Care England response to CQC discussion paper 'Building on Strong Foundations'

Introduction

This document details Care England's preliminary responses to the questions posed in the CQC discussion paper of October 2015. It should not be considered Care England's final response on these issues, and we will be responding to the full consultation in the New Year, when we hope to have a fuller picture of the CQC's proposals. Care England has not had time to take feedback from our membership in the time available and hope the consultation in the New Year will give an appropriate timeframe for us to give a comprehensive response, informed by our membership.

Q1: Are there any other important issues, relating to our approach to regulation and the context in which we are working, that we need to consider?

1.1 In what way does the recent CQC fees consultation, which sets out proposals to raise fees, relate to this document, which effectively proposes a reduction in CQC's functions and reach? If, as this discussion paper suggests, CQC is scaling back its activity due to a lack of funds, then Care England would suggest that it is right that fees are reduced to reflect CQC's reduced role. This would be fair and also mindful of the fact that financial pressures are affecting providers just as much as CQC itself. We believe it would be inappropriate to retain high fees while scaling back regulation, and would not be respectful of the financial pressures that providers are facing.

1.2 CQC has in the past acknowledged its role in alerting government to the lack of funding in social care. At the launch of the State of Care report, David Behan said that he would alert government when he believed that a lack of funding to the social care sector was negatively impacting quality. We believe that a lack of funding is already affecting quality for our members.

1.3 CQC talks in this discussion paper about 'using our independent voice', and we would urge CQC, in the context of a reduction to their core funding, to use this voice and position of influence to call for more, and more sustainable, funding to the social care sector. The scaling back of CQC's regulatory reach could put providers and service users at increased risk.

1.4 At October's CQC board meeting, and at a recent CQC co-production group that Care England attended in Westminster, the issue of the public profile and the public's understanding of CQC was raised. In a world where

the CQC's role is rapidly changing, Care England believes that it is vital that the CQC makes a concerted effort to ensure full public understanding of the difference between the LGO and the CQC, and their respective roles going forward.

1.5 The CQC states that it will ensure that information "for providers is clear about what our ongoing quality expectations are and what they need to do to register." We welcome increased clarity about inspection regimes and registration, to make it as easy as possible for services to seek regulation. We also would like transparency and co-working to continue between ourselves and CQC: we think that it is vitally important that the best interests of providers, and the people they care for, are at the heart of these changes.

Q2: Given that regulation is just one influence on care quality, how do you think CQC can best work with others to encourage improvement in the quality of care over the next five years?

2.1 The CQC should continue to work with providers by promoting good practice and sharing it. CQC should offer tools and resources to providers that can help them to understand and improve their rating and demonstrating what 'good' and 'outstanding' person-centred practice looks like. This will be especially important under a new regime, where providers may feel unsure about the quality benchmark or how to demonstrate their quality under a new system. Care England would urge CQC to ensure that this new strategy brought with it no additional burdens for providers.

2.2 Although CQC is reconfiguring its role in regard to fostering quality in care, we would remind CQC of David Behan's words in evidence to the Health Select Committee before the last CQC strategy consultation:

"… the 2008 Health and Social Care Act… says that our job is to measure whether people are meeting these essential… standards… Then it goes on to say that we will do that for the purpose of encouraging improvements in services. So the very legislation that created CQC gives a function which is to encourage improvement in the way that services take place…"

2.3 As we outlined in our response to the 2013-16 CQC strategy consultation, David Behan's statement posits a consequential relationship between regulating against essential standards and encouraging quality improvement. It is thereby well enshrined that quality improvement is a core duty of the CQC, and Care England believes it must continue to be, especially in times of less extensive regulation.

2.4 Care England thinks that it would be beneficial to have a formalised channel for providers to tell CQC which factors are impeding their progress towards high quality care. This could be in the form of an advice line, or a question on a national survey, and CQC should remain receptive and willing to act on information about impediments to achieving quality in care.

2.5 If CQC are going to do considerably less to improve quality while maintaining its regulatory powers to take decisive action, it must be careful to retain good relationships with the provider sector and make explicit the new relationship between providers and CQC, and what can be expected on both sides. We consider it essential to clarify and define the relationship between providers and the CQC going forward, so that responsibilities towards quality are clearly understood. We hope that co-working between Care England, CQC and providers will continue and improve to best reflect the needs of care providers.

Q3: We have described what risk-based registration could look like.

a) What do you like about this?

3.1 A risks-based, differentiated approach holds the potential to reduce bureaucracy for quality care providers while maintaining a level of scrutiny where risks do lie in the sector.

What do you not like about this?

3.2 However, as stated above, Care England is concerned that a move towards less independent regulation would not be sufficient if it meant in principle providers were self-assessing, and a risks-based approach took its intelligence from providers' self-assessments only, or in the main.

3.3 Our concerns regard: how risk would be determined, how the regulatory system would retain authority and impartiality if information came chiefly from providers, how CQC manages the *risks* of a risk-based approach, and how providers inspected would experience and be able to manage any potential burdens of a risks-based approach. Would it be more work for the provider than the existing inspection? Would inspection under a risks-based system reflect badly on the provider, in terms of local press and reputation? These are questions that must be considered and addressed in the upcoming consultation.

3.4 Finally, while we recognise that this approach could reduce unnecessary regulation for providers, we would stress the need to ensure such a risk-based approach does not act to discourage new approaches, expansion and innovation, if these are considered the most 'high risk' examples of care provision. We hope that CQC will ensure that this is not the case and address this potential pitfall in the consultation.

Q4: What impact would risk-based registration have on you?

4.1 Because our members turn to Care England for guidance on regulation, it would be important to have good channels of communication open between Care England and CQC, as well as between CQC and providers directly.

4.2 We feel that the whole sector could be negatively affected if the CQC bases its inspections solely or mainly on providers' self-assessments and takes a risks-based approach based on these. We foresee that this would have implications for transparency, whistleblowing, culture and quality.

Q5: We have described what smarter monitoring and insight from data could look like.

a) What do you like about this?

5.1 We welcome an evidence-based approach from CQC. We believe that providers would feel comforted by the increased use of data, and if regulation were truly evidence-based, then CQC decisions could be even more justified and concrete.

b) What do you not like about this?

5.2 Care England can see benefit in improving data use, as long as this does not place providers under additional strains or generate more bureaucracy. We know that providers feel like a lot of data is already gathered from them by different organisations, so we advise that as far as possible the CQC undertakes data-sharing with Local Authorities, NHS England and CCGs to prevent providers suffering from replication of data collection.

5.3 As well as this, the CQC's strategy consultation 2013-16 said that improved use of data and intelligence would be a core part of this period of CQC's work. Will the CQC's use of data improve and extend, or is this simply a restatement from the last consultation, and therefore a continuation of the current scope of data usage? We think it is right to address this in the upcoming consultation in the interests of continuous improvement.

Q6: What impact would smarter monitoring and insight from data have on you?

6.1 Better data and data sharing (ensuring that this data is readily and publicly available) would benefit our work and make it easier to keep our members informed about trends and forecasts for the sector.

Q7: We have described what a greater focus on co-regulating with providers could look like.

a) What do you like about this?

7.1 We welcome the proposal of better cooperative working, and agree that providers are well-placed to take an active role in regulation.

What do you not like about this?

7.2 While increased co-working and less intrusive regulation for services is positive, we are concerned that 'co-regulation' is another term for self-assessment. Care England does not believe that self-assessment is appropriate for the social care sector. CQC must formulate a scheme for co-regulation that befits the sensitivity and the risks involved in care. Like our views on regulating commissioners, which we have previously communicated to CQC, Care England does not believe that self-assessment is sufficiently rigorous.

7.3 Care England would like to see more in the January consultation about what the proposed co-regulation scheme would entail: how information submitted from providers would be used, and how it would be weighed against CQC's independent regulation, before we could give full judgement on the scheme. At present, we have a number of concerns about a system which relies on at least some element of self-regulation.

Q8: What impact would a greater focus on co-regulating with providers have on you?

8.1 Providers may well come to Care England with more questions about their rights and responsibilities during and around inspection if their duties are different and they have more responsibility to report. To answer these questions, there would need to be a clear framework and information available so we could advise providers about the process and their new duties.

8.2 If the proposed 'co-regulation' were to be effectively a form of self-assessment, then Care England believes that the entire social care sector would feel the impact of less stringent and independent regulation. It would be extremely challenging to work in a climate of even less public and press belief in the care sector, and less quality assurance.

Q9: We have described what more responsive and tailored inspections could look like.

a) What do you like about this?

9.1 We feel positive that tailored inspections hold the potential to reduce excessive paperwork. We strongly approve of the suggestion to align better with other agencies.

What do you not like about this?

9.2 While random sampling could reduce administrative burdens for care homes, but could also be an increased source of stress for care homes, and this must considered.

9.3 How would a regulation regime 'tailored to the particular situation' ensure the same level of scrutiny and quality assurance across all services? How could quality be benchmarked under such a system, so that the general public can choose a care home or service based on quality, and that providers feel confident in their actions and ratings? We are concerned that tailored inspections would limit the sector's ability to define 'good' and 'outstanding' care by having no fixed criteria for inspection and varying methods.

Q10: What impact would more responsive and tailored inspections have on you?

10.1 If responsive inspections led to the reduction of high fees, excessive regulation and duplication then providers would be relieved of many pressures these bring with them. We do want CQC to address how they would manage the risks of such an approach.

Q11: In this section we have detailed four areas which will help successfully achieve the next phase of our regulatory approach. In order of importance, which will have the most impact in encouraging improvements in the quality of care?

11.1 It is difficult to assess these in order of importance and impact as we are unsure what many of the proposed schemes will mean in practice. We may be able to respond more fully to this after the January consultation.

Q12: We have described how we could assess how well organisations are working together to provide health and care services for specific populations and in specific local areas.

a) **What do you like about this?**

12.1 There are obvious benefits to this approach. Providers often tell us that partnership working is poor across agencies, and that this leads to duplication of effort and poor communication. Information about an area and its systems would help Care England to monitor the success of health and social care integration. It would also allow us to target areas where agencies are not working well with care homes and providers.

b) **What do you not like about this?**

12.2 Care England is concerned about the potential impact of having less information about providers in favour of more information about place and partnership working. We would be concerned that providers might meet with more public scrutiny and media criticism as a result of a system where less information was collected about providers.

Q13: How useful would this information be for you?

13.1 We are concerned that any work on specific populations and place is clearly outcomes-focused and there are clear plans for the use of the data and the benefit for people's experiences of care. We would also want close scrutiny of commissioning behaviours and a commentary of the impact on people. Providers should be part of the evidence base for this and their views should be proactively sought.

Q14: Should it be a priority for CQC, given that it would mean allocating resources from other activities?

14.1 We would wish to reflect further on this in discussion with our members which the short timeframe for responses to this paper haver not allowed.

Q15: We have described how we could assess the use of resources in NHS trusts.

a) **What do you like about this?**

15.1 Work around efficiency and resources could also help providers to be more efficient, especially if there were examples of best practice around resources shared. Care England approves of the suggestion that this piece of work should require limited fieldwork, which would reduce potential pressures on providers.

b) **What do you not like about this?**

15.2 Care England will give more full comment once the system has been in place for some time and we have been able to see what, if any, impact this has had on use of social care services in the NHS Trust areas.

Q16: In terms of the three ways we could develop our regulatory approach, which one would you most like us to focus on, given that CQC has to prioritise where it allocates its resources?

16.1 It is difficult to respond to this question as we are unsure what the proposals in this document will mean in practice. We may be able to respond more fully to this after the January consultation.

Rank in order of importance:

16.2 The below seems like a sensible order:

1. Making our model more efficient and effective
2. Looking at the quality of care for populations and places
3. Assessing how providers use resources

But as above, it is difficult to respond to this question as we are unsure what the proposals in this document will mean in practice. We may be able to respond more fully to this after the January consultation.

20th November 2015

For more information contact

Saskia Goldman

sgoldman@careengland.org.uk