

United Kingdom Homecare Association

response to the

Care Quality Commission's

consultation on

Our next phase of regulation; A more targeted, responsive and collaborative approach

Cross-sector and NHS trusts

December 2016

By email to

Next phase consultation
Care Quality Commission
151 Buckingham Palace Road
London
SW1W 7AH

Tuesday 14th February 2017

Dear Sirs,

Proposals for CQC's next phase of regulation - A more targeted, responsive and collaborative approach

Thank you for the opportunity to respond to the above consultation, which I have the pleasure to do on behalf of the United Kingdom Homecare Association (UKHCA).

UKHCA is the national professional association for organisations who provide care, including nursing care, to people in their own homes. Our mission is to promote high quality, sustainable care services so that people can continue to live at home and in their local community. The vast majority of our members in England provide services which are regulated by the Care Quality Commission, and therefore will be within the scope of these regulations.

The following paper responds to the questions that CQC has asked within the consultation exercise. Please do not hesitate to contact our team if you require any additional information.

Yours faithfully

By email

Veronica Monks

Policy Officer

1a Do you think our set of principles will enable the development of new models of care and complex providers? [Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]

Neither agree or disagree

1b Please tell us the reasons for your answer.

We agree with the stated aim of CQC to prevent regulatory demands from standing in the way of developing new and innovative services, but remain to be convinced that proposals will work until we see the second consultation on *how* CQC will regulate adult social care.

We agree that regulation should not be a barrier to developing new models of care, but we also recognise that evidence for what works in social care is thin on the ground and where it exists, it is not necessarily transferable between different areas of the country.¹ UKHCA supports measures taken by the regulator to promote consistency within the inspection process in a way that can underwrite better models of care and improved delivery mechanisms: we consider that any proposed changes to the regulatory process should have as its founding principle the gathering of 'gold standard evidence' and routine impact analysis to ascertain the most effective components of the CQC's approach.

What is standing in the way of developing new models of care is insufficient funding of social care alongside increasing demand from an ageing population. UKHCA has seen increasing attention being paid by the public and the media to the question of whether homecare services are sufficiently funded to be economically viable, whether local care markets are stable and whether homecare workers are properly rewarded for the valuable work they undertake. UKHCA have calculated that the weighted average hourly price paid by councils in England was £14.66 compared to the minimum price of £16.70 necessary to deliver sustainable homecare which meets the National Minimum Wage.² In addition, there has been an apparent increase in homecare providers handing back homecare contracts or individual packages to their statutory sector purchasers on the basis of inadequate fee levels.³ This does not bode well for the future when we can expect increasing demand for homecare, and at the same time fewer providers available and willing to take on contracts from councils that barely cover the provider's costs.

UKHCA understand that the integration agenda is behind many of the changes proposed to the regulatory regime. We would again emphasise that integration is a long way from being achieved and shaping regulation around services that may not

¹ Harwich, E., Hitchcock, A. and Fischer, E. (2017) *Faulty by Design. The state of public service commissioning. Reform*

² The Homecare Deficit 2016, A report on the funding of older people's homecare across the United Kingdom, UKHCA

³ For example, see the ADASS Budget Survey 2016, page 18. URL: <https://www.adass.org.uk/adass-budget-survey-2016-full-report>

come into fruition or have any longevity risks further alienation of providers and also risks to CQCs credibility as a regulator. It is also worth noting that 'integration' has rarely proved to be a 'cheap option' and frequently incurs additional setup and 'double run' costs as new models are initiated whilst decommissioning antecedent provision in parallel. These costs will have a material impact on the viability and sustainability of many new models of care being considered within the integration agenda and will add significantly to the regulatory and inspection workload.

Sustainability and Transformation Plans (STPs) are the vehicle by which local health economies are looking to integrate services, manage demand for NHS services, and develop new models of care as well as measures to prevent the need for admission to residential and nursing care. To support implementation of STPs, good sustainable homecare provision will be vital. One can easily envisage an NHS organisation commissioning a homecare service, and it would be useful to understand whether the process by which the NHS commissions a homecare service will be examined during an inspection as CQC looks at whether an NHS organisation is being well led.

This brings us to the potential for hybrid models of care that cross, or blur, traditional organisation, operational and professional boundaries: vertically integrated care services will create significant challenges to the regulator over operational accountability and legal persons. Horizontally integrated services could undermine traditional ideas of 'responsiveness' and 'well-led' as care packages, quite legitimately, revert between professional domains, as acuity, dependency and complexity undergo subtle shifts of emphasis that outpace regulatory capacity to observe and assess, based on the current CQC's 'snapshot' inspection model.

However, UKHCA agrees that CQC should look at leadership in a more holistic way if services are to adopt a culture of continuous improvement and deliver effective services in an innovative way. Our members are increasingly frustrated that commissioning practice by local authorities is not currently independently examined given that delivery of good quality and effective care starts with competent commissioning.

Local authorities, which purchase the vast majority of homecare services, are using their dominant purchasing power to drive prices for homecare services down as a result of public spending cuts. The impact on providers' businesses, and their ability to recruit, retain and reward social care workers sufficiently, carries serious implications for the sustainability of the homecare sector.

UKHCA is consistent in its view that the CQC has a role, albeit a moral (rather than statutory) duty, to play in bringing the consequences of poor commissioning into the public domain. For example, CQC's own data shows that there are significant quality issues in social care in parts of Yorkshire, Liverpool and Manchester where, in tandem, UKHCA data clearly illustrates low fee rates. We are convinced that there is a causal relationship between institutional, wide area based, quality deficits and low fees, even if the CQC find this equation challenging: the provision of social care services is not a unitary enterprise.



UKHCA considers that commissioning practice of local authorities should come under scrutiny if CQC are serious about examining leadership of services within an integrated system. It is not only a matter of how councils are currently meeting the needs of their local populations, or whether they are developing the capacity to manage future populations, but also the effects of poor commissioning on some of the most vulnerable service users.

Providers report to UKHCA that councils are now purchasing homecare for very elderly people with such complex physical and mental health needs that even five years ago they would have considered admitting them to residential or nursing care. Providing a service to very old people in their own home is often what individuals want but the costs of contracting for a bare minimum homecare service results in additional costs and pressures to local systems, i.e. GPs, mental health, district nurse, ambulance, A&E and so on. Older people receiving home care are now typically very old and very frail, in their late 80s, early 90s with five or more serious medical conditions including incontinence and dementia and most have no relatives or carers who can assist with day to day care. UKHCA feel councils are not delivering the homecare people need but a trying to manage people at home who are in a constant medical or social crisis. Our members have deep concerns that they will be penalised by inspectors for not giving the care a person needs when what people really need is a service the cash strapped NHS or local authority is unable (or unwilling) to pay for.

The double jeopardy in this situation is that severely compromised people are maintained at a level of service far below that which is required, often for purely financial reasons, which can mean that by the time they reach crisis level the scale of unnecessary deterioration is beyond reparation. UKHCA considers this to be an abuse of monopsony purchasing power and which constitutes a failed commissioning of care. We are concerned that the regulatory and inspection regime should take into account not just 'outcomes' but the consequences of outcomes, such as failed inputs beyond the control of providers.

UKHCA consider that what is needed is a regulatory system that not only looks at the development of new models of care and complex providers, but also looks at commissioning as part of a whole system of care and treatment. In UKHCA's view, without oversight of local authority commissioning, CQC's next phase of regulation will not meet its stated aims.

Turning to the principles outlined in Section 1 of the consultation document where CQC has set out 9 principles to guide the approach, UKHCA considers a tenth principle is needed. We suggest CQC should adopt a principle to rate and report providers in a timely way, especially given the 313% increase in regulatory fees over three years to 2017/2018. Homecare providers rightly expect value for money from CQC and we support their views entirely. Our members also expect well trained inspectors who understand the sector they are examining, who will make judgements

based on evidence rather than opinion and who will be consistent in their approach so that ratings are fairly attributed.



We note the desire to work with stakeholders for the consultation planned for Spring 2017 and UKHCA would be pleased to work with CQC to develop proposals.

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)? [Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]

Disagree

2b Please tell us the reasons for your answer.

We have deep reservations about the proposed Assessment Framework which moves from 11 assessment frameworks to two. Some of our members have argued that the case has not been made for moving to two frameworks when the current arrangements have only been in place for less than three years and hardly had the time to bed in. UKHCA has not seen the evidence that suggests the current 11 frameworks are not working, and cannot verify CQC's assertion that existing arrangements might stand in the way of developing innovative services. Consequently, we are unable to satisfy ourselves of the purpose behind the proposed changes, as we do not see how the case for change has been evidenced. We are not convinced that a universal interpretation of 'quality' and the proposed changes are mutually complementary, and could be seen to be based on a false premise of universal applicability across two significantly different care settings, such as an institutional model, staffed by highly qualified practitioners and a peripatetic outreach model based on a national minimum wage workforce. Our members, particularly those operating small businesses, are disappointed at the thought a new framework will add additional administrative burdens through unnecessary changes which will add further costs to their already financially stretched organisations.

However, on the assumption that CQC will go ahead with two assessment frameworks, we would urge that within the social care assessment framework, CQC develops sector specific material for care services delivered in a person's own home. UKHCA would like assurance that the nature of homecare will be evident in the social care assessment framework and the measures used and evidence collected by homecare inspectors will be qualitatively different from those in a care home or other community setting. UKHCA would be pleased to assist with the further development of the assessment framework to provide a homecare perspective.

When the original model, based on the 5 KLOE's was introduced, we expressed concern that the approach was an untested formula. In the years since implementation, it has been necessary to 'fine tune' that process. We are now concerned that yet another untested regulatory model is about to be implemented, devoid of the advantage of field testing, impact analysis, cost benefit analysis or even sufficient piloting. UKHCA members find this approach by CQC to be consistently challenging. We would seek assurances that there has been an analysis of the perceived deficits of the previous 5 KLOE model that has informed the design of the

new approach, some product testing of the new model and some measure of impact analysis to quality assure the proposed changes.

UKHCA urges CQC to ensure that homecare providers are involved as inspection methodologies are updated and to allow sufficient time for the new processes to be tested. Our concern is that the rating of providers is going to depend very much on subjective data from service users and their carers, and we want to see data being captured so that it can be compared over time and across providers. New models of evaluation may be needed and we would support the use of knowledgeable and trained individuals who can feed the views of service users into the inspection process. This is particularly important since it is much more challenging, and requires a very different skill-set, using a model based on critical appreciation to observe in detail the care provided in a person's own home rather than in a residential or community setting.

Our members have also reported their concerns that the new assessment framework will be rather unwieldy and complex when inspectors try to apply it to standalone small and medium sized homecare businesses. In a framework that tries to cover large multifaceted organisations, the characteristics and the environment within which a small homecare business operates may not be understood and indeed might be misunderstood by inspectors. Smaller standalone businesses do not have the same economies of scale of larger businesses or those who are subsidiaries of larger companies and this should be recognised and acknowledged during the inspection process. UKHCA considers the new assessment framework to be an unwarranted risk to small and medium social care businesses and we cannot think of any logical reason for this approach: the shoe should fit the foot, not the reverse.

UKHCA are concerned there is a risk that one assessment framework for adult social care will lead CQC back to a more generic inspection process which in turn will fail to recognise the specific nature of homecare provision and the role homecare plays in older people's lives. We seek reassurance that inspectors will be experienced and knowledgeable about homecare services and judgements about quality will be supported by the development of empirical measures as well as qualitative evidence from service users.

3a What do you think about our proposed changes to the key lines of enquiry, prompts and ratings characteristics?

UKHCA notes CQC's *hopes* that proposed changes to the assessment framework will reduce regulatory burdens on providers. However, our members tell us that any changes to the framework, KLOEs and ratings characteristics will impose a burden on homecare providers. UKHCA are concerned that there will be yet another steep learning curve for inspectors as the new approach is implemented and we are concerned that this will introduce disruption to an inspection process that is still in its infancy. We urge CQC to monitor the effect of the changes, particularly for small businesses and be willing to adapt if, contrary to CQC's hopes, burdens are not reduced or are even increased. We have made specific comments on the changes to

the key lines of enquiry, but are disappointed that the key lines of enquiry, prompts and ratings have not been published alongside the potential sources of evidence on which inspectors will base their judgements.

Specific comments on proposed changes to KLOEs can be found at Appendix A

UKHCA notes that CQC will consider a well-led healthcare provider to be one that is organised and plans for the benefit of the population it serves. We query how this requirement will be met in an environment of increasingly integrated health and social care and how ratings will be applied to homecare providers where they are commissioned by healthcare or jointly with local authorities. We are further concerned that this measure is a wholly opinion based judgment and is not founded on any published objective criteria that can achieve comparable results from different inspectors: subjectivity, such as 'organised' and 'benefit' are of little value to the sector without material criteria that can be validated and replicated.

UKHCA found it very helpful that CQC made clear in the Appendix where the KLOEs and prompts have changed, but substantive changes to ratings characteristics were not similarly made clear. We urge CQC to ensure that the final document notes where any major changes to ratings characteristics have been made so providers and inspectors are clear about how ratings will be determined. UKHCA seeks reassurance that where changes to KLOE's and ratings characteristics adversely affect providers awarded ratings under the erstwhile scheme that they are safeguarded against any compromise to their reputation.

We note that CQC propose all KLOEs will be mandatory unless they are not applicable because of the type of service being provided. We would urge CQC to include a reference within the KLOEs when they do not apply, or a different approach is needed because care is being provided in a person's home. This will help ensure that inspectors are more consistent in their approach and avoid a 'pick and mix' approach to inspection of homecare services. For example, the new KLOE S1.6 refers to care records being securely stored - which should be expected in an office or a residential setting. We would also expect this KLOE to recognise that in homecare, a person's records will be stored in accordance with the wishes of the individual concerned.

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)?

UKHCA considers this KLOE should remain where it is so that ratings can be tracked over time. If there isn't sufficient justification to make the changes, then leave

things as they are. UKHCA cannot identify any logical purpose in moving issues around consent and the MCA to the 'responsive' context: we have always maintained that the boundaries between the KLOE's are frequently hazy to the extent that they can logically can be in *either/or* and on occasions some inspection reports have lacked a certain sense of cohesion because of this.



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.

This section focuses on registration of services for people with learning disabilities and closure of inappropriate in-patient services. Homecare providers are not directly affected by these proposals, but they may, however, be commissioned to provide homecare to people with learning disabilities within a supported living environment.

As for other service users, we will expect that people in a supported living environment who need homecare will be assessed on an individual basis for their needs and not as a group. This is especially important for those with an autistic spectrum disorder who need individual specialised care to help them live independently.

5 What should we consider in strengthening our relationship management, and in our new CQC Insight approach?

UKHCA has not commented on this question as CQC's insight approach concerns monitoring of information from NHS Trusts and as such homecare services are not directly affected by this change.

6 What do you think of our proposed new approach for the provider information request for NHS trusts?

UKHCA has not commented on this question as it concerns provider information requests by CQC from NHS Trusts prior to an inspection and homecare services will not be directly affected by this change.

7 What do you think about our proposal that our regular trust inspections will include at least one core service and an assessment of the well-led key question at trust level approximately annually?

UKHCA has not commented on this question as this proposal concerns inspection of NHS Trusts and homecare services not directly affected by this change.

8 What do you think about our proposal that the majority of our inspections of care services will be unannounced?

We assume the questionnaire contains a typo as it refers to 'care' services whereas the consultation document refers to inspection of NHS 'core' services. Nevertheless, UKHCA can see some theoretical advantages for unannounced inspections in services, particularly from the point-of-view of public assurance that inspections reflect what was happening in services at the time. However, unannounced inspections pose



particular issues for small and medium sized homecare providers, which may be disproportionate to the benefit of CQC's intentions:

- An unannounced inspection at a care provider's office environment may be unsuccessful if the provider of a SME is not present (they may be actively providing or supervising care in someone's home)
- In very small services, the person who can assist inspectors with the inspection may not be present. It would be unreasonable for an inspection to proceed with inspectors trying to question members of administrative staff
- Inspection activity in homecare services is time consuming. An inspection can have a disruptive impact to care delivery if it proceeds when there are insufficient staff to continue to service and assist the inspector accordingly
- By the very nature of homecare, it is a peripatetic service that will frequently only afford an inspector a 'snapshot' of care on the day. Unannounced visits are unlikely to enhance the inspection process in many instances where key personnel may not be readily available.

9a What do you think about the changes we have proposed to inspecting the maternity and gynaecology core service?

UKHCA has not commented on this question as homecare providers do not provide maternity or gynaecology services.

9b What do you think about the changes we have proposed to inspecting the outpatients and diagnostic imaging core service?

UKHCA has not commented on this question as homecare providers do not provide these services.

10a Do you agree with our proposed approach to inspecting additional services (services that we do not inspect routinely) across a range of providers or sectors?

[Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]

Neither agree nor disagree

We have referred to the "potential for hybrid models of care that cross, or blur, traditional organisation, operational and professional boundaries" in our response to Q1.b above and we envisage that within many STP proposals and future Accountable Organisation models of care there will be occasions when NHS Trusts enter into 'additional service' provisions with tertiary providers where homecare is an integral part of that envelope of services.



UKHCA are concerned that the regulation and inspection of 'additional services' in this context must take into account the inter-operability of the overall system-of-care as delivered within this hybrid type model. We are concerned, for example, by the potential for a social care provider to be adversely rated because of systemic failures within the 'additional service' framework: for example, would the regulator place Accident & Emergency services that are a key component within the hybrid model under Special Measures if the General Practice element of this integrated system-of-care created a gridlock in patient flow? We consider that such models must be viewed holistically.

10b Please tell us the reasons for your answer.

Not applicable to homecare services.

11a Do you agree with our proposals for using accreditation schemes to both inform and reduce CQC inspections? [Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]

Neither agree nor disagree

11b Please tell us the reasons for your answer.

UKHCA has not commented on this question as homecare services are not directly affected by this change as it refers to accreditation of services within the NHS unless the caveats in our response at Q10.b apply.

12 What do you think about our current approach to trust-level ratings and how do you think it could be improved (taking into account the new use of resources rating)?

Homecare services are not directly affected by this change, but homecare providers would very much welcome shorter, more succinct reports and the new approach to reporting proposed for NHS organisations. In particular, they would welcome an evidence appendix which includes all factual evidence relevant to the service inspected.

Appendix A

Comments on KLOEs

S1.5

The majority (around 70%) of homecare provided in England is commissioned by local authorities and the provision of an advocate for a person involved in a safeguarding enquiry or investigation is the responsibility of the commissioner. Homecare providers can provide information about advocates to clients, but they cannot provide additional services that have not been commissioned or budgeted for.

S1.6

It needs to be clear that it is for the individual to decide where care records are stored when care is provided in a person's own home.

S2.1

Our understanding is the reference to 'financial risk' refers to risks to the money or assets owned by the person receiving care which is sensible. However, it is not clear in the KLOE itself. It can be argued that a financial risk is posed to a homecare provider by not paying a sustainable fee which in turn will impact negatively on the service provided to the individual.

S2.7

References to premises and communal spaces do not apply to homecare provision. Supply and maintenance of equipment in homecare will be different to residential or community providers and account must be taken of this in the ratings characteristics. While equipment is normally supplied through the local authority or directly to the service user, it is appropriate to ask about training for care workers in the use of technology designed to assist with a sensory loss, or moving a service user such as a hoist or bath lift. Questions might also ask whether staff know how to report when a need for equipment develops such as when a person becomes unable to weight-bear, or how to report when equipment is no longer suitable or requires repair.

S2.8

Do you mean 'staff' should be supported - or individuals with challenging behaviour?

S4

UKHCA support this KLOE.

E1.1



It needs to be clear in the ratings characteristics that homecare providers in the main provide the service contracted for by the local authority who will have carried out the formal assessment. For clients who arrange their own care, the assessment will be led by the clients. In either case, the homecare provider will discuss with the client how the service will be delivered.

E2.3

This should include the phrase 'where the service is responsible'

E5

It's not clear how this KLOE can be evidenced by homecare providers in the context of care commissioned by the NHS or local authorities.

C1.3

More information about the intention of this KLOE and the expectation CQC has of homecare providers would be helpful.

C2.1

More information about the intention of this KLOE and the expectation CQC has of homecare providers would be helpful particularly as family and friends are not always the most suitable choice as a supporter and given the intermittent nature of the provision of homecare. CQC also needs to recognise that people may not want close family and friends involved in decisions about their personal care.

C2.2

More information about the intention of this KLOE and the expectation CQC has of homecare providers would be helpful given the intermittent nature of the provision of homecare.

C2.3

How much time a homecare service gives to a client when the service is commissioned is determined by the commissioner and this must be recognised in the inspection process. CQC is well aware of the constraints on local authorities and the pressures being put on homecare and other social care providers. CQC must ensure providers don't pay the penalties when clients need more care than a commissioner is prepared to pay for which could become a safeguarding issue that may impact on a social care providers ratings.

C3.9

This sits oddly with C2.1



R1.5

Refers to sharing information with 'others', but presumably after obtaining consent from the service user?

R1.6

Would be better to ask whether the service user finds the equipment easy to use?

R3.3, 3.3, 3.4

More information about the intention of these KLOEs and the expectation CQC has of homecare providers would be helpful given the intermittent nature of the provision of homecare.

R4.2

Is this needed as a standalone KLOE? Overlaps with R1.2,R1.3 and R1.4

W1.5

More information about the intention of this KLOE and how far it is intended to overlap with the process for registration of managers would be helpful