local community. Either way, this needs to encourage a balance between people being able to take risks and being able to protect themselves or to be protected.

Caring

- **C 1.3** (adult social care framework) about communication – there needs to be examples of when this might be needed and what
- **C2** (adult social care framework): there could be an additional prompt relating to person-centred care and support that is evidenced in ways of working (e.g. in support plans etc.)

Responsive

- **R1:** We support the focus on supporting people's interests and aspirations and family life/friendships within R1 (adult social care framework). However, we would suggest more of an emphasis and focus on a life in the community focusing on an asset-based approach that enables and supports people to be active members of their communities. Good and effective support should be focused on supporting people to be a part of their community, as well as supporting people to 'bring' and contribute to their community.
- **R1.3** – this could be enhanced to say 'how are people supported to follow their interests and take part in activities **in the community**" [additional text in bold]. I.e. it is not just about activities that go on within the social care setting in which the person is living.
- **R1.4** – although we support this prompt, we think it could be strengthened. Relationships and participation in the community is broader than 'developing and maintaining relationships with people that matter' to the person. Again, this comes back to empowering people to be part of their communities and to have day-to-day interactions with people that are broader than immediate friends and family, but also to develop friendships and relationships with people beyond the setting in which they live.
- We agree that moving the key line of enquiry on consent and the Mental Capacity Act from the effective to the responsive key questions will support a more person centred approach.
- R4 (healthcare) and R2 (adult social care) both relate to the complaints process. We feel that there should be some reference to the availability of accessible information (specifically relating to the relevant procedures/information) within the prompt questions – and potentially reflected in the ratings characteristics.

- We also feel that there is an opportunity within the KLOES/ratings characteristics on complaints to reflect the need to ensure the protection of individuals (and staff) where specific members of staff are identified within the complaints process and where, for example, it may not be appropriate for continued support of the person by the named member of staff.

Well-led

- **W3** (adult social care framework): we support this new KLOE around input into the service. However, this may warrant a separation of the prompt question around people and staff being actively involved, so that there is a distinct focus on engaging with those people who use the services and their families. This is reflected in the equivalent new KLOE within the health framework (W7), where there is a prompt specific to those who use services, "those close to them and their representatives".

As noted in the response to 2a) and 2b) above, it would be useful to ensure consistency in approach across the two frameworks, particularly in aspects which are relevant to both health and social care and where issues are clearly equally applicable and important. Below are some key examples of where KLOES are only used in one or the other, or where there is slightly different wording to describe what appears to be the same 'prompt':

Safe

- S1 in the adult social care framework covers how people are protected from bullying, harassment / breach of human rights, with some relevant prompts (e.g. S1.2). The equivalent is not included within the health framework and should be.
- The new S1.1 on systems and practices is very similar to the equivalent prompt in the health framework (also S1.1), but the wording is slightly different. It is therefore unclear whether this is deliberately intended – i.e. in order to be asking something different.
- S2 in both frameworks covers risk, but there are prompts that are contained in one that could equally be applied to the other, but are not – for example, S2.5 (care) on recording and reviewing safeguarding concerns. The equivalent prompt would be relevant to the health framework too but is not included.
- S5 in the healthcare framework (what is the track record on safety) and S6 (are lessons learned and improvements made when things go wrong), also equally apply to the adult social care services framework too and should be reflected.

Effective

- E2 within the adult social care framework is 'How are people supported to eat and drink enough to maintain a balanced diet'. Whilst there is a prompt about people's nutrition and hydration needs in the healthcare framework (E1.5), the issue and importance of people getting the support they need to eat and drink the right sorts of food and maintain a balanced diet also applies to healthcare settings, particularly where people may spend relatively lengthy period of times in hospital – for example in mental health/learning disability hospitals.
- The new E5.2 (healthcare services) asks about how people are involved in regularly monitoring their health, including health assessments and checks. There is a KLOE in the adult social care framework around how people are supported to maintain good health (E3). This same prompt would be relevant within adult social care settings (e.g. supporting people with a learning disability in residential care settings to go and have their annual health check).
- E5.3 (healthcare services) about how people are empowered to manage their own health, care and wellbeing and to maximise their independence again is an important aspect of good care and support within adult social care services.

Caring

- C.1 – this KLOE within the healthcare services framework asks whether people are treated with kindness, respect and compassion and given emotional support. A very similar 'prompt' (c1.1.) is within the adult social care framework, but without the wording around emotional support, whereas emotional support would also be relevant here too.

Responsive

- R2 (adult social care framework) – there are two 'prompts' within the health services framework relating to the KLOE on complaints that apply equally to social care settings but are not included – these are around explaining the outcome to the complainant, transparency and openness and how lessons learned result in improvements in care and support.

Well-led

- W5 in the adult social care framework is focused on how the service works in partnership with other services and a multi-disciplinary, joined-up approach to the delivery of care and support. This would seem to be a key issue for health services too.

Rating characteristics

- As noted above, there are slight differences in some of the wording across the two frameworks which is quite confusing. For example, under 'safe' and a good rating under the adult social care services, the sentence is: "people are protected from avoidable harm and abuse. Legal requirements are met." The equivalent for healthcare services includes the first sentence but makes no reference to legal requirements.
- More generally, the difference in approach as outlined above impacts on the descriptions for the ratings characteristics. For example, as mentioned earlier, the KLOE on protection from bullying, harassment and abuse is not in the healthcare system framework, meaning that this is not used specifically in the ratings characteristics section for healthcare, even though it would seem a priority to consider in terms of assessing whether the service is 'outstanding', 'good' or 'inadequate'.
- Under the 'outstanding' rating for KLOE R4 (healthcare services) and the equivalent R2 within the adult social care framework (both focusing on complaints processes), there may be an opportunity to strengthen the position that the process for complaints should be regarded within services as a positive rather than a negative and defensive process; a good and robust process is one that is focused on using the learning as a positive contribution towards continuous service improvement. Within R4 specifically (health), the outstanding rating describes involvement by those who use services but this also needs to reflect the views of family carers, advocates and others who know the person well (where appropriate), as well as the individual.

4. We have revised our guidance 'Registering the right support' to help make sure that services for people with learning disabilities and/or autism are developed in line with national policy (including the national plan, Building the right support). Please tell us what you think about this.

We welcome CQC's ongoing support and work in response to the lessons learnt from Winterbourne View and the subsequent inspection programme. We support the CQC's approach to ensuring that Building the Right Support and the national service model are embedded into its regulatory framework, ensuring that models of care reflect best practice, values and policy.

We welcome the reference to small-scale accommodation and the addition on page 20 about the proximity of premises. Additional comments are as follows:

- Page 5: we think that the three bullet points would benefit from a rewrite, and in particular the second and third bullet points. These are set out following a paragraph about registration decisions being made based on best practice. They read, however, as if they are supporting large scale models of care, rather than stating clearly that whilst it is recognised that a) larger facilities may be more financially attractive to providers and that b) the housing crisis might mean it is tempting for commissioners to use placements which do not comply with best practice models, that such provision would nevertheless *still* not comply with the regulations.

- Page 6, top bullet – the Local Government Association (LGA) is missing as a partner.

- Page 25, final reference – S missing off the end of ADASS.