# Consultation Response

## Care Quality Commission: Our next phase of regulation (2) – a more targeted, responsive and collaborative approach to regulating in a changing landscape of health and social care

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Age UK is the country's largest charity dedicated to helping everyone make the most of later life. The Age UK network comprises of around 150 local Age UKs reaching most of England. Each year we provide Information and Advice to around 5 million people through web based and written materials and individual enquiries by telephone, letters, emails and face to face sessions. We work closely with Age Cymru, Age NI and Age Scotland. Local Age UKs are active in supporting and advising older people and their families in the care market.

## About this consultation

This consultation, issued by the Care Quality Commission (CQC), asks for views on changes to the regulation of registered health and care services, to be implemented as part of CQC's five-year strategy between 2016 and 2021[1]. Some of the proposals apply to all regulated sectors, and include new approaches to complex or integrated services that might currently fall within several registration categories. The consultation also looks specifically at regulation of primary medical and adult social care services.

## Key points and recommendations

- Age UK welcomes a number of key aspects of the new approach to regulation set out in this consultation, particularly around transparency of information, accountability and the emphasis on using data and intelligence more effectively to inform inspection decisions.
- Age UK is however not convinced that CQC has the resources to respond to integration and new models of care, taking on new roles such as assessing local population-wide outcomes. Similarly, while we welcome the introduction of an insight-driven approach to regulation, we are not convinced CQC has the capability to gather the best possible insights from the data collected throughout the system and to act promptly and effectively in response to data.
- Data gathered through the CQC Insight model should be supplemented by knowledge of individual experiences of service users. Experts by Experience can make a great contribution to gathering this intelligence from the ground but they need to be supported to do so.
- We are also concerned about proposals to amend the scope and frequency of inspections, particularly when it comes to good and outstanding services. Unless there is a clear demonstration that a robust monitoring and quick response mechanism is in place to respond to sudden change, we fear that proposals to

1 Care Quality Commission - Shaping the Future; our strategy for 2016-21 - http://www.cqc.org.uk/content/our-strategy-2016-2021

increase the period between comprehensive inspections will pose a significant risk to patient safety.

- We still have concerns about CQC's proposals to aggregate assessments and ratings at provider-level as we fear they might dilute the notion of quality ratings by the CQC and undermine the public's confidence in the judgements made by the regulator. CQC's assessment of the quality of a service should always be judged on evidence-based standards and not on what is achievable within a particular financial allocation.
- Age UK believes there should be further consistency and transparency in defining 'requires improvement ratings' and in taking enforcement action. Although we welcome the proposal to be more transparent with the public when it comes to publishing sooner the details of enforcement action taken, we also think it is the enforcement action itself that should also be seen as taking place sooner.
- We strongly agree with the proposal to share all information with service providers when CQC receives concerns from the public relating to the fit and proper persons requirement. While this might increase costs due to the possibility of more investigations for a provider, we would argue that any extra cost is entirely proportionate to the risk to service users. However, we are also clear that we do not want to see additional costs passed on to residents/service users.

## Age UK's response

### *PART 1: REGULATING IN A COMPLEX CHANGING LANDSCAPE*

### *1.1 Clarifying how we define providers and improving the structure of registration*

- *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?*

Age UK welcomes the approach of making sure accountability sits at the highest level within any complex structure. This could help to ensure that resources are unlocked for providers to improve the quality and lives of the individuals that receive their services.

With reference to the following:

*'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. 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' (p12).*

We believe that requiring providers to share their CQC ratings with investors will assist in ensuring that appropriate governance and oversight is in place within those organisations.

- *1b What are your views on our proposed criteria for identifying organisations that have accountability for care?*

We agree with the criteria for identifying who is accountable within large group structures. CQC may also want to consider the influence of funders like local authorities and clinical commissioning groups – reductions in funding along with the restrictions imposed in some contracts can have a direct impact on the quality of care an organisation delivers, especially within the adult social care sector.

- *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?*

Age UK agrees that the register should hold more details on the provider, its services and more specific descriptions of the services it provides. This will help people make more informed decisions when looking for a care service. As such, we would recommend that the relevant qualifications of senior members of staff are made available to view on the register. This would help enhance transparency about the leadership and skills of each organisation.

We also understand that the location rules have been confusing for both service providers and service users. For example, in the case of a community-based service, the register will state in what location that registered office (CQC registered) is but it does not state what area that registered location covers. Therefore changing the location rules would be helpful for service users looking for a service more local to them. It could also help them understand how services are combined when looking at integrated care and complex organisations.

***1.2 Monitoring and inspecting new and complex providers***

- *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.

- *3b Please explain the reasons for your response.*

We believe that this approach would help to create a more proactive, planned quality assurance process, hand in hand with continuous improvement. We also think it could enable wholesale change across an organisation, ensuring that all service users feel their service is improving. We have concerns, however, as to whether CQC will have enough resources to deliver this plan in a context of tightened finances, not only for the regulator, but also for the health and social care sector as a whole. Indeed, CQC is expected to make further efficiency savings over the coming years, with its total funding envelope

falling from £249 million a year in 2015/16 to £217 million in 2019/20. Meanwhile, in its 2016 State of Health and Social Care report, CQC warned of a social care sector reaching a *'tipping point'*, and health services finding it increasingly difficult to sustain quality.

In addition, we welcome the emphasis on hearing the voices of service users. However, with reference to *'speaking to people using services about how well care is coordinated to meet their needs'* on page 19, we would want to be assured that a wider range of questions will be asked, with a person-centred focus and in straightforward language that promotes the inclusion of marginalised older service users, for example people with dementia. Indeed, while there is value in asking how well coordinated a service is, we believe this could narrow down the answers provided. We would recommend using the narrative set out in *I'm still me,* including the '*I statements*' as a support for engagement with services users.

Where failings are identified in one area of an organisation, CQC should examine shared services and practice across the organisation as this may help to prevent issues arising elsewhere. This should include training, recruitment/human resources and financial management. Safeguarding issues and compliance with the Mental Capacity Act should also be assessed across both the whole organisation and its component services.

### *1.3 Provider-level assessment and rating*

- *4a Do you agree that a provider-level assessment in all sectors will encourage improvement and accountability in the quality and safety of care?*

Agree.

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

Extending the provider-level assessment to corporate providers of health and social care services, large-scale GP practices, new care models, NHS trusts, and other complex organisational forms will be beneficial in terms of strengthening accountability at that level. It will be important to ensure, however, that such a provider-level assessment does not devalue the role of the registered service managers, which we fear could potentially cause more services to fail at that level.

Additionally, it is vital that the public are clear what these assessments and potential aggregated ratings are for, and how they relate to individual service assessments. In our response to CQC's first consultation on its *'Next phase of regulation'*, Age UK already voiced concerns about proposals to aggregate assessments and ratings at provider level, as we feared they might dilute the notion of quality ratings by the CQC. In particular, we have concerns that the combination of *use of resources* and *quality* ratings within CQC trust-level ratings, as initially suggested, risks watering down the idea of what good-quality care is. Quality of care should always be judged on evidence-based standards and not on

what is achievable within a particular financial allocation. This risks undermining the public's confidence in the judgements made by the regulator on quality, by elevating resource-related considerations.

Service users and their families expect that a service with an '*outstanding*' rating will be outstanding, not outstanding considering its limited resources. We therefore believe it is crucial that the quality of all services is measured by the same yardstick, regardless of demand or financial pressures, otherwise it will become unclear what is meant by quality. It will also become more difficult to link variations in quality to factors such as demand and financial resources. Where regulation can incorporate use of resources into inspection, it should be in pointing out where fundamental standards are not achievable within the budgets available. We look forward to responding to further proposals on this matter later this year.

### *1.4 Encouraging improvements in the quality of care in a place*

- *5a Do you think our proposals will help to encourage improvement in the quality of care across a local area?*

Agree.

We believe there is value in encouraging improvement across a local area, using local evidence more effectively to understand system-wide issues. This could help understand the impact of the quality of services on a given population and at a more micro-level, help understand a service user's journey across the system, which is in itself a differing method of assessing quality. However, as highlighted in our response to CQC's consultation on its Five Year Strategy, evaluating the impact of services on whole populations would require new forms of evidence gathering, potentially like the proposed CQC Insight products, and it is unclear whether the CQC will have enough capability to deliver this.

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

Age UK's view is that any review of care services in a place must be supported by clear improvement and implementation plans. Without these plans, it risks being a costly, high-level exercise that has little impact on the experiences of communities and individuals.

In addition, we also believe that the assessment of the quality of care in a place should include an overview of how adult safeguarding is led, make sure prevention is emphasised, and that the Mental Capacity Act is embedded across sectors. It should include an examination of how those who use health and social care services are empowered, how their personal goals are met, and how community assets are developed and used. It remains a concern to Age UK that CQC is not a mandated member of the Safeguarding Adults Board.

## *PART 2: NEXT PHASE OF REGULATION*

### *2.1 Primary medical services*

- *6a Do you agree with our proposed approach to monitoring quality in GP practices?*

Agree.

- *6b Please give reasons for your response.*

As stated in our response to CQC's Five Year Strategy consultation, we support the introduction of an insight-driven regulatory model, and strongly agree that CQC should make better use of data. However, as previously mentioned, it is what CQC does in response to the data that will be important. For example, a key aspect of this will be around ensuring CQC inspection teams are sufficiently trained and fully equipped to respond to the data, including understanding its practical implications for service users and providers. Similarly, CQC should ensure it develops a robust analytical capability in order to gather the best possible insights from the data collected throughout the system, and also be able to demonstrate the reliability of insights gained through the new tool. This is particularly key as data monitoring and analysis will underpin the scope and frequency of inspections in the new regulatory model. We are not convinced at this stage that this capability is in place and would seek assurances about what steps CQC is taking to bring up this capability.

We also think that this section of the consultation, and any paragraph on gathering data, should make an explicit reference to the role of Experts by Experience in gathering person-centred insights. Age UK is a strong supporter of this programme. Experts by Experience can play a valuable role in assisting service users to consider person-centred outcomes relevant to their overall life and wellbeing as well as the extent to which services are supporting them to achieve those outcomes. They can also help CQC make a stronger assessment of the quality of a service based on what's most important to people. We know from our contact with older people living with frailty that the best examples of positive care are those that respond to the goals set by the person and address the specific challenges they live with, beyond pure medical needs. In gathering insights to support regulatory decisions, CQC must ensure that the data reflects older people's goals for care, and that involves engaging with service users and partners across the sector.

- *7a Do you agree with our proposed approach to inspection and reporting in GP practices?*

Disagree.

- *7b Please give reasons for your response.*

The consultation proposes that *'For providers rated as good or outstanding overall, we will move to an inspection interval of up to five years […] Every year a proportion of the providers rated good or outstanding will be inspected to make sure that they are all inspected at least once every five years'.* The decision to inspect will be based on rating and monitoring information, and inspections for those GP practices rated as outstanding or good – that is, the current majority of GP practices – will be *'more focused'*.

While we do recognise the importance of reducing the regulatory burden on GP practices at a time when they are particularly stretched, we are concerned that a focused and less frequent inspection regime could represent a risk for patients, especially at a time when change can happen quickly. Indeed, as previously noted, there can be dramatic change to service provision over a critically short period of time due to changing external or internal environments, sometimes due to a tight financial background, staff changes (e.g. change of manager or senior team), or seasonal pressures. In light of this, we would urge CQC to establish a clear set of criteria on what would prompt an inspection among good and outstanding services in response to a dramatic change. These criteria could include: winter/seasonal pressures; staff/leadership changes as well as signals from other parts of the system.

As highlighted in our response to the consultation on CQC's Five Year Strategy, it will be crucial to develop an effective methodology to ensure that targeting does not result in increased risks to services users. At the moment, while we understand that CQC aims to develop ongoing monitoring processes through its new Insight tool, it is not clear to us whether there is enough capacity to avoid potential risks to patient safety and to act promptly in the face of sudden change.

We therefore continue to oppose the reduction in the scope and frequency of inspections. This should be seen in the context of our position on funding for inspection and regulation: we do not agree with cuts in resources available for regulation and inspection, and we know from our frequent contacts with the public that there is a strong and consistent desire for more regulation, not less.

We do welcome the fact that reports will be made more accessible to the public and aim to give them a better understanding of what they can expect from their local care services.

- *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.)*

Neither agree or disagree.

- *8b Please give reasons for your response.*

When it comes to inspecting and reporting on a practice's safeguarding arrangements, we believe it is important that adult safeguarding remains a key element of GP practice

inspections. Our regular contact with older people has shown that some of them find it hard to disclose abuse and neglect, for a variety of reasons, and their GP or practice team can be a vital point of contact in identifying concerns. Therefore we would recommend that comprehensive inspections continue to assess differences in quality between population groups when it comes to adult safeguarding.

- *9a Do you agree with our proposal that the majority of our inspections will be focused rather than comprehensive?*

Disagree.

- *9b Please give reasons for your response.*

See 7b above.

- *10a Do you agree with our proposed approach for regulating the following services?*

- *i. Independent sector primary care*

Neither agree or disagree.

- *ii. NHS 111, GP out-of-hours and urgent care services*

Agree.

- *iii. Primary care delivered online*

Strongly agree.

- *iv. Primary care at scale*

Agree.

- *10b Please give reasons for your response (naming the type of service you are commenting on).*

***Primary care delivered online***
Age UK welcomes the inclusion of online primary health providers as an area of focus. There have been concerns from practitioners on the ground about the availability of sedatives, sleeping disorder medication and strong painkillers through these services, including concerns about inappropriate administration of these medications due to a lack of adequate oversight. While there is no clear picture of the impact of such services yet, we hope that CQC's regulation of this sector and a robust oversight will help prevent inappropriate and unsafe practices.

### *2.2 Adult social care services*

- *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?*

Agree.

- *11b Please give reasons for your response.*

Age UK broadly welcomes the changes. Promoting a single shared view of quality is a positive step as there is currently a wide range of approaches to quality used by service providers and this can lead to unwarranted variations between areas. However, it remains to be seen how a consensual, shared view of quality will be able to deliver tangible improvements on the ground at a time when social care is in crisis.

We have serious concerns about the limited number of '*outstanding*' care services and the persisting issues of service improvement, as identified in CQC's recent *State of adult social care services 2014-2017* report. The ability of CQC to 'speak truth to power' must remain, and they should be empowered to speak out about the impact of national policy on service delivery.

The Local Government and Social Care Ombudsman also has a significant role to play in the monitoring of practice, and we have welcomed the reports it has produced on systemic issues such as abuse of top-up fees. However, these reports do not have their full impact if there is nobody charged with monitoring the outcome on the market as a whole. We would like to see ownership of such a role formally identified with CQC, capitalising on the new CQC Insight model.

When it comes to proposals around monitoring quality, it will be important to ensure that all stakeholders work in partnership when concerns emerge. Care Act and NHS Continuing Healthcare reviews as well as safeguarding, Deprivation of Liberty Safeguards applications (or lack thereof) can also assist in developing the wider picture. As well as collecting online information from the provider, CQC should involve Experts by Experience to understand the realities of care provision on the ground from a person-centred perspective (see 6b). As highlighted previously, CQC will need to ensure that it invests in data management systems and capability that can provide the right data to identify emerging trends and enable responses to new and existing concerns.

- *12a Do you agree with our proposed approach to inspecting and rating adult social care services?*

Disagree.

- *12b Please give reasons for your response.*

Age UK broadly supports the new approach, however, as highlighted in response to proposals for primary medical services, we have concerns over extending the period between inspections for good and outstanding services. Two and a half years/three years can be a long time and services can deteriorate. Thus, a family visiting the CQC website to find a care home will have no guarantee they will find recent information about the quality of care in their area. They may find making a choice particularly difficult, at a time when imbalances in the information available to the public are still high. This is especially problematic if a service changes the organisation within which it sits or changes its registered manager. While we do recognise that section 1a will hopefully ensure that large groups take responsibility at the top, any significant change should prompt an earlier inspection to ensure that it is maintaining standards.

Similarly, we know, from CQC's recent *State of adult social care services 2014-2017* report that *'not all services that were originally rated as good maintain quality',* and that when they were re-inspected, over a quarter (26%) of them received a lower rating. This suggests that the sector continues to be fragile and that services can struggle to maintain high-quality care. Unless there is a clear demonstration that a robust monitoring and quick response mechanism is in place, we fear that the increase in the period between comprehensive inspections, with seemingly little guarantee that focused inspections may take place in the meantime, may pave the way for more unsafe, inadequate care. The recent *Times* story about the failure by CQC to act quickly following reports of a serious assault in a care home further highlights the need for robust monitoring and response mechanisms to be in place[2].

- *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?*

Agree.

- *13b Please give reasons for your response.*

Firstly, we believe the removal of the '*six-month limit*' is a positive step as anything that can help get a real-time understanding of the quality of a service is to be encouraged.

Secondly, we are pleased that CQC is developing a more extensive *'toolkit'* for inspectors that will include methods for gathering additional information from home care providers, service users and their families, and other stakeholders. Gathering views from service users should always be a priority and anything that helps to improve the quality of this input is welcome. Given that older people are the largest demographic group using adult social care services, Age UK would welcome joint development work in this area.

[2] *The Times, "*CQC covered up suspected rape in care home", 27 July 2017

- *14a Do you agree with our proposed approach for services which have been repeatedly rated as requires improvement?*

Agree.

- *14b Please give reasons for your response.*

While we agree with the overall approach for regulating services which have been repeatedly rated as *'requires improvement'*, we feel this is an area where the views of service users and support networks are essential. They can provide insights into the everyday aspects that can make a service work or fail. We strongly believe that older people in services with repeated failings must be understood as an asset and as key stakeholders. There is also value in engaging with Experts by Experience to understand what is happening and what needs to change (see our response to 6b).

We also think there should be further consistency and transparency in defining '*requires improvement'* ratings and in taking enforcement action. If a provider has repeatedly failed to meet the minimum standards of care required then an escalation should happen and accountability held throughout the management and leadership structure. However, it must be done against a backdrop of consistency not subjectivity. One provider's *'requires improvement*' could be 'simply' a failure to provide adequate information, whereas another provider's '*requires improvement'* could mean several breaches to regulation. We therefore believe that this move must go hand in hand with tightening up of what a *'requires improvement'* rating means, as well as clarifying the timescales for CQC enforcement action to be taken. As such, we welcome the proposal to be more transparent with the public when it comes to publishing sooner the details of enforcement action taken. However, in light of the serious assault incident mentioned in question 12b and recently covered in the media, it is the enforcement action itself that should also be seen as taking place sooner.

## *PART 3: FIT AND PROPER PERSONS REQUIREMENT*

- *15a Do you agree with the proposal to share all information with providers?*

We strongly agree with the proposal to share all information. We expect that all providers will take all concerns raised seriously, and take care that issues which may appear less important are considered where they may indicate deeper, underlying problems. Some instances of mismanagement may be hard to prove given that some organisations may cover up the reasons for a Director's exit. However, in the long run, this could encourage providers to become more rigorous in their recruitment of directors, and therefore can only be a positive move.

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

Yes, we believe this might increase costs due to the possibility of more investigations for a provider, but we would argue that any extra cost is entirely proportionate to the risk to service users.

However, we are also clear that we don't want to see additional costs passed on to residents/service users. As such, we believe CQC and Government should recognise these potential extra costs, which should be reflected into funding allocations.

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

We agree with the proposed guidance set out in Annex A of the consultation document, although we remain concerned that CQC may not have adequate capacity to monitor whether it is complied with. We would welcome assurances around its monitoring and enforcement.

In addition, we would like to suggest a number of changes to the guidance:

- Paragraph 1.4 should also include *'f) Does not have commercial or clinical conflicts of interest that are at odds with the primary purpose of the service'*
- Paragraph 2.7 could be expanded to reiterate more strongly the point that instances of misconduct and mismanagement, although not '*serious*' individually, may amount to serious misconduct and mismanagement if repeated over a period of time.
- With regard to paragraph 2.9, which refers to a *'failure to follow agreed policies or processes when undertaking management functions where the failures had limited repercussions or limited effects, or were for a benevolent or justifiable purpose'*, we believe that the potential seriousness of a failure should be taken into account. Indeed, a failure may have been potentially serious, such as management of medications, but have limited repercussions.
- Paragraph 2.10 should include any actions which result in a referral to the Disclosure and Barring Service, any safeguarding concerns where someone's actions have been found to cause abuse or neglect.

In addition, the focus throughout Annex A (presumably for brevity) is just on directors rather than also on people performing '*functions equivalent*' to a director. The term '*shadow directors'* is used in the guidance, and '*director level responsibility'* on the CQC website. This introduces a certain level of ambiguity. We suggest that it would be more helpful to refer more consistently to one term or another, or indeed whether another term

might be more helpful, e.g. persons of '*significant influence'* (assuming this is an accurate reflection of the law). Throughout the guidance it should be reiterated that the fit and proper regulations also apply to those performing equivalent functions.

Finally, in Annex A it is suggested that enforcement applies only reactively (on receipt of information) or in the case of a new aspirant registrant. We think CQC should consider how it can take a more proactive approach to ensuring that this regulation continues to be complied with, rather than relying mainly on the initial registration or on receipt of information.