UKHCA Consultation Response

CQC 2016-21 Strategy Consultation
Citygate
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Newcastle upon Tyne
NE1 4PA
Sent by e-mail to: strategyconsultation@cqc.org.uk

Monday 14th March 2016

Dear Sirs,

UKHCA consultation response to
"CQC's strategy 2016 to 2021. Shaping the future"

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. We do this by campaigning, through leadership and support to social care providers.

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 the proposed guidance.

The following paper responds to the questions that CQC has asked within the consultation exercise. Please contact me should you require any additional information.

Yours sincerely,

Duncan White
Senior Campaigns Officer

1a Do you agree with the vision we have set out for regulation of the quality of health and adult social care services in 2021? (see pages 6-11)

Strongly agree

Agree

Disagree

Strongly disagree

1b What do you agree with, or not agree with, about the vision?

I. UKHCA accepts that the vision set out by CQC pursues a positive position that is consistent with the recent approach of the regulator. However we hold a number of reservations, outlined below.

II. UKHCA members welcome an acknowledgement of the challenging environment in which social care operates. The CQC's strategy document refers to various pressures within the sector, ranging from rises in the national minimum wage, to changes in demographics and the continued need for 'efficiency savings'. Overt recognition of these pressures by the regulator and recognition of the impact on the logistics and quality of care that can be delivered could lead to a more affirmative, productive relationship with providers that could lead to a shared vision of the sector.

III. Placing the service-user at the centre of the CQC's visionary statement is likely to further the regulator's ambitions to be held in higher regard by the public. However, we have reservations about what could appear to be a 'them versus us' attitude that seems to have arisen in some elements the vision statement. For example, it could be seen for the regulator to state that it is "on the side of people who use services" could be construed as portraying the regulator as having a negative start-point in its relationship with providers. We are concerned that this may not help the CQC in its strategic objectives**:** our impression from co-production events with CQC is that the Commission is aiming to promote a more positive message

about the sector and to work with providers to promote quality care. Much of the language in the CQC's strategy is about discovering poor care rather than supporting the development of improvements and the transfer of 'lessons learned' throughout the sector to promote best practice. Clear reference is made to improving public confidence in the regulator, but little is said about the confidence of those that the CQC regulate. We are concerned that this attitude may hinder the development of a more positive relationship with providers, particularly given how much fees will increase to cover CQC's costs.

IV. UKHCA members inform us that they are concerned that there should be a stronger focus on consistency of regulation, particularly between services and regions, and that the regulator maintains independence in making judgements, avoiding public or political pessure to be realistically "professional, consistent, transparent and fair". Otherwise such claims to impartiality can become a tired public relations cliche, that adds little value to the regulatory scheme.

V. UKHCA members welcome a strategy that identifies the regulators' increasing role in encouraging and improving quality. However, we cannot see how the CQC intends to deliver this**:** we would welcome a description of the mechanisms by which this is achievable within the fee framework identified by the regulator elsewhere. UKHCA frequently hears from members who have been encouraged to 'improve', but who have not been given any clear indications of what improvements are expected, or why, or against what benchmark this aspiration has been prescribed. It often appears that the desired improvement-outcomes have been set at the sole discretion of an individual inspector, and what is deemed as 'quality' continues to vary considerably between Inspectors and localities. We do not think this situation is compatible with the CQC's strategy and neither do we consider it to be a measure of a "professional, consistent, transparent and fair" regulator. We suspect that this approach is also unsustainable if the CQC is to establish enduring credibility across its spectrum of activities.

VI. UKHCA suggests that there must be a much clearer description from the CQC as to what constitutes 'quality' and how this might be achieved by providers. Clearer quality frameworks and performance measures would not only help to create a more nuanced and balanced regulatory relationship with providers, responsive to the operating environment, but would also give service-users clarity concerning the quality of care that providers have achieved. A further added-value would be that Inspectors could work in a discernibly "professional, consistent, transparent and fair" framework rather than the current unsystematic approach based on the infinitely variable opinions generated by different staff. This is particularly important when considering the lasting impact that CQC reports have, particularly in view of the scale of financial support the CQC is now seeking from registered providers.

VII. The last paragraph of page nine should also make reference to local authority contract monitoring arrangements. Homecare providers often tell us about the amount of duplication of oversight due to disproportionately burdensome contract monitoring requirements by councils. This diverts important resources away from providing services and often means providers have to satisfy two different sets of demands to operate their business.

VIII. UKHCA members are concerned that the CQC has still not managed to recruit its full complement of Inspectors which could jeopardise the delivery of the vision.

IX. UKHCA members have expressed some concern over the four paragraphs dedicated to the effective and efficient use of resources. It is not clear from the strategy how far the CQC consider that its remit stretches to the business decisions of providers, aside from market oversight for a small number of the largest providers. This should be clarified.

X. UKHCA has concerns that the persistent refrain to be 'efficient' could be seen to condone the current under-funding of the sector. Figures

from the Health and Social Care Information Centre from 2013 refers to the average cost for in-house local authority provision of homecare services as £39.10 and outsourced services provided by the independent sector as costing £15.30 per hour on average, including the commissioning process.[1] This illustrates that an extraordinary level of efficiency already exists within the market for homecare services. Furthermore, UKHCA's Minimum Price for Homecare (http://www.ukhca.co.uk/downloads.aspx?ID=434) demonstrates that for an hour of homecare, paid at the National Living Wage, providers would need to be paid £16.70 per hour. Our research, through Freedom of Information requests to local authority commissioners of homecare, suggests that there are very few councils across the country who pay anywhere near this, with several paying less than £12.

XI. UKHCA supports the CQC's commitment to be an 'independent voice'. This must include a willingness to comment on the operating environment. Without this it would be hard to believe that the regulator is genuinely independent of government, particularly when it is well aware of the challenges faced by the sector and for the end user it promises to protect. We have considerable reservations that it is within the CQC's remit to pursue financial efficiency at this level unless full account is also taken of the role of the commissioners of care in fee setting as an indicator of risk transfer, commercial viability of the market and market stability at that price level: these elements are intimately linked and co-dependent. We are concerned that isolating provider efficiency as a stand-alone rating measure creates a false image of the system of homecare provision.

XII. The consultation document refers to the need for the "health and social care system needs to be transparent about resources", yet makes little reference to the CQC's own position within that system.

[1]HSCIC, Personal Social Services Expenditure 2013-14 http://www.hscic.gov.uk/searchcatalogue?productid=16602&topics=2%2fSocial+care%2fSocial+care+expenditure%2fPersonal+Social+Services+expenditure&sort=Most+recent&size=10&page=1#top

The significantly expanded costs of the CQC regulatory model is a key issue in how provider money is spent. CQC proposals will see fees for homecare providers increase by 313% in two or four years. UKHCA members consider that this has materially changed the relationship between the regulator and providers who will now expect a significant improvement in the value for money of their fees. UKHCA provided a clear argument on these effects in a consultation response, accessible at http://www.ukhca.co.uk/cons.aspx?id=232874

XIII. Views on "Our current model of regulation".

a. Registration, either when entering the market or registering a new branch, must be streamlined and occur without undue delay whilst achieving a safe assessment of meeting requirements. Too often the process takes an unreasonable amount of time, particularly if a potential provider is expected to already have premises and staff secured for registration.

b. UKHCA members have been content with the introduction of quality ratings. However, ratings can have a significant impact on how a provider is viewed by people who may choose or receive their service. Therefore ratings need to be consistent, accurate, equitable and provided quickly after an inspection has taken place to remain relevant.

c. Appeals based on matters of accuracy or opinion should be considered and resolved quickly, to prevent unfair representation of the provider.

d. As referenced previously in this response, UKHCA are concerned that the regulator continues to convey the impression that its independence is limited by a need to provide messages which are palatable to government. UKHCA do not consider that this supports the CQC's drive to be an 'independent voice' or a "professional, consistent, transparent and fair" regulator.

2a Do you agree with our proposal to make greater use of data and information to better guide us in how we identify risk, and how we register and inspect services?

Strongly agree

Agree

Disagree

Strongly disagree

2b What do you agree with, or not agree with, about greater use of data and information?

I. We agree with the intention of evolving the regulation process to reflect improvements in technology and information collection techniques, but would argue this cannot be, nor should not be, the driving force to guide how regulation is carried out.

II. We also agree that there is an increased role for data and information to play in informing inspections and their outcomes. It is also likely to be particularly useful for helping inspectors and providers prepare for an inspection before it takes place.

III. However, we have serious concerns that the reality of the proposals within the consultation will be a reduction in the amount of time and resource that is put into location based inspections. This could have a particularly detrimental consequence on the quality of inspections, the relationship between the regulator and providers, and an increase in the volume of challenges raised. Local authorities have a track record of viewing reduced CQC inspections as an issue of contention and many have adopted a policy of separate inspections which has added significantly to the costs of providing the service because of the duplication that this has created.

IV. UKHCA hold serious concerns about a move for less frequent inspections unless CQC can demonstrate lasting confidence in its judgements by council commissioners and the public. Providers, even

with a positive rating and report, are likely to be viewed with suspicion if their latest report is deemed to be dated.

V. This is unlikely to be deemed acceptable by homecare providers who are being asked to pay fees that will increase by 313% in only two or four years. The provider sector will not regard less frequent inspections at the same fee levels as providing a fair basis on which to charge fees**:** a reduced inspection regime is a product of the regulator determining a lower risk factor and this should attract pro-rata fees from the provider.

VI. The Commission for Social Care Inspection (CSCI) previously developed a similar system. This resulted in a rapid increase in contract monitoring inspections by councils who had lost confidence in the regulator being able to pick up deterioration of services quickly enough. We are concerned that something similar will happen again, leading to resources and energy being spent on replicating inspection processes.

VII. If data and information is to be requested, CQC, providers and commissioners need to put that material into best use. The sourcing, filing and use of this information will require significant time and technology. The consultation document does not incentivise providers to collect data purely for the basis of regulation, particularly when this data will need to be updated quite frequently to remain relevant.

VIII. For data collection and collation to be a worthwhile undertaking for the provider it would be advantageous if there was a dual use for that material. For example, CQC could specify user satisfaction surveys and other assessment techniques which could provide information that providers themselves could use. If the use of data and information is seen as mutually beneficial, it is likely to have improved buy-in from care providers. CQC should seek to spend money in the short term to stimulate data collection.

IX. Data provided by people using services or their family is likely to often be negatively skewed, and data provided by care providers is likely to be positively skewed. Developing an independent system of data collection will be a significant issue that will need the backing and confidence from providers and the public. We have doubts as to where the finances to develop this will come from, as providers are not in a position where they can absorb these additional and quite significant costs within the prevailing economic climate.

X. It has been suggested that the CQC intend to use Facebook and Twitter to collect performance information on Providers. UKHCA is sceptical that this proposal will provide the quality of data that fee-paying organisations would expect from a statutory registration and regulatory agency. We would strongly urge the CQC to not pursue this option because we consider that the CQC should demonstrate how it could validate this data to remove the bias created by 'trolling' activity be detractors or falsely positive postings created deliberately to influence data.

XI. On page 14 it is stated that "CQC is aspiring to become 'intelligence driven'. This means we will strengthen the way we use data and information to underpin our decision making". There is not an explanation of how the CQC will do this or the resources this will demand to create a robust and systematic approach.

XII. UKHCA members are interested in how often information is gathered and whether the frequency of data collection will also depend on the rating received at the last inspection.

XIII. There is also apprehension as to whether these proposals are intended to support the challenging target CQC has been set in relation to completing inspections. CQC must not see this as an opportunity to speed up the process of inspection at the cost of being thorough and fair.

XIV. The consultation document appears confident in its assertion that the data that is "available nationwide" will help to predict risk and judge effectiveness. UKHCA is less confident on this point, and would welcome greater partnership working with representative bodies from the care sector to explore how accurate this assessment is or can be. It may prove beneficial to the sector if the CQC could cite the data it anticipates will support this initiative and how it will corral this into useable intelligence.

XV. We are pleased to see reference to highlighting good performance.

3a Do you agree with our proposal for implementing a single shared view of quality? (see pages 17-19)

Strongly agree

Agree

Disagree

Strongly disagree

3b What do you agree with, or not agree with, about a single shared view of quality?

I. In principle UKHCA agrees with the proposal to implement a shared view of quality.

II. A shared framework for measuring quality of care is likely to help providers, the public and inspectors to grasp the concept of what makes good care.

III. The desire to see all national and local oversight bodies use the same framework would be particularly useful if the policy agenda around integrated services is achieved. It is not clear from the CQC's strategy document what mechanisms will be at the disposal of the Commission to bring this aspiration to life**:** what leverage with 'local oversight bodies' will be available? UKHCA would welcome a description of the processes and resources that this will entail.

IV. However, we consider this to be a theme that should be low priority in comparison to some of the other activities proposed in the strategy. The challenging operating environment of care provision, largely brought about through constrained finances, means there are a number of issues around market stability and the workforce that should be prioritised.

V. Improving the CQC's cost effectiveness and reducing costs safely within regulatory processes should be prioritised above this theme.

VI. If CQC pushes forward with measures of quality under a single vision that do not adequately reflect what homecare providers actually do, or the environment in which they operate, there is a significant risk of producing unreliable conclusions. For example CQC may wish to promote a vision of choice and control, when in reality the aim is often to negate risk as best as possible and establish a degree of safety and crisis avoidance. For a single vision to work, all sides involved in regulation must be prepared to take it forward.

VII. There are further risks behind a shared view of quality. There is a risk that in aiming to establish something that covers all bases, the 'view of quality' becomes bland or aims for the lowest common denominator. The services that CQC regulate are very different, and the use of a shared view could risk losing the commitment of all parties by failing to reflect their uniqueness. Some homecare providers already believe CQC is out of touch with some of the specialisms they offer, and see the inspection process to be more of a tick box exercise rather than a true view of the service they offer.

VIII. UKHCA and our member organisations are concerned that any shared view is likely to be weighted towards the health sector. Organisations that seek to find common ground between the two often find that the NHS takes precedence because of the political impact and the high regard in which it is held by the public. It is our opinion that even the CQC strategy consultation document prioritises

the health sector over social care, with some sections making reference to social care almost as an afterthought.

IX. We assume that part of the driving force behind the implementation of a shared view of quality is the integration agenda. We must be wary of directing regulation in line with this policy before any genuine integration has taken place between health and social care. Whilst integration has become a favoured theme in many quarters, the reality is that integration is a long way from being achieved. Shaping regulation around something that may not occur is risky and may further alienate providers and the public from giving due credence to he results of regulation.

4a Do you agree with our proposal for targeting and tailoring our inspection activity, including reducing the frequency of some inspections so we target our resources on the greatest risk? (see pages 19-21)

Strongly agree

Agree

Disagree

Strongly disagree

4b What do you agree with, or not agree with, about targeting and tailoring our inspection activity?

I. UKHCA and member organisations disagree with proposals to target inspection activity.

II. We are disappointed that an important part of the Strategy, which could have a significant impact on regulation, has been explained in no more than two pages of the strategy.

III. Social care is again demoted to last on the list, and the limited information that is available about the proposals gives the distinct impression that it is focused on stretching resources more than delivering improvements to regulation.

IV. As noted in the foregoing, UKHCA is concerned that the proposals, as they stand, will lead to an unbalanced approach to regulation.

V. UKHCA hold serious concerns about a move for less frequent inspections unless CQC can demonstrate lasting confidence in its judgements by council commissioners and the public. UKHCA considers that an inspection frequency of more than a twelve month period does not provide such confidence.

VI. This is unlikely to be deemed acceptable by providers who are being asked to pay fees that will increase by 313% in only two or four years.

VII. The Commission for Social Care Inspection (CSCI) previously developed a similar proportionate inspection frequency. This resulted in a rapid increase in contract monitoring inspections by councils because of an apparent loss of confidence in the regulator being able to detect deterioration of services quickly enough. We are concerned that a similar situation will emerge, leading to resources and energy being spent on replicating inspection processes.

VIII. UKHCA members would like to see further information, or be involved in, CQC intentions to develop "how we gather evidence effectively on services provided in people's homes". As it stands this aspiration lacks any indication of the mechanism by which this can be achieved.

5a Do you agree with our proposal for a more flexible approach to registration? (see pages 22-23)

Strongly agree

Agree

Disagree

Strongly disagree

5b What do you agree with, or not agree with, about a more flexible approach to registration?

I. UKHCA agrees with proposals for a more flexible approach to registration, but we consider that 'flexible' lacks definition and is open to interpretation. We would therefore welcome a concrete explanation of the intention behind this proposal.

II. In particular this could be helpful in reducing duplication and streamlining processes for providers who are well established with good track records.

III. However, we are often informed by homecare providers of the slow and inconsistent approach to registration. This can be very costly to an organisation if they have established an office and staff in preparation of offering a service but are waiting on a response from the regulator. Often these things have to be ready in the first place to pass the registration process.

IV. Flexibility will inevitably require an understanding, knowledge confidence of CQC inspectors to make a judgement. They will therefore require training and help with understanding what is required. We are concerned that without this confidence and understanding, decisions will be completely risk averse and will err on the side of caution, leading to potentially good providers being declined registration at a time when demand for care services is rising.

6a Do you agree with our proposal for assessing quality for populations and across local areas? (see pages 25-27)

Strongly agree

Agree

Disagree

Strongly disagree

6b What do you agree with, or not agree with, about assessing quality for populations and across local areas?

I. We can see value to the proposal. For example it may help to identify where there is the possibility of a 'postcode lottery' of care, with some areas continuing to receive more substandard services than others. Additionally, it could help to highlight where commissioning is sub-optimal, and how close the relationship is between rates paid for services and the standard of care provided.

7 What impact do you think our proposals will have on equality and human rights?

I. UKHCA agrees with the prominence placed by the regulator on equality and human rights, and believes appropriate considerations have been put into place to ensure a positive outcome.

8 Are there any other points that you want to make about any of the proposals in this document?

I. We are content with the opportunity provided to raise our points in the previous seven questions.