The Red Tape challenge for social care - ECCA response

1. Introduction

In responding to this consultation, ECCA believes that the focus should be on the individual receiving the service and as such our recommendations are based on achieving an efficient and effective health and social care system that ensures personalised care for individuals. We understand that regulations are still needed to ensure essential protections for vulnerable people and the public. It is our belief, however, that there are certain regulations that are no longer fit for purpose, and can be improved or streamlined to help care businesses without affecting the public interest in ensuring people are safe and treated with dignity. Indeed certain regulations and the way in which they are implemented positively work against providing good personalised care for people.

Services which people rely upon must:

- be relevant to them,
- give them choice,
- give them voice,
- give them dignity
- safeguard and promote their rights and welfare.

As a result, we welcome the Government's commitment to re-examine their regulations to make sure they are fit for purpose. We have emphasised that the independent sector is committed to working with the Government and with people who need the services to get regulation right - smart regulation on the right things.

It should be noted that the DH is currently consulting on applying new regulation to social care providers with respect to financial oversight and we are not sure how that fits in to the intentions behind the Red Tape Challenge?

2. Duplication

ECCA has always advocated that regulation should be proportionate and reflect the setting in which care is given, the type of care given and the needs of its recipients. As a representative of care homes ECCA would want to emphasise right at the beginning of this consultation that a care home is a person's 'home' and not a temporary place of treatment.

There have been efforts over the years to move to greater proportionality for example by the care regulator. These include attempts by the previous regulator,

CSCI, and now CQC, which ECCA welcomed. However it is our experience that where this has happened, the local council, or PCT has often moved to replicate or replace what had been removed, using their power as monopsony commissioners. This development was rooted in the belief that CQC could no longer be trusted to undertake the role of regulating service quality, a position that was exacerbated by the CQC abdication of its responsibility for awarding star ratings. This perceived failure of CQC - for which we do not intend to rehearse the reasons here - has had huge repercussions for this sector and has left the quality agenda without clear leadership.

In this way the burden of red tape has not reduced but actually increased as councils introduced their own systems under the guise of contract monitoring. These were presented as contract monitoring or local quality assurance systems, to which extra payments were sometimes linked. It is with dismay that we note so many being based on CQC essential standards, therefore effectively duplicating statutory regulation. Where the local schemes offer extra funding for meeting local quality requirements this represents a huge conflict of interest as the Council and/or PCT is both paymaster and judge of quality, linking fees to the quality rating it judges appropriate. Worryingly, the incidence of such approaches appears to be on the increase.

In one example, a local council quality monitoring document (a report of 178 pages) had to be completed within a month by all homes. It actually replicated all 28 CQC outcomes and required evidence for each of the CQC prompts under each of the outcomes.

The tone of the introductory pages is also revealing. It includes the sentence:

Allocate time to complete the statements and meet the deadline. You may provide an excellent service, but can you manage a project on time? This will be a clear indicator of the management of your service.

The home that sent this example estimated that 2 weeks senior staff time was needed, for preparing the evidence, completing the form and accompanying the council staff on the initial and subsequent visit.

We are at loss to understand how councils believe they can afford the additional resources that are necessary to implement these schemes at a time of severe resource constraint. The Local Government Group has already offered to take more control over its own affairs as a *quid pro quo* for achieving greater efficiency, citing evidence revealed by the Total Place pilots of how "much waste and unnecessary bureaucracy comes from multiple public bodies trying to achieve the same goal, leading to inefficiency and duplication"[1] We would expect ministers to hold them to the terms of that offer.

The care home sector, in particular, is subject to a wide variety of overlapping and duplicating quality monitoring systems - the local authority commissioner, the NHS commissioner, CQC, Monitor, the Charity Commissioner and LINks (HealthWatch), alongside the provider's own quality monitoring processes. We have bemoaned the

[1] www.lga.gov.uk/lga/core/page.do?pageId=12319207

lack of leadership and commitment required to address eliminating these overlapping systems many times, which present a confusing picture to individuals, their families and providers as well as wasting public money. This is a particular problem for providers relating to more than one council/PCT.

In response councils argue that there is DH guidance which requires the council to take responsibility for the quality of all local services, whether they commissioned them or not. However, we do not accept that this means they have to set up new local systems – they should instead use information already available through CQC and others. A way through would be to amend the legislation to say the council should work in cooperation with other agencies, including the regulator, to in order to reduce duplication – i.e. not to do what others are responsible for completing. In effect there needs to more overall clarity as to who does what in the system and how the different organisations' responsibilities fit together so that there are no gaps in assuring quality.

Anything councils and PCTs subsequently do over and above what CQC has already done should be justified in terms of cost and benefit. It should include a proper impact assessment, which incorporates the time and investment needed by providers to meet Council requirements, explains how it will be communicated to local people and how it will benefit individuals. Finally, it should be done in consultation with providers, as genuine partners.

One council sent out a self-assessment process for providers as part of their Quality Assurance Framework. This process was allegedly to allow council staff 'more time to spend with residents, their families, care staff and managers' when they visit the home. The self-assessment form consisted of 24 pages of questions on personal care policies, business practices, staff management, health and safety, nutrition, premises information, registration, insurance and several other areas. In addition to this the provider was expected to fill in 19 pages of health and safety information, much of which was already covered in the self-assessment.

Ultimately the question is whether we want numerous council and PCT quality rating schemes each different to the other, demanding a huge amount of time and effort from an underfunded provider sector. As stated above, for providers caring for people from a number of councils and/or PCTs the demands will be even greater - and possibly contradictory.

3. MCA and DOLS

The sector has raised a number of problems concerning the **Mental Capacity Act** - Best Interests and Deprivation of Liberty Safeguards. Processes are lengthy and confusing for staff to use and require more clarity, especially as these processes tend to operate locally and not nationally. Although CQC has a statutory duty to monitor the deprivation of liberty safeguards, the processes and forms involved remain the Department of Health's responsibility. CQC has highlighted the complexities in the application and assessment process in two of their annual reports on the safeguards, and suggested that the Department of Health consider this. The process around the statutory notification of Deprivation of Liberty Safeguards has recently been subject to a regulatory amendment that means that providers now

need only to submit one notification covering both applications and outcomes - previously there were two separate notifications.

4. Safeguarding

Safeguarding against abuse is vital and we support the leadership role of local authorities in safeguarding adults in all settings. However we believe safeguarding is being used inappropriately and as a stick to beat providers with. The previous Social Care Minister, Paul Burstow, recognised the unsatisfactory nature of some safeguarding investigations, which actually reduces the resources local authorities can use to tackle real abuse. In addition, we believe that independent and NHS providers are not always treated equally with respect to safeguarding, and that issues that are raised as safeguarding within independent care homes would not have been seen as safeguarding issues within an NHS hospital.

Safeguarding can be less than effective. There are companies selling standard policies - so a service can appear compliant - but might not be. A compliance approach does not differentiate priorities. Non-compliance can include both major and minor issues - the information does not always assist the public.

It would be more efficient if all Local Authorities, had the same procedures and guidelines instead of each authority having a different one.

The increasing introduction by councils of 'embargo' policies is worrying, particularly when it is not clear what a provider has to do to lift the embargo - a problem which can persist even when CQC judges a service is compliant. The length of time it can take to lift an embargo is also of concern. And yet whilst a council may stop admissions it does nothing to stop funding existing residents. If there was a genuine concern as to the safety of all residents then a partial request - i.e. an embargo on new admissions - would seem inadequate. This demonstrates one of many inconsistencies when safeguarding policies are being applied across the country.

5. CQC

We have been presented with a number of specific issues relating to CQC, and how the regulations are implemented, by our members. In a number of these areas CQC are already addressing the problems raised, which we welcome. However we are giving a full list of issues for information (the provider comment is in bold, with CQC response noted afterwards) – see Appendix 1.

Before mentioning other issues raised in relation to CQC we wanted to reiterate the points made earlier in this submission that LAs and PCTs are regulating quality themselves because of the lack of trust in CQC to adequately undertake this role particularly in the light of the ending of the star rating system. Having greater clarity of the role of the regulator and how the system works together in assuring quality will reduce duplication of effort.

Other issues related to CQC and raised by members are listed below

Communication

Providers with multiple locations often experience difficulty in respect of the way CQC communicate with them. CQC do not always send compliance reviews to the correct person and when documents are not sent as agreed with the organisation it is difficult to track and monitor registrations and compliance reviews.

Manager registration

This relates to how managers register and the relationship between their registration and the providers they work for. Should manager registrations be more 'stand alone', and 'portable'?

Improvement beyond essential standards

We are disappointed that the narrow definition of "improvement" – from unacceptable to acceptable – with which CQC intends to operate, is not one that providers and the public will recognise as improvement. We do, however, recognise that it has been imposed by the Department of Health (DH)[2] as a means of ensuring that the regulator gives its undivided attention to protecting the health, safety and welfare of service users.

The definition springs from an interpretation, resting on a reading of Ss.2(2) and 3(2) of the 2008 Act which is taken to mean that the regulator's *only* functions are those set out in the former and that they in turn define the *only* circumstances in which, consequent on the latter – although, significantly, there is no cross reference – the Commission is to encourage the improvement of services. We prefer a more inclusive interpretation, which understands the reference to the performance of CQC's functions in a non-specific sense, analogous to the wording in Part I (Page 5) of the Care Standards Act 2000, setting out the previous regulator's functions in general terms.

This presupposes a consequential relationship between measuring compliance against essential standards and encouraging service improvement, one that we do not see reflected in the legislation.

However, Mr Behan has stressed the importance within CQC's repertoire of responsibilities of promoting the health, safety and welfare of users of health and social care services for the general purpose of encouraging improvement.[3] We agree, and point, once more, to the regulator's earlier commitment, which appears to have slipped under the radar:

> *"In addition to the assurance about compliance with essential standards that registration will provide, we have an important function in promoting improvement by providing independent,*

[2] Public Accounts Committee report, The Care Quality Commission: Regulating the quality and safety of adult social care, March 2012, Ev 26, Una O'Brien answer to Q.201

[3] Health Select Committee transcript of evidence, op cit, answer to Q.139

reliable and timely information about the quality of care in providers above essential standards ..."[4]

The theme of driving improvement in the quality of health and adult social care services runs through the new CQC strategy proposals like a watermark. We believe this focus is admirable but we remain concerned about the restricted horizons within which the process of improvement is to take place: principally by regulating and monitoring services and taking necessary enforcement action.[5]

CQC promises to "identify and highlight what works well in the services we inspect … to motivate providers to continuously improve*.*"[6] However, there is no indication of the benchmarks against which it will exercise such judgements – other than essential standards, and we would question how they could possibly motivate continuous improvement. In which respect we would draw attention to an internal CQC report which recently drew what we believe to be a telling distinction between the Commission's *regulatory* standards and NICE's *improvement* standards (our emphases).[7]

Following on from that, we would welcome clarification on how the intention to motivate providers to continuously improve will be delivered. Will CQC inspectors draw attention to NICE's quality standards? As we understand them, these standards will be aspirational; they will not be independently verified, rather their adoption will be declared unilaterally by providers. So, for example, does the Commission intend to verify providers' audits of compliance?

We share the hope that the Commission's reports will provide the necessary momentum to improve how services are provided and commissioned – the "bow-wave effect"[8]. However, many of these are located firmly in the context of compliance with essential standards and we believe more evidence is required to demonstrate that they can be described as a force for improvement.

In order to be registered and maintain registration, providers must meet essential standards, which have been described as "a bedrock from which improvement can be made towards the higher levels of practice and outcomes."[9] Yet CQC has defined its "vision of success" as being limited to "fewer providers dropping below the national standards of quality and safety, and where they do they are picked up quickly and improve."[10] We would ask if it is reasonable to expect people to accept that compliance with essential standards, or a return to compliance, represents improvement in the sense in which we believe providers and the public would understand it, i.e. performance gains not at but beyond the basic, legally required level.

[4] CQC, Guidance about compliance with essential standards, p.6
[5] CQC, The next phase: our consultation on our strategy for 2013 to 2016, p.5
[6] Ibid, p16
[7] CQC*,* Adult Care System Reforms – Implications for CQC, paper presented to September 2012 meeting of CQC Board, p.4
[8] Health Select Committee transcript, op cit, answer to Q.5
[9] Department of Health, Transparency in outcomes: a framework for adult social care, p.29
[10] The next phase, op cit, p.6

As such we would argue that "clarity" on the regulator's role and purpose for the public and others should be demonstrated by the Commission being explicit, beyond any possible doubt, on the parameters within which essential standards operate and from which improvements in service quality can reasonably be expected. It should make clear in particular that it lacks the leverage to drive improvements above essential standards. Further, we suggest that might best be demonstrated graphically by reproducing the illustration of the quality curve in the National Quality Board's recent report on quality[11], which places essential standards on the quality spectrum, on the line dividing substandard from adequate.

We have regularly expressed our concern as to who monitors local authority commissioner behaviour. We regret that the CQC has no official role in assessing commissioning but believe that CQC can, through its evidence from inspections of providers, seek to influence how well commissioning is undertaken. It is vital that all information and views are accounted for in improving commissioning for the benefit of individuals and, where care is inadequate and the causes can be traced to poor commissioning, the CQC needs to say this clearly.

Defining how essential *Essential standards of quality and safety* actually are.

In accordance with section 23 of the Health and Social Care Act 2008, the Commission issued guidance about compliance with the requirements of regulations made under section 20. That guidance, which contains 28 standards, was first published in December 2009, and was designed to help providers of health and adult social care to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009, and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect.[12]

By this definition, these 28 standards, are the "essential" ones. However, at the same time, the Commission decided to focus its judgement framework for inspections on 16 standards, based on 16 regulations that come within Part 4 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This condensed version of the full guidance, said to contain the standards that most directly relate to the quality and safety of care,[13] is now commonly referred to as "the essential standards", albeit while excluding those that cover, *inter alia*, "fitness", notifications and financial viability.

On the one hand, then, the 28 standards are described as "the essential standards of quality and safety that people who use health and adult social care services have a right to expect." On the other, the 16 "core" standards are presented as "the standards that most directly relate to the quality and safety of care."
The DH subsequently added to the confusion by conflating these descriptions:

[11] National quality Board, Quality in the new health system: maintaining and improving quality from April 2013, p.14
[12] Guidance about compliance with essential standards, op cit, p6
[13] CQC Guidance about compliance: Judgement framework, p4

The 16 registration requirements reflect the essential levels of safety and quality of care that people should be able to expect, and are built around the main risks inherent in the provision of health and adult social care services.[14]

Finally, in September 2010, the Commission explained its approach to monitoring compliance thus:

> *… we will look at any of the 28 essential standards, but will focus on one or more of the 16 essential standards and associated outcomes that most directly relate to the quality and safety of care. Our judgement framework focuses on these 16 standards.*[15]

The contrast between "looking at" any of the 28 essential standards and "focusing on" one or more of the 16 core standards implies that the excluded 12 standards form some sub-essential species. We would welcome a measure of clarity being brought to this issue.

Amending the regulation requiring sound finances and making non-compliance a criminal offence for registered providers in all sectors.

The current position is this:

> *(1) Subject to paragraph (2), the service provider must take all reasonable steps to carry on the regulated activity in such a manner as to ensure the financial viability of the carrying on of that activity for the purposes of— (a) achieving the aims and objectives set out in the statement of purpose; and (b) meeting the registration requirements prescribed pursuant to section 20 of the Act.*
>
> *(2) This regulation does not apply where the service provider is— (a) an English local authority; or (b) a health service body*.[16]

Whichever agency is responsible for ensuring compliance, services must be effectively monitored. CQC believe the current regulations represent a diminution of the CQC role with respect to financial monitoring and that the responsibility for ensuring the viability of a business coming into the market does not lie with the CQC. It believes it does not have the expertise to act as a financial regulator in the accepted sense. CQC has argued that Monitor should take on the role. The regulations seem to imply to us, however, that the role is for CQC. In such an event clarity is required and the provider sector needs to understand who monitors and what is expected of them as part of the scrutiny process. In addition we need specific protocols and a shared understanding as to how providers with financial difficulties can and should behave.

In addition whilst there is a supervisory apparatus already in place for publicly accountable services, they are not subject to the regulation on financial position and consequently there is no provision for legal penalties. To be clear: we do not

[14] DH response to consultation on transparency in outcomes: a framework for quality in adult social care, p31
[15] An overview for providers on the CQC approach to monitoring compliance, p3
[16] Regulation 13 of the Care Quality Commission (Registration) Regulations 2009

consider internal disciplinary measures in the public sector to be sufficient; there must be must be parity between public and independent sector services on these legal sanctions. In our view, the current position is no longer tenable.

Regulated Activity

The current regulated activity of "Accommodation for people who require nursing or personal care" has been identified as causing difficulties to service users and relatives by some member homes which primarily deliver residential care. It is difficult for residents to understand why staff employed cannot provide nursing care when the documents publicly available appear to state that this is what the home delivers. This is an area that requires review.

6. LA and NHS contract issues

Much of the administrative burden on providers arises from local contracting requirements. This ranges from complex and lengthy tender processes, to lengthy and inappropriate contracts, disproportionate monitoring requirements and inappropriate fee setting methodologies. On top of this there may be late payments by commissioning authorities, a lack of understanding of people's rights to choice, and a complete disregard of providers as partners in the contracting process.

The NHS standard care home contract is not fit for purpose for the commissioning of NHS services from care homes. We have engaged in the development of this contract but many of our comments were not taken on board, with the result that we still have many concerns about the length, inappropriateness and purpose of many of the contract requirements. We would still urge the DH to simplify the care home contract, working in partnership with provider representative bodies. The NHS Contract runs to several hundreds of pages (plus various associated documents embedded within the web-links), which care homes are bound to sign up to if they wish to provide any NHS CHC business. As such it has become substantially larger, and more complex than the approximately 200 pages of CQC Essential Standards, (which of course are a legal requirement for providers).The NHS Contract, must be carefully considered (with appropriate paid for professional advice) by each provider in conjunction and in context with a myriad of other standards, contracts and similar documents – irrespective of the level of NHS business the PCT may procure from the care home, which could be as little as one placement.

The current national standard contract used by the NHS care homes for continuing healthcare is an extremely complex and lengthy document that has not been adapted appropriately for people residing in care homes. The contract conditions, monitoring requirements and language used does not reflect the fact that this is a person's home and not a hospital. As a result care homes are turning away from providing continuing healthcare to the NHS. This deprives people of being cared for in care home of their choosing and forces people to stay in hospital inappropriately for longer.

The Finance Director from a member provider care home recently made a presentation to his Board on the subject of NHS contracts. He had three piles of paper on the table to represent three NHS contracts from different eras:

- *The first had just 5 pages and represented a contract from 1989.*
- *The second had just fewer than 50 pages and represented a contract from 2006.*
- *The third had 1,260 pages and represented the 2012/13 NHS standard contract for care homes.*

The 1,260 pages was arrived at by taking the NHS standard contract itself, and adding those NHS/DH documents (other than Acts and statutory regulations) that are required by the contract to be complied with - e.g. the NHS Mental Health Code of Practice, which runs to around 400 pages.

Each local authority has its own contract which may or may not be reviewed regularly. For corporate providers, dealing with many local authorities is an extremely onerous and costly process. We have become increasingly concerned that there is no national agreed methodology in setting fair fees. Instead this is usually done without proper discussion with providers and the people they support. More and more preferred provider lists are emerging where independent providers can be ranked in price order, cheapest first, rather than 'best placed to provide the required service at the right level of quality'. Independent providers must be seen as equal partners with commissioners in ensuring delivery of quality services to people in need.

The poverty and immaturity of some commissioner/provider relationships has been highlighted by ECCA on many occasions. This needs to be seriously addressed by leaders within the health and social care system.

7 Documentation

Providers working nationally are frequently being required/requested to implement specific and individual documents preferred by commissioner. These are often very different to an organisations standard documentation and this has serious impacts on internal quality monitoring. Currently here is no standard set of assessment documentation either related to the overall assessment of care needs or related to individual areas of risk. With the continual requirement to evidence the quality care it remains unfair that providers are penalised for implementing their own internal processes which are capable of being monitored and used to inform and direct continuous improvement.

8 Incident / Event Measuring

There are multiple requirements associated with reporting incidents / events externally. In the event of a serious injury to a service user, the staff in a care environment will often be required to report to the local safeguarding team, undertake a statutory notification to the regulator and perhaps report to the commissioner of the service. The introduction of one standard document would reduce this documentary burden.

9. Action Planning

In the event that areas of non-compliance identified in a care home, the concerns of one external agency are often communicated (quite correctly) to other agencies involved at the location. In these situations, a home manager / provider can often find themselves required to submit multiple action plans to remedy the issues. The production and monitoring of multiple action plans often has the potential to become a focus and burden that distracts from the essential requirement of undertaking remedial requirements. A standard action plan (containing the requirements of all agencies) would be a useful amendment to current practice.

10. NHS changes and transition and Social Care Reform

Monitor

Unsurprisingly the relationship between CQC and Monitor regarding the registration and licensing of organisations in future has been raised. The fear that the additional burden providers already bear as a result of CQC registration monitoring being duplicated by commissioners' contract compliance could be exacerbated by Monitor's licensing regime. Providers would appreciate an assurance that that will not be the case.

HealthWatch and powers of entry

HealthWatch as with the current LINks will have powers of entry into care homes. It is important in developing these powers that there is clarity about how they are implemented and assurances people's privacy in their own homes will be protected. Care homes are happy to be transparent and open and welcoming places but the new reporting requirements on homes mean that if these are not joined up with those mentioned above i.e. CQC, Council and PCT commissioning then it simply adds to the confusion and burden when requirements simply do not fit together as a comprehensive picture.

Quality Surveillance Groups

The new Quality Surveillance Groups (QSGs) being proposed have posed a number of questions from providers:

- How will providers be informed they are the subject of discussion at these groups?
- Will there be neutral observers/members to assure natural justice and fairness?
- If not how will we be assured that QSGs do not treat NHS providers more leniently than independent providers and instead that there is consistency of approach regardless of provider ownership?
- What will be the criteria for judging the quality of the information being discussed about individual providers and do individual providers have the

opportunity of a right of response or reply to the evidence been used against them? There is a danger of disparity and subjectivity when assessing the quality of individual providers over and above essential standards.

- Will there be any provider input to the groups whether from NHS trusts or other independent providers?

We would not want to see the QSGs becoming like Star Chambers in judging and punishing independent care homes that will have little right of redress unless there are independent members involved.

NICE Standards

We must currently reserve judgement on how the NICE standards will work for the social care registered providers. The first NICE social care standard for dementia has only just been consulted upon and we are equally unsure as to how NICE standards for the NHS are compatible with, or achievable within, social care registered providers.

CQUIN Standards

Unfortunately we are also struggling to collate and understand data around CQUIN indicators for social care registered providers such as care homes. We have seen examples of good practice - CQUINs which are concise and developed in partnership with care home providers. We have however equally seen CQUINs that seem entirely inappropriate, lengthy and irrelevant to care home settings. Using 30 or more CQUIN indicators for the small care homes caring for no more than one or two people commissioned by the NHS, is disproportionate and simply does not recognise that a care home is somebody's home and not a hospital.

Health and Well Being Boards

There is equally no recognition of the role of independent providers within Health and Well Being boards. Providers have a unique and close understanding of what local communities need and are asking for, and what solutions are appropriate to meet identified needs. Yet there seems to be no acknowledgement of the role providers or their representatives might play in helping these boards prepare needs assessments and health and well-being strategies.

8. Choice Directive

We very much support keeping and better enforcing of LAC(2004)20 otherwise known as the choice directive. This is a fundamental piece of legislation that allows people choice of care home when funded by their local council and also addresses issues around top ups, and costs of care. We believe there should also be similar provisions for those funded by the NHS.

Appendix 1 CQC issues

Registration

In the main, the registration process is greatly improved however there appears to be no valid reason for the submission of the Provider's Statement of Purpose with every application made to CQC.

CQC - We are working on an online process for applications, Statements of Purpose and notifications that will significantly reduce burden and duplication by recording submitted information and changes just once, without duplication. Information supplied through one of these three processes will automatically inform the other two.

We feel the Statement of Purpose is a key document setting out the provider's intention of how the service will operate and what users can expect.

Lastly, there have been discussions with the Department of Health on enhancing the significance of the Statement of Purpose.

Managers continue to report errors made by Post Office staff completing CRB documentation on CQC's behalf; this results in delays in receiving CRB Disclosure Certificates and subsequent submission of manager registration applications

CQC - Every issue brought to CQC's attention with regard to CRB and Post Office is investigated. The majority of errors (over 80%) are by the applicant rather than the Post office e.g. they do not have correct information that is required by CRB for verification or they go to a Post office that is not in the scheme.

We have listened to providers and have developed a new service with the Post Office to offer an electronic solution, this has the following benefits to providers:

- Over 300 Post Offices now offer CRB service (an increase of 300% and including areas where there was previously no service e.g. Isle of Wight)
- The electronic version checks input and verifies information as applicant enters details therefore there will be less errors
- Cost reduction of 25% for new service
- Average wait for CRB is down to 1 week

Our CRM system enables us to extract data and report on issues relating to CRB errors which we plan to share with the Post Office to support ongoing improvements to the service.

It would be easier for a Provider to manage their corporate registration if notifications surrounding managers who have left the organisation could be submitted from the Provider and not the registered manager

CQC - The law does not currently support this; applications have to come from relevant registered persons themselves, though we understand the problem and suffer from it ourselves.

We have taken steps to develop changes to processes where providers cancel their registration in respect of all regulated activity(s), and where a new provider takes over relevant locations from an existing provider. In the first case manager registrations will shortly be automatically cancelled. In the second we have developed a fast track process that from the manager's point of view combines applications to cancel with applications to register in one 'continue registration under a new provider' form and process. The law does support these changes.

In the longer term we have opened discussions with the Department of Health over the standing of manager registrations, and will engage with the sector in relation to this. We are considering the risks and benefits of changing how managers register and the relationship between their registration and that of the providers they work for. We are exploring whether manager registrations should be more 'stand alone', and 'portable'.

Although correspondence received from CQC is allocated a reference number, this bears no relation to the location number and, where a large Provider has numerous variation requests submitted, can be time consuming in confirming the location to which the letter refers

CQC - This is a very interesting one and we would like to come back with some options about how we might deliver this, it's a very good idea.

Inspection

Statutory notifications forms are complex and difficult to follow with different categories which often bear no resemblance to the notice detail.

CQC - In the medium term we are developing online web forms that will dramatically simplify the process. After answering certain key questions, providers will only be presented with further enquiry fields that are relevant to their particular notification and its circumstances. These questions will be presented in a logical sequence that will much better support accurate submission of required information.

In the meantime we have to strike a balance between a small number of forms with multiple 'conditional' sections (e.g. if your circumstances are this, then answer part A, if this, then answer part B) and a larger number of forms with fewer sections. The first brings the risk of the wrong parts of forms being completed, the second risks people becoming confused about which form to complete.

We'd be more than willing to review comments about particular forms and look for quick win opportunities, but the online system should resolve most difficulties when rolled out.

No national safeguarding policy or process to follow. All Local Authorities have different processes which make it difficult for organisations to train managers and staff on processes to follow and makes it difficult to develop a

consistent national policy.

Also consistency of the local safeguarding teams and processes can be variable and not provide a clear benchmark for organisations.

CQC - We will publish our revised CQC safeguarding protocol, which aims to clarify our position within the wider safeguarding system and how we will work with safeguarding partners. However, we recognise that there remains regional inconsistency in the way that safeguarding structures and processes are implemented and understood.

Warning notices can make representations but cannot appeal – so lack of purpose surrounding process

CQC - Regulations require that we allow a representations process if we wish to make warning notices public and this includes reporting on these in Inspection Reports. Making this information public reassures people that we are taking action when there is non-compliance.

More clarity regarding timescales and process to follow surrounding draft / final report process

CQC - We will send a copy of the draft inspection report to the registered person as an attachment by email (or by post if the registered person is registered to receive communications by post). This will usually be within 10 working days of the date of our (last) visit. It may be longer, for example if we have been accompanied by an expert by experience or professional adviser and we need to wait for their report so that we can include their evidence and findings.

The provider has 10 working days to submit factual accuracy comments on the report. We will usually send a copy of the final report to the provider within 15 working days of the date that we sent the draft report.

Using homes own resident / relatives surveys and other information rather than regulatory body undertaking own processes

CQC - CQC's action plan for the Performance and Capability Review recognises the need to increase the range of information available to assess the risk in sectors other than the NHS. It is essential that we have robust information to identify risk of providers being non-compliant against the essential standards of quality and safety. We use a range of intelligence to understand the level of risk, including the following:

- Skills for Care information
- qualitative information, including that shared locally with CQC inspectors, for example Local Involvement Networks, councils, staff or members of the public
- statutory notifications from providers
- admissions to hospitals from post codes containing care homes,
- Environmental Health, Fire Enforcement and Health and Safety Executive reports, and

- information from inspections (which can help to target subsequent inspections).

The intelligence is used to inform which locations and which outcomes should be inspected and when, and to inform lines of enquiry for the inspection. As we undertake unannounced inspections, if the information from homes and their own residents/relatives survey are to be of use then they would need to be shared in a routine and systematic way. We would welcome working with provider organisations to consider whether this could be done in a way that did not represent undue burden on providers (particularly smaller providers) and was manageable within our resources.

Our preference is to use information that is available elsewhere and to work with the sector and other stakeholders to make sure that our need for information is considered meaning we don't have to separately request information from providers. We will always look to use information that is already available, if this is possible, but it is also important to consider:

- the accessibility of the information to CQC and whether it is available in a timely manner for regulation,
- coverage - are providers able to choose not to provide information where it indicates poor quality,
- quality of information - can CQC be assured that they information is not biased,
- does the information relate to the essential standards of quality and safety

If sufficient information is not available to effectively identify the risk of non-compliance then we may need to collect information in other ways. We are exploring a range of ways of improving intelligence.

CRB process is slow and prohibits the timely employment of staff

CQC - We have been pushing for improvements to the CRM process and believe we are making progress

The Post Office and CQC are working with a third party, Atlantic Data, to provide an electronic solution. The benefits of the new system for applicants include:

- It will be easier to complete – the form will be submitted electronically.
- The result will be received much quicker – one week or less.
- There will be a slight reduction in the fee.
- The electronic form checks the fields are completed, reducing the risk of applications being returned as incomplete.
- Moving the application online removes the risk of people filling out the wrong CRB application form.
- Applicants will be able to log in to the Post Office site and check the status of their application.

Needs to be more coordination between NMC and CQC and other regulators to ensure consistency in treatment of staff

CQC - CQC have developed Memoranda of Understanding with the professional regulators (NMC, GMC, HPC, GDC, GSCC); these have been in place for some time and have /or are currently undergoing the annual review. We hold quarterly meetings with all of the regulators to discuss joint working and information sharing. We are currently working with all of the professional regulators to develop Joint Working Frameworks which will clearly articulate how we work together at all levels; these will detail the key points of contact in each organisation, how they will relate to each other; including detailing the processes for doing so and will detail all aspects of information that we will share, when, including processes for escalating issues of significance. We already have in place systems for sharing information and making referrals about fitness to practice. Our role is to regulate providers so we will always inform the provider when we refer a registrant to a professional regulator where we consider there is an issue for the professional regulator. We have worked closely with the professional regulators to ensure CQC makes appropriate referrals.

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For more information contact

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