United Kingdom Homecare Association
The professional association for homecare providers

Next Phase Consultation
Care Quality Commission
151 Buckingham Palace Road
LONDON
SW1W 9SZ

8 August 2017

Dear Sir or Madam,

CQC's next phase of regulation - A more targeted, responsive and collaborative approach to regulating in a changing landscape of health and social care

Thank you for the opportunity to respond to the above consultation, which we 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.

UKHCA held a workshop with our member organisations on 10th July in Birmingham specifically to consider the proposals within this consultation exercise. The responses detailed in the paper represent the considered views of UKHCA informed by those given directly by a representative group of homecare providers at the workshop.

Please do not hesitate to contact our team if you require any additional information.

Yours faithfully,

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Evidence submitted for CQC's next phase of regulation consultation

Introduction

1. In view of the importance of this consultation exercise, UKHCA arranged a workshop for members which was held on 10th July in Birmingham. Sixteen delegates attended including owners and senior managers from large and small homecare providers including franchisors and franchisees. It was clear from discussions held that members were deeply concerned by the proposals in the consultation document. They were also keen to ensure their views and experiences of registration and inspection were shared with CQC in this consultation response.

2. Therefore the first part of UKHCA's response details the concerns of members about how CQC are carrying out their registration and inspection functions currently. Members' responses to the consultation questions will follow.

Comments about CQC, inspectors and the inspection process

3. All providers at the workshop agreed that they want to work closely with CQC to continue to support safe care. However, you will see from the points they made below that relationships with local inspection teams are far from ideal and frequently frustrate providers' efforts to get on with providing a good homecare service. The bullet points capture their strongly held views:

    a. There is still a great deal of inconsistency between inspectors. Members query whether inspectors have sufficient training in how domiciliary care services operate.

    b. The background of inspectors does not always match the business being inspected, i.e. an inspector's background and expertise may be from acute care but nevertheless they are inspecting a homecare business, with insufficient knowledge about the sectors they are inspecting.

    c. Frequently members find themselves having to explain the regulations to CQC inspection teams, especially where there has been a change of location or services.

    d. Providers regularly report an unwillingness on the part of CQC's inspectors to visit people receiving homecare, particularly those with cognitive or sensory impairment. This is a particular concern where the inspection is not undertaken with the assistance of and Inspector by Experience.

    e. Providers who have stepped-in to improve a failing service run by a competitor are seldom given credit for doing so in inspection reports.

    f. It was reported by members that inspectors said an outstanding rating cannot be achieved at first inspection. Providers and this association believe that this is unjustifiable, and we do not think it is the position of CQC nationally.

    g. In a similar vein, members reported being told by inspectors that companies with fewer than 20 clients cannot achieve an outstanding rating, and neither can companies with over 50 clients. If accurate, such statements pose questions about the training of CQC's inspectors.

h. In the light of the comments above, UKHCA urged members to complain to CQC. Members however said they have little faith in the complaints process which they felt to be unresponsive and ineffective.

i. Some of the members said they have never seen an Expert by Experience, and where they had, their 'expertise' and independence appeared to be questionable. One member commented that the Expert by Experience she had dealt with appeared to have an 'axe to grind' about homecare provision.

j. Members were very anxious that UKHCA make the point that inspections on a particular day represent a snapshot in time and do not necessarily reflect the quality of service provided overall. They were strongly of the view that homecare inspectors needed a much better understanding of homecare businesses and how they operate in order to reach a fairer and more rounded judgement of their service.

Comments about commissioning and funding

4. Members at the workshop were strongly of the view that CQC inspectors do not understand the role of commissioners in delivering homecare, nor have an understanding of the respective responsibilities of commissioners and providers. This lack of knowledge of how a homecare service is performing and the constraints under which providers have to work impedes an inspectors judgement and leads to ratings which don't truly reflect the service being provided.

5. UKHCA have referred in previous consultations to the need for oversight of the commissioning practices of local councils. We stand by our comments in December 2016:

> "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."

6. In UKHCA's workshop, commissioning and funding concerns featured highly with one member asking, "How can commissioners be allowed to commission services on such low rates that providers cannot meet their obligations for the national minimum wage/national living wage?" It is a reasonable question to ask in a context where, quite rightly, society expects a high quality service but the funding is not made available to homecare organisations to enable them provide that service.

7. We note that CCQ recognises the fragility in the adult social care sector is influenced by funding and resource pressures, however UKHCA considers it unrealistic for CQC to continue separating the issues of quality assessment from the wider funding context. Some of our members have already reached a tipping point of not being able to continue providing services or have handed back contracts to councils. ADASS in their budget survey for 2017 found homecare providers continuing to withdraw from council funded contracts. They note:

> "The introduction of the National Living Wage and other pressures have driven an increase in fees paid to providers. This was the case in 2016/17, with further increases reported in 2017/18. There is a wide variation in price paid. However, as these figures demonstrate,

councils overall have been unable to meet the desired 2016/17 UKHCA benchmark of £16.70."[1]

8. In June 2017, ADASS wrote in their top tips for homecare sustainability that,

> "Home Care is the primary reason for social care Delayed Transfers of care and the most fragile part of the social care market. Some providers are running with sustainable profits but many with losses or on the verge of being unsustainable. ADASS, CQC and others are most concerned about this aspect of the care market."[2]

9. As an independent regulator, with an ambition to share its view of quality across health and social care to highlight cross-system issues, CQC could and should use its data to determine the relationship between commissioning, funding and the quality of care delivered by homecare providers.

UKHCA's response to consultation 2 - next phase of regulation

1a. What are your views on our proposal that the register should include all those with accountability for care as well as those that directly deliver services?

10. UKHCA's view is that the proposal to extend registration to include all those with accountability for care and those that directly deliver services is a fundamental requirement of an equitable provider landscape.

11. However, the fundamental issue is *where* the accountability for care sits within an organisation carrying-on regulated activities and *where* the boundaries for the scope of regulation should properly sit. We consider that there are two aspects to this. Firstly, in a financialised commercial environment and secondly, as a consequence of the emergence of hybrid organisations, such as Accountable Care Organisations (ACO). Members consider it is important for CQC to look at who influences quality and responsibility for monitoring and auditing rather than focus on corporate structures.

12. UKHCA consider that the quality of care is a direct consequence of the financial management of a service: fees balanced against the actual costs of providing the service. If financial decisions are made outside of the agency being evaluated by the CQC then it is inequitable to pass adverse comment or ratings when the levers of authority remain beyond the scope of registration. We are concerned that CQC is unwilling or unable to point to factors outside the provider's direct control, when they affect the quality of the service. It suggests an inspection regime that is only willing to challenge what might be considered easy targets.

13. It is therefore important to UKHCA members that different forms of care service are fully recognised by the regulator for what they are. We see it as virtually impossible to disaggregate elements of an Accountable Care Organisation (ACO) into easily identifiable parts that the CQC could apply its current regulatory and inspection model to. We challenge the idea that disaggregating an ACO would be of value,

[1] http://bit.ly/2uConXR NB. This figure is now £17.19 using NMW and NLW figures from April 2017
[2] http://bit.ly/2uConXR

because the whole premise is of a fully integrated delivery model spanning every aspect of a particular care pathway or Health or Disease Related Group (HRG / DRG).

14. In principle, members attending the workshop supported development of the register and holding to account those who are responsible for quality of care, but queried whether CQC's proposals will achieve their stated aim. The nominated individual is already likely to sit at multiple levels of a company so the feeling of members at the workshop was that the proposal might not add anything to existing processes. Members also felt there is a potential for CQC to take unwarranted or punitive action against an accountable person when responsibility for quality should properly lie with the registered manager.

15. Members were concerned that inspectors will not understand the difference between inspecting 'owners' and inspecting 'providers'. Members also felt that there needs to be a lead auditor system for inspecting providers owned and managed by parent companies.

16. To balance the increase in inspection at one level, members suggested that CQC should introduce lighter touch and fast track registration for new branches where an existing company has a proven track record of providing services rated as "good".

17. Workshop attendees felt that helping the public to understand the relationship between the various parts of large organisations and registering those parts was felt to be a laudable aim, but registration and inspection at headquarter level fails to take into account companies who are franchisors. Franchisors have influence over franchisees but not control. CQC should clarify whether or not these proposals apply to franchisors.

18. Members also asked whether CQC has taken into account the UK's exit from the European Union, and how CQC will deal with directors of organisations registered in England who are living abroad.

19. Members felt that there is a cross over with CQC's market oversight function querying what the proposals will add and were unconvinced the proposals will make a difference to the quality of the service. They noted the proposal to exclude pure financers from registration but felt that they can significantly influence culture. They commented, "Funders can influence decisions more than CQC has grasped."

20. Another question asked by members at the workshop concerned how CQC will manage the 'well-led' concept within the new inspection regime for corporate/national organisations. Members were unconvinced CQC have the skills and knowledge to deal with very complex organisations where provision of care is may be one element within a multifaceted company structure.

21. Members were also unclear how arrangements for sub-contracting fitted in with these proposals and asked that CQC clarified their position at the earliest opportunity.

1b What are your views on our proposed criteria for identifying organisations that have accountability for care (see page 12)

22. UKHCA members have a number of concerns with CQC's proposals for "defining who is accountable for the quality of care" as per page 12 of your document.

23. Clarity is needed on how CQC will define certain elements of a care provider following the statement that "In all cases, we will only be interested in those parts of an organisation that exert significant influence over the quality and safety of services".

24. UKHCA members consider a further consultation exercise is necessary to determine the precise mechanisms proposed by the CQC to undertake this element of the revised approach to regulation and inspection. UKHCA finds CQC's approach to this complex issue lacking in detail, and we would recommend CQC carry out a pilot scheme to eliminate variations and inconsistencies at a very early stage.

25. UKHCA members concerns extend to the statement in the consultation document that "Organisations such as hedge funds and other types of investors that do not exert this influence will not be required to register with us and will not appear on the register on our website". Our response to Q1.a above also applies here, in part because we consider it extraordinarily unlikely that any investor, would undertake never to exercise any such levers of authority in any context: the mere act of selling the investment is exercising such leverage; hedge funds and other financial bodies imply an absolute authority to exercise such leverage, that is why they do what they do.

26. Members also queried an inconsistency in approach in terms of publishing details of owners of companies. From the consultation, it appears that investors based in England and who are not judged to exert influence over delivery of quality will not be registered with CQC and will not appear on the register on the website. Whereas owners not based in England will have details published on the website. Members were keen to understand the rationale for the difference in approach.

27. Members were worried about the effect publishing ratings history would have on the market. They felt that good providers would not pick up failing providers to try and turn them around if the rating of the failing company remained on the public record. There needs to be some recognition on the website that the failing company was now in new hands and improvements to quality of service were being undertaken, and ratings of the previous owner removed once re-inspected under the new providers ownership.

28. Members were also unclear how arrangements for sub-contracting fitted in with these proposals and asked that CQC clarified their position at the earliest opportunity.

2 We have suggested that our register show more detailed descriptions of services and the information we collect. What specific information about providers should be displayed on our register?

29. UKHCA members felt that current rules on location are not currently working well for homecare providers and pointed out that CQC can already refuse a registration application from providers who want to open a new location.

30. UKHCA members also felt that providers whose majority of services were already rated 'good' should benefit from an assumption of registration in a new location and CQC should carry out an inspection once a new branch is open.

31. Members were particularly vexed by the proposal that CQC could set limits on the geographical area a domiciliary care provider can operate (see page 16). The anger that this suggestion generated is difficult to convey and the very strong view was that CQC should not have any impact on commercial decisions made by providers; it is not within its remit.

32. Comments included:

> "What would this mean when tendering for new services? Would we need CQC to certify that we are authorised to operate in new location?"

"CQC should not be able to dictate the market. This is totally wrong and unbelievable."

"CQC is not responsive enough to implement this sufficiently."

"Reduces choice of customers purchasing care, which is counterintuitive and goes against CQC using the regulations to support care providers."

"Role of regulator is to monitor, not to say where companies should operate."

"How would CQC determine geographical location? By head office, funder location, local authority or customer location?"

"This cannot apply to franchisors surely?"

33. Members who were franchisors were clear that such a proposal if implemented represented a clear interference in the operation of a commercial business and CQC had not considered franchising organisations in determining its registration structure.

34. In terms of collecting information to support a new register structure, members asked who will have access to this information and what will be the impact on data protection? They also asked whether there will there be different levels of access to this information.

35. They were keen that any increases of fees should be kept to a minimum and that any additional information collected should demonstrably support CQC's core function and not be collected without a specific requirement to enforce regulation.

36. Members were also very keen to point out that providing additional information is an added cost to providers and therefore CQC must ensure that its systems allow providers to give information in a user friendly and responsive format.

3a Do you agree with our proposals to monitor and inspect complex providers that deliver services across traditional hospital, primary care and adult social care sectors? [Strongly agree / Agree/ Neither agree or disagree/ Disagree / Strongly disagree]

37. UKHCA agrees with the proposal *in principle* to regulate and inspect complex providers across traditional boundaries, subject to further consultation.

3b Please explain the reasons for your response.

38. In keeping with our response to Q1.b above we consider a further consultation exercise concerning the precise mechanisms proposed by the CQC is needed to undertake this element of the revised approach to regulation and inspection. We note that the consultation document says, 'there could be benefits in taking a coordinated and approach to monitoring and inspecting those services', but the rationale for doing so seems weak and poorly developed and the costs to CQC (and by definition costs to providers who pay the fees) for development of the proposals are not explained.

39. The key question for CQC is whether this proposal will actually result in better services for people, or just provide information that is interesting for CQC to know. From what we understand, those providers that are not working well together can

easily self-identify and there are existing mechanisms and portals through which providers can learn to work together more effectively for the people they serve.

40. Members pointed out that looking at how well providers work with other organisations is already part of the assessment process under the 'well-led' key question. CQC already has data from its various inspections and should be able to analyse what it holds already - or if not, it should develop a process that can capture the data from inspection reports rather than inventing a new process with all the costs associated for CQC and providers.

41. In particular, we are concerned whether CQC's inspectors have the ability to assess leadership, governance and integration across a whole system and suggest that discussions with social care stakeholders are as wide as possible. UKHCA is happy to participate in such discussions.

4a Do you agree that a provider-level assessment in all sectors will encourage improvement and accountability in the quality and safety of care? [Strongly agree / Agree / Neither agree or disagree / Disagree / Strongly disagree]

42. UKHCA *disagrees* with this proposal.

4b What factors should we consider when developing and testing an assessment at this level?

43. UKHCA considers that provider-level assessment is unlikely to apply to homecare services under current market conditions. Some providers may currently offer services to more than one client group but it is essentially the same service, with only subtle differences tailored to the service user typology, such as dementia care, learning disability or stroke recovery, for example. We do not consider that there is sufficient differentiation to warrant a provider-level approach at this time.

44. UKHCA members at our workshop did not feel well-disposed to considering the possible options for a new provider-level assessment. They considered it a proposal that CQC itself had not thought through and the rationale for its application to the social care sector had not been provided. It appeared to them to be much more relevant to large NHS Trusts than to social care providers.

45. In any case, members considered that a provider-level assessment would not add anything of value to current ratings of services for larger homecare companies. If, as currently assessed, 80% of all homecare providers are rated 'good' then the chances are the provider-level assessment would also be 'good'. It was felt that people looking for a homecare service would be more inclined to rely on the rating for the local service than the company as a whole.

46. They felt that once again franchised organisations had not been considered. Franchise operations, are by their nature separate legal entities.

47. The element missing in this proposal for members is the crucial relationship between local authority commissioning practice and homecare provision. This is where they felt increased accountability and transparency was needed as state-funded homecare, as it currently operates, is driven almost exclusively by the cost pressures facing local government. Improving quality of homecare cannot be seen a priority by council employed commissioners given the unwillingness to fund care adequately. CQC must be aware there are local authorities who even today are offering contracts at below cost for homecare provision and passing on the risk of failure to the provider.

48. If transparency is the aim, members felt CQC could support the research and development of a model tender document that could be used throughout England for use in social care. They feel that not only would this bring greater transparency, but would produce large savings for councils and providers alike. Similar to the model NHS contract, a social care contract could set fair terms and conditions and allow for care to be commissioned in a way that aims to support people to live independently and prevent or delays admission to care homes or hospital.

49. Members were keen to point out that provider-level assessments can put good companies at risk when associated with companies within the same group who attract a poor rating from CQC. Investors and insurers in the good company could pull out leaving the good company stranded and unable to continue providing a service. UKHCA consider CQC has not fully considered the risks of these proposals to companies within complex organisations and further exploration and consultation is needed.

5a Do you think our proposals will help to encourage improvement in the quality of care across a local area? [Strongly agree / Agree/ Neither agree or disagree / Disagree / Strongly disagree]

50. UKHCA *disagrees* that these proposals will help encourage improvement across a local area.

51. UKHCA has held the position that an inspection of care providers in isolation of the commissioning practice in a local area is fundamentally flawed and unlikely to address the principle problem within the health and social care sectors.

52. Without addressing the commissioning of care we are uncertain that any inspection regime can ever bring about embedded and significant improvements in local areas. Our hands-on experience of working with members provides us with evidence that until the competency of commissioners generally is significantly improved the potential for realistic and long-lasting structural improvements in the sector can only be an aspiration.

53. Our surveys of the prices paid for homecare by some local authorities demonstrate that there is a direct connection between service-quality and the costs associated with delivery. It is a matter of regret to UKHCA members that this simple equation is disregarded by many commissioners of social care.

5b How could we regulate the quality of care services in a place more effectively?

54. Members at our workshop made clear their views that if quality of care - specifically homecare - is to be improved across an area, CQC need to focus on:

    a. Professional regulation of inspectors who need better training, monitoring and a programme of continuing professional development. Providers are very concerned about the lines of questioning adopted by many inspectors, feeling strongly there is a lack of openness by some who seem determined to evidence judgements formed on their pre-inspection information, regardless of what they see in practice

    b. Inspectors spending time getting to know individual providers, the nature of the services being provided and the context within which the service is being provided, including financial constraints placed on companies through local authority contracts

55. As we have already said in this response, looking at how well providers work with other organisations is already part of the assessment process under the 'well led' key question. CQC already has data from its various inspections and should be able to analyse what it holds already - or if not, CQC should develop a process that can capture the data from inspection reports rather than inventing a new review process with all the costs associated for CQC and providers.

56. Our members were deeply unhappy with the proposals for developing a new framework to support local inspection teams to identify and respond to system-wide issues. As discussed in the document on page 31, CQC's proposed approach of having 'internal cross-sector conversations and risk meetings' lacks the transparency CQC demands from providers. Homecare providers are extremely concerned that they will not know what it is they are being inspected against during routine inspections and they do not want to be in the position of second guessing what evidence the inspector might demand from them.

6a Do you agree with our proposed approach to monitoring quality in GP practices? [Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]. 6b Please give reasons for your response.

57. UKHCA has not commented on this question as this proposal concerns GP Practices and homecare services are not directly affected by this change.

7a Do you agree with our proposed approach to inspection and reporting in GP practices? [Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]. 7b Please give reasons for your response.

58. UKHCA has not commented on this question as this proposal concerns GP Practices and homecare services are not directly affected by this change.

8a Do you agree with our proposal to rate population groups using only the effective and responsive key questions? (Safe, caring, and well-led would only be rated at practice level.) [Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]. 8b Please give reasons for your response.

59. UKHCA has not commented on this question as this proposal concerns GP Practices and homecare services are not directly affected by this change.

9a Do you agree with our proposal that the majority of our inspections will be focused rather than comprehensive? [Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]. 9b Please give reasons for your response.

60. UKHCA has not commented on this question as this proposal concerns GP Practices and homecare services are not directly affected by this change.

10a Do you agree with our proposed approach for regulating the following services? i. Independent sector primary care [Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree] ii. NHS 111, GP out-of-hours and urgent care services [Strongly agree/Agree/Neither agree or disagree/ Disagree/Strongly disagree] iii. Primary care delivered online [Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree] iv. Primary care at scale [Strongly agree/Agree/Neither agree or disagree/Disagree/Strongly disagree]. 10b Please give reasons for your response (naming the type of service you are commenting on).

61. UKHCA has not commented on this question as this proposal concerns GP Practices and homecare services are not directly affected by this change.

11a Do you agree with our proposed approach to monitoring quality in adult social care services, including our proposal to develop and share the new provider information collection as a single shared view of quality? [Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]

62. UKHCA agrees with *some* of these proposals but not others.

11b Please give reasons for your response.

63. Members at the workshop were very concerned at the prospect of having to provide further information to CQC on-line, especially smaller localised providers who are currently using paper records – a system that works well for their business.

64. A great deal depends on what information CQC want to collect and how it will be shared. Providers asked for much more information on this proposal so they can assess how much it will cost and how long it will take in terms of developing their own systems and software so they can calculate the costs of regular uploading of information. Unlike NHS providers, social care organisations are not backed by a single publicly funded social care digital service so investment of this nature must have a clear purpose and be of benefit to homecare clients and businesses. It must not duplicate information already collected by other bodies such as local authorities or NMDS for example.

65. Members noted the data led nature of the information captured by CQC Insight for example, by GP practices, and are worried about the type of information they could be expected to collect from clients in order to pass on to CQC. They are concerned about subjectivity, data confidentiality, and the resources they might need to safely collect such data. They also reasonably ask the question what CQC Insight will show about all locations of a provider that CQC cannot get from provider-level registration.

66. Members stressed the very different nature of homecare businesses from NHS organisations, and referred to the variety of clients they serve and their constantly changing needs. They were not convinced that data on provision of homecare could be provided in an objective way that would be directly comparable over time or with other homecare businesses.

67. Much more discussion with the sector is needed then before a version of CQC Insight is introduced in homecare. There should be no expectation on CQC's part that homecare businesses will invest in developing data collection systems simply to supply information to CQC that will serve no real purpose for the homecare provider.

68. The proposal to remove the 'six month limit' where the rating can only presently be changed where a focused inspection is carried out within six months of a comprehensive inspection is welcomed. This will allow the rating to reflect service

improvement where services improve which is fair. Similarly when services deteriorate, ratings should reflect the findings of a focused inspection where services have deteriorated.

12a Do you agree with our proposed approach to inspecting and rating adult social care services? [Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]

69. UKHCA agreed with some of these proposals but not to others.

12b Please give reasons for your response.

70. Members *did not* welcome increasing the length of time between inspections when they were rated good or outstanding. They forcefully made the point that a good or outstanding service would prefer to have its rating as current as possible. They also pointed out that new providers rated good in their first inspection will have to wait a long time to try and get outstanding and they considered this to be unfair. They also considered that they should have their registration fees reduced if CQC lengthened the time between inspections.

71. Members rather emphatically made the point that any inspection can only represent a snapshot in time. Inspectors, it seemed to our members, are often unable (or, on occasions unwilling) to take into account the sometimes uneven nature of homecare provision and will base their judgements on what they have seen on one particular day, rather than make a judgment on how a service is provided over a period of time. Based on their experience, they do not consider lengthening the period will benefit their service.

72. They also made the point that change of ownership should flag up the need to bring forward an inspection since that is often when a good service deteriorates. They note that CQC will focus on services that require improvement or are inadequate but based on their experience of inspections, remain sceptical that CQC are sufficiently responsive to concerns that suggest a comprehensive inspection is warranted.

73. In terms of specifying a period within which a homecare inspection could be carried out, members were of the very firm view that this was a backward step. Not having a specified date for an inspection shows a lack of trust by CQC in providers and the proposal suggests that rather than work with providers, CQC want to try and catch providers out.

74. Members welcomed the proposal to include the 'well-led' question in a focused inspection.

13a Do you agree with our proposed approach for gathering more information about the quality of care delivered to people in their own homes, including in certain circumstances announcing inspections and carrying out additional fieldwork? [Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]

75. UKHCA agrees with CQC's aims but not with their proposals

13b Please give reasons for your response.

76. Development of a more rigorous inspection process is welcome. However, members at the workshop were wholly sceptical of CQC's proposals for inspection of homecare.

77. The nature of homecare means that unannounced inspections can waste the time of inspectors. Registered managers will not always be in the office and individuals receiving homecare must be given the chance to say whether they are happy for an inspector to call when homecare is being delivered. For very small services, the registered manager plays such a fundamental role in the operation of the service that to continue an inspection in his or her absence, would provide a misleading picture of the service.

78. Members were disappointed that more information was not given about the toolkit referred to on page 51. Our understanding is that the toolkit has in fact been developed and piloted, so UKHCA is surprised more detail was not included in the document. It suggests that the outcome of the consultation exercise has already been determined and our comments will serve no useful purpose.

79. The lack of information about the proposed toolkit is a problem and UKHCA would urge CQC to talk more extensively with providers about its content and how it will be used, perhaps through a facilitated forum. Members expressed their concern that a toolkit will take away initiative from inspectors and increase generic use of checklists. This goes against the CQC's own commitment to enable innovation in services.

80. Our members reiterated in the strongest possible terms that if CQC are serious about understanding how a homecare service is provided, then inspectors should make much more effort to accompany careworkers on visits. Their feeling is that inspectors are generally reluctant to undertake work outside the provider's premises. Members were confident they could make the necessary arrangements and obtain permissions from clients and are more than willing to do so.

81. The main point members wanted to reiterate about inspecting homecare services is that CQC should have the skills to deal with service users with cognitive or sensory impairments. CQC needs to consult with providers and train inspectors to understand the needs of those service users. It is the experience of providers that inspectors do not go out when the provider is visiting people with cognitive impairment. Inspectors need to have "signers" and translators with them on inspections when this is indicated.

82. Members again expressed concerns regarding Experts by Experience and transparency regarding inspection times. Some services are experiencing considerable variation despite the services similar to each other. For example some comprehensive inspections lasting four hours and others two days.

14a Do you agree with our proposed approach for services which have been repeatedly rated as requires improvement? [Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]

83. UKHCA strongly disagrees with the proposals.

14b Please give reasons for your response.

84. Members agreed that corporate leadership should be held to account where a significant proportion (say, more than half) of services require improvement. However, UKHCA notes that CQC want to 'explore' the use of provider-level conditions and it seems to us that the consultation document is doing nothing more than floating an idea. Further discussion on this proposals would be welcome and we would be pleased to comment on any definite proposals in this area.

85. Our workshop for providers noted that CQC will require consistently poor performing services to put together an action plan to be agreed with the provider's

commissioners. Members asked about the mechanism for this and queried whether CQC are prepared to put pressure onto commissioners to allow for more reasonable fee rates for providers allowing them to improve quality of care.

86. Members were very clear that they *did not agree* with CQC's proposal to publish details of enforcement action prior to the outcome of representations or an appeal. CQC's rationale that this proposal would mean more transparency for the public is not accepted since a requirement or warning notice could be withdrawn by CQC following representations. In the meantime, businesses could be adversely affected and clients suffer as a result.

87. Members further suggested that if enforcement information is published regarding an umbrella company, this could adversely affect other providers in that group with satisfactory/good ratings.

88. Members are also highly aggrieved that requirement or warning notices will appear in inspection reports even in situations where swift action has been taken by the provider to rectify any faults before the inspection report is published. Members consider this to be grossly unfair and misleading to the public. CQC should ensure that if action is taken by providers to improve their service in line with a requirement or warning notice and the improvement occurs, this is reflected promptly by CQC on their website and in reports.

89. Our members acknowledge that CQC often feel themselves to be attacked on occasions of serious service failure and accused of not taking action when it seems 'obvious' to the media that that a service should have been closed down. However, members also feel strongly that as a regulator, CQC must first and foremost act within the law and not bow to public pressures to disclose confidential information. Many organisations dealing with the care of individuals are unable to discuss the information they hold and similarly other regulatory bodies are unable to give information about the organisations or individuals they regulate until the processes of representations and appeals are exhausted. Keeping information confidential is part of that process and is a cross CQC must be prepared to bear.

90. If evidence points strongly to a service being unsafe or potentially harmful through unsafe practice, then CQC must use the powers it has at its disposal to take the relevant enforcement action in a timely manner. It is far more important that it takes the right action promptly against failing providers than it is to publicise its actions on its website or across the media.

91. UKHCA considers the lines of appeal are already very limited and this proposal is likely to result in a Judicial Review.

15a Do you agree with the proposal to share all information with providers? [Strongly agree/ Agree/ Neither agree or disagree/ Disagree/ Strongly disagree]

92. UKHCA strongly *disagrees* with these proposals.

15b Do you think this change is likely to incur further costs for providers?

93. In connection with the sharing of information "of concern from a third party" we consider it incumbent upon the CQC to determine the facts and accuracy of any such information to eliminate the potential for vexatious and unfounded statements "of concern". Some UKHCA members have been the target of wholly unfounded criticism where the CQC has not sought to validate those claims and this has caused considerable effort to ameliorate the adverse impact on providers and their clients of injudicious handling of spurious third party claims.

94. Of further concern to us is the statement on page 55,

> "When we receive concerns from the public or health and social care staff about the fitness of directors, our current approach is to assess the information and to ask the provider to consider and respond only to the information that we believe is relevant."

95. We consider the use of the word 'believe' to be unhelpful: either the CQC has prima facie evidence of a problem or it hasn't. To pursue an issue on the basis of a 'belief', lacking corroborative strength, is insufficient and without due cause. We urge the CQC to use its investigative powers to better effect than giving credence to a *belief*.

96. Members said they would comply with any request from CQC to provide any information that the company might have regarding the fitness or otherwise of a director. However, members stressed that companies will want to take their own proportionate view of what they consider to be the most serious or systematic concerns.

97. Members felt that there are already provisions in the Health and Social Care Act regulations and in company law to deal with directors who are not fit and proper persons for the role. Their view is that in proposing to carry out inspections of companies with a director that is alleged not to be a fit and proper person, CQC is unnecessarily straying into what can be very complex areas that are not their responsibility and for which they lack experience and knowledge.

98. Members considered there may be significant costs and reputational damage if any concerns about directors raised via CQC had no basis in fact and became widely known.

16 Do you agree with the proposed guidance for providers on interpreting what is meant by "serious mismanagement" and "serious misconduct"?

99. UKHCA *disagrees* with the proposed guidance as currently drafted.

100. Members felt very strongly about this proposal. The criteria for serious mismanagement and serious misconduct is far too wide and indicate a failure by CQC to understand that tough decisions need to be made in the "real" world.

101. They were also deeply concerned about the imprecision of the language in the draft guidance on the implementation of the fit and proper persons requirement, for example mismanagement could include 'failing to interpret data in an appropriate fashion'. It begs the questions, what data? What is appropriate? While it is acknowledged that providers asked for guidance, UKHCA considers the current draft to be so imprecise as to be unworkable in practice.

102. It appears that the purpose of this proposal seems to be to ensure there are punitive measures for serious failures to ensure safe care. However, any enforcement action will touch upon employment law and professional regulation at senior level and UKHCA suggest this is not the role of the CQC - save for where there has been loss of life or serious injury – in which case the law is already there.

103. It is likely that individuals will challenge such findings (and obtain representation to do so) which ironically could hold up the publication of reports. UKHCA suggest this proposal is too ambitious for the CQC and will be disproportionate and expensive for them to investigate.

104. Members expressed doubts as to whether CQC have the requisite skills base needed to understand what it takes to manage a commercial service and how to judge whether a director has committed acts of serious mismanagement or misconduct.

105. Members expressed concerns that the guidance will put off valuable and experienced candidates for directors. As there is such a wide array of providers, the different calibre of directors will also be wide ranging but delegates did not feel that criteria reflect this.

[ENDS]