ADULT SERVICES COMMITTEE AGENDA

Thursday 27 July 2017

10.00 am

Committee Room B,
Civic Centre, Hartlepool

MEMBERS: ADULT SERVICES COMMITTEE

Councillors Beck, Hamilton, Hind, Loynes, McLaughlin, Richardson, and Thomas.

1. **APOLOGIES FOR ABSENCE**

2. **TO RECEIVE ANY DECLARATIONS OF INTEREST BY MEMBERS**

3. **MINUTES**

   3.1 To receive the Minutes and Decision Record in respect of the meeting held on 22 June 2017 *(for information as previously circulated)*.

4. **BUDGET AND POLICY FRAMEWORK ITEMS**

   No items.

5. **KEY DECISIONS**

   No items.

6. **OTHER ITEMS REQUIRING DECISION**

   6.1 Care Quality Commission State of Care Report and Consultation: Next Phase of Regulation – *Director of Child and Adult Services*

6.2 Transport for People with a Disability – Action Plan Update – *Director of Child and Adult Services*

7. **ITEMS FOR INFORMATION**

7.1 Commissioning Award for Integrated Approach to Hospital Discharge – *Director of Child and Adult Services*

7.2 Care Quality Commission: Appreciative Review Programme – *Director of Child and Adult Services*

7.3 Fire Safety in Residential Care Homes – *Director of Child and Adult Services*

8. **ANY OTHER BUSINESS WHICH THE CHAIR CONSIDERS URGENT**

FOR INFORMATION

Date of next meeting – Thursday 14 September 2017 at 10.00am in the Civic Centre, Hartlepool

ADULT SERVICES COMMITTEE

MINUTES AND DECISION RECORD

22 JUNE 2017

The meeting commenced at 10.00 am in the Civic Centre, Hartlepool

Present:

Councillor Stephen Thomas (In the Chair)

Councillors: Lesley Hamilton, Brenda Loynes and Carl Richardson (Vice-Chair).

Also Present: Councillor Dave Hunter as substitute for Councillor Paul Beck in accordance with Council Procedure Rule 5.2.

Daniel Maddison, Hartlepool and Stockton-on-Tees Clinical Commissioning Group.

Frank Harrison, Years Ahead Forum
Members of the Public – Evelyn Leck, Sue Little, Gordon and Stella Johnston.

Officers: Sally Robinson, Director of Child and Adult Services
Jill Harrison, Assistant Director, Adult Services
Neil Harrison, Head of Services
Alastair Rae and Oliver Brewis, Public Relations Team
David Cosgrove, Democratic Services Team

1. Apologies for Absence

Councillors Paul Beck and Mike McLaughlin.
Judith Gray, Hartlepool HealthWatch.

2. Declarations of Interest

Councillor Stephen Thomas declared a personal interest as an employee of Hartlepool HealthWatch.

3. Minutes of the meeting held on 2 March, 2017

Confirmed.

4. Hospital Discharge Update (*Director of Child and Adult Services*)

Type of decision

For information.

Purpose of report

The purpose of the report was to provide the Adult Services Committee with an update in relation to hospital discharges and delayed transfers of care.

Issue(s) for consideration

The Assistant Director, Adult Services reported that following this issue being raised at the Health and Wellbeing Board, there had been a consideration of Delayed Transfers of Care by the Audit and Governance Committee.

The report to the Audit and Governance Committee on 23 March 2017 identified that, while the very challenging target within the Better Care Fund plan was not being achieved, local data showed a significant improvement in performance in recent months.

The Assistant Director highlighted that the number of delays reported in the week commencing 6 March 2017 was three for Hartlepool; the lowest number of delays since this measure was introduced. Of these three, one was a lengthy delay relating to a patient choice issue; the other two were short delays while people were waiting for Pre Admission Assessments to be undertaken by their chosen care home.

The position was expected to improve further over the next six to twelve months with one new care home operational from May 2017 and another planned development early in 2018. The new Rossmere Park Care Centre had significantly increased availability of both residential and nursing care beds within Hartlepool and would reduce reliance on out of area placements for those people who wish to stay within Hartlepool.

Members welcomed the news of the reduction in delays. A Member reported experience with patients being told that they could leave hospital on a morning but not being able to leave until early evening due often to delays in receiving prescribed medication. The Assistant Director indicated that such delays would not be included within these statistics as delays on day of discharge are not captured in this measure. It had been acknowledged previously that shorter delays,

such as these need to be addressed.

The Chair commented that Healthwatch had noted a trend around these delays and would be undertaking some additional work on this issue. The Chair also considered that some additional work around admissions was warranted as with some additional support, fewer elderly residents in particular, may need to be admitted to hospital in the first place. The Assistant Director confirmed that work on admission avoidance was being undertaken under the remit of the Better Care Fund.

Decision

That the report be noted.

5. Update: Care Homes for Older People (*Director of Child and Adult Services*)

Type of decision

For information.

Purpose of report

To provide the Adult Services Committee with an update in relation to care home provision for older people.

Issue(s) for consideration

The Assistant Director, Adult Services provided an update on the situation in relation to care homes for older people in Hartlepool highlighting the following key points: -.

- Rossmere Park Care Centre successfully opened for residents on 22 May with an official opening planned in late June.
- Since the last report officers had been working closely with providers, managers and staff to implement any actions required from the various Action Plans. The home rated as Grade 3 in the Council's Quality Standards Framework had been allowed a three month period to make required improvements and the Assistant Director was pleased to report at the meeting that the home had been re-assessed and achieved Grade 2, which now meant that all homes in the town were rated Grade 1 or 2.
- A summary of current CQC ratings was submitted which showed that two homes had recently been re-inspected and rated as 'Requires Improvement'.
- Work was continuing on the redevelopment of the Admiral Court

Care Home by a new provider.

- Regular discussions with proprietors and managers continue and there is good engagement from care home providers. These sessions continue to have an excellent attendance rate and feedback regarding relevance is good.
- Since the last update report North Tees and Hartlepool Education Alliance had been launched. This was a partnership approach between Hartlepool Borough Council, Stockton-on-Tees Borough Council, Hartlepool and Stockton on Tees CCG, North Tees and Hartlepool NHS Foundation Trust, Tees Esk and Wear Valley Foundation Trust and Alice House Hospice to provide a range of training for care homes.

The Chair indicated that he had visited the recently opened Rossmere Park Care Centre and commented that it was a very welcome new facility for the town. The Chair encouraged other Members of the Committee to take the opportunity to visit the home when its official opening took place on 27 June. The Chair also welcomed the increase in both residential and nursing beds in the town which showed a significant improvement over the situation over the past 12 to 24 months ago and showed what could be achieved through working with existing and new partners.

The Chair did express a slight concern at the cascading down of training to staff through organisations/homes, particularly in areas such as dementia awareness. The Chair suggested that this was an issue that should be discussed at the next Managers Forum. The Assistant Director indicated that she would include the matter on the agenda for the meeting. Members commented that a similar situation appeared to exist in hospitals.

In light of the recent Grenfell Tower tragedy, Members sought assurance that appropriate fire safety measures existed in residential and nursing care settings throughout the Borough. Officers stated that all homes had to have regular fire safety checks and hold appropriate fire safety certification to maintain their registration. It was unknown if any of the homes had a sprinkler system in place, or whether this was a requirement in current regulations, as this would potentially be linked to age of the building.

The Chair requested that an update report be submitted to the Committee in the near future setting out the current requirements and the actual picture within homes in the borough for the Committee's information. Members of the public referred to concerns expressed in the past when residents with dementia were housed on the first or upper floors of premises which could prove difficult to evacuate should there be a fire. Concern was also expressed regarding situations when elderly and infirm patients had to be evacuated and lifts would be unavailable. The Assistant Director advised that homes were required to have evacuation plans in place for all residents, regardless of where

they lived within the building. The Assistant Director also advised that care homes were regulated by the Care Quality Commission who assess compliance with health and safety requirements, and confirmed that health and safety issues are also addressed in the Council's Quality Standards Framework.

The Vice-Chair sought details of how the ratings of homes in Hartlepool compared with other neighbouring authorities. The Assistant Director commented that only the CQC ratings could be compared; the Quality Standards Framework rating was a Hartlepool only assessment. There was also a time lag in up-to-date CQC ratings being published. Comparison information will be included in future routine update reports when available. The Chair reported that officers were visiting one of the few residential care homes locally that had an 'outstanding' CQC rating to assess firsthand what that actually meant, though it was anticipated that the level of fees paid by residents may be a factor.

Decision

1. That the report be noted.
2. That a report be submitted to a future meeting setting out the current fire regulation requirements for residential and nursing care homes and the existing standards within Hartlepool homes.

6. Direct Care and Support Services – Outcome of CQC Inspection (*Director of Child and Adult Services*)

Type of decision

For information.

Purpose of report

To inform Adult Services Committee of the outcome of a recent Care Quality Commission (CQC) inspection into the Direct Care and Support Service provided by Hartlepool Borough Council.

Issue(s) for consideration

The Head of Service reported that the Direct Care and Support Service, based at the Centre for Independent Living was registered with the CQC and regulated by the Health and Social Care Act (Regulated Activities) Regulation 2014.

The Direct Care and Support Service (Hartlepool) is a domiciliary care service which provides reablement support, a 'telecare' response

services and an emergency respite care service for family carers to over 2,000 people in the Hartlepool area.

The CQC undertook an inspection of the Direct Care and Support Service provided by Hartlepool Borough Council on 10, 16 and 17 February 2016 and rated the service as 'Requires Improvement' in three of the five domains and 'Requires Improvement' overall.

An action plan was implemented to address the issues identified by the CQC, and to deliver the required improvements and the CQC had undertaken a re-inspection of the service on 25 April, 26 April and 5 May. The re-inspection report gave all the domains a 'good' rating and the service overall was also declared 'good'.

The Head of Service recorded his thanks to the Healthwatch team that had assisted with a pre-inspection report and also the Council's own Commissioned Services Team for their assistance in supporting the service to deliver the required improvements. The Chair echoed the comments and requested that the Committee's congratulations be extended to all the staff involved for the improvements made to the service.

Members and members of the public present highlighted the general compliments that the service received from people who have used the service, which reflected the efforts of the dedicated staff team.

Decision

1. That the inspection report and the improvements that have been delivered be noted.
2. That the Committee's congratulations be extended to all the staff in the service thanking them for the improvements made.

7. Transforming Care – Respite Services Review Update (*Director of Child and Adult Services*)

Type of decision

For information.

Purpose of report

To update the Adult Services Committee on the review of health funded respite care for adults with a learning disability and complex needs linked to the wider Transforming Care agenda.

Issue(s) for consideration

The Head of Service reported that Hartlepool and Stockton-on-Tees Clinical Commissioning Group and South Tees Clinical Commissioning Group (the CCGs) had been requested to review existing respite care services for adults with a learning disability in relation to the intentions of the national Transforming Care agenda. The review focused on health respite services for people with learning disabilities and complex needs in the CCG areas. This was to ensure that these services appropriately meet the needs of the population now and into the future.

Work had been undertaken to map respite services currently available, commissioned directly by the CCGs, by Local Authorities and by other means. Analysis of capacity and activity within service settings had been undertaken in significant detail to enable a robust understanding of the current operation of the NHS respite services.

Stakeholder engagement activities had been undertaken by local voluntary community sector organisations and had sought views and involvement from approximately 120 individuals across the two CCG areas. In addition 86 completed parent-carer surveys had been received.

There were currently 43 people from the Hartlepool and Stockton-on-Tees localities regularly accessing services at Aysgarth, Stockton, two of these were from Hartlepool. There are 3 young people (Stockton) who would reach 18 in the next four years who currently access bed based short break respite services at Baysdale, Roseberry Park and who were likely to need similar types of support into their adulthood and who would be likely to be referred to Aysgarth (based on geographic location). There were 60 children and young people known to Hartlepool Borough Council's Transitions Teams who will reach 18 in the next four years who may have respite needs into the future.

In terms of the stakeholder engagement activities, the Head of Service reported that four engagement activities took place in Hartlepool, held at Café 177 and Place in the Park on separate dates, with a total of 29 people being spoken to about their experiences and views of respite now and in the future. The people involved in these conversations were a mixture of parents, families and carers as well as people who use (or who may use) services. A parent carer survey has been developed and circulated to relevant individuals who are currently using NHS provision or who have been identified as being stakeholders in the service.

The information, research on other models, market engagement and informal engagement findings had been utilised to develop a number of possible options for the provision of health respite services for people with learning disabilities and complex needs in the future. Further development work was required to articulate in detail what the options

might look like and it was the intention that these would be developed with individuals, families and parent carers as part of ongoing engagement and consultation opportunities.

The representative from Hartlepool and Stockton-on-Tees Clinical Commissioning Group added that there was a detailed work plan behind the consultation process and financial modelling work was also being undertaken on the options for the future. No changes to any services would be made until there was full assessment of the implications. While the numbers did look low for Hartlepool, residents had access to a wide variation of 'respite' services, mainly through personal budgets, and this was a model that may be extended to other areas.

Members were concerned that demand may be out-stripping supply. The Head of Service indicated that the model in Hartlepool was based around the use of personal budgets so people had the ability to tailor their respite to their own needs, whereas in other areas, short breaks were largely provided through building based services. The Assistant Director highlighted that this report specifically related to a service to people with learning disabilities and other complex needs who require health respite. The Council commissioned a building based short break service at Greenfields Lodge but also supported a large number of individuals with learning disabilities to access short breaks tailored to their needs using a personal budget. This could include weekends away, longer holidays and accessing other interests outside their home. Members should not read from the report that only two Hartlepool residents with learning disabilities access respite as this is not the case.

The Director clarified that the term 'respite' is not helpful, and is no longer used in Children's Services. The term 'short breaks' is more representative of the way that services are now used in a planned way as part of a wider plan to meet an individual's care and support needs. There were occasions when a short break (or 'respite') was needed in an emergency situation and this was commissioned within the Greenfields Lodge service.

The meeting briefly discussed the assessment of children and young people with learning disabilities and other complex needs and eligibility criteria.

The Chair commented that the Transforming Care agenda was still developing and it would be worthwhile the Committee receiving an update report in six months time. It was reassuring to hear that Hartlepool residents were not experiencing difficulty accessing short breaks in general. The Chair did feel that the approach taken by Children's Services in referring to such services as short breaks was a direction that Adult Services may wish to adopt.

Decision

1. That the report be noted.
2. That a report be submitted to a future meeting in around six months time updating the Committee on developments in the Transforming Care agenda.

8. Disabled Facilities Grants (*Director of Child and Adult Services*)

Type of decision

For information.

Purpose of report

To provide the Adult Services Committee with an update regarding Disabled Facilities Grants and progress that had been made to reduce waiting times.

Issue(s) for consideration

The Assistant Director, Adult Services reported that at the time of the last report to Adult Services Committee in December 2015, the average waiting time for a DFG, from referral to completion of the work, was 207 days, and there had been 183 DFGs completed in the past 12 month period.

As at end of March 2017, the waiting list had reduced significantly from 110 at the end of 2015/16 to 48. The average waiting time for a DFG had also reduced significantly to 189 days, when previous average waiting times of 346 days had been reported. This improved performance has been achieved through additional investment in DFGs from the Better Care Fund Pooled Budget.

DFGs were available to both children and adults based on the national criteria. In the financial year 2016/17 213 DFGs were completed, comprising 235 adaptations (as some grants cover multiple adaptations to the same property). 224 of these (95%) were for adults and 65% of the total DFGs in 2016/17 were provided to people aged 65 and over.

The Chair welcomed the update report as excellent progress in improving the situation for people requiring adaptations via a DFG. A Member questioned the requirement that “the owner or tenant of the property [and] intend to live in the property for the period of the grant (five years)”; and what would happen should the service user die within

that period. The Assistant Director indicated that the specific condition was to ensure that significant works were not undertaken in a property when the recipient of the grant intended to move home in the relatively short term. Some works could require extensive modifications to a home such as an extension or downstairs bathrooms for example.

Decision

That the report be noted.

9. Any Other Items which the Chairman Considers are Urgent

None.

The meeting noted that the date of next meeting had been changed and would now be Thursday 27 July 2017 at 10.00am in the Civic Centre, Hartlepool.

The meeting concluded at 11.05 am.

P J DEVLIN

CHIEF SOLICITOR

PUBLICATION DATE: 29 JUNE, 2017

ADULT SERVICES COMMITTEE

27 July 2017

Report of: Director of Child and Adult Services

Subject: CARE QUALITY COMMISSION STATE OF CARE REPORT & CONSULTATION RE: NEXT PHASE OF REGULATION

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1. TYPE OF DECISION/APPLICABLE CATEGORY

Non key decision.

2. PURPOSE OF REPORT

2.1 To provide the Adult Services Committee with information regarding the Care Quality Commission's consultation on the next phase of regulation, and to give the Committee an opportunity to inform the Council's response to this consultation, which is attached as **Appendix 1**.

3. BACKGROUND

3.1 The Care Quality Commission's Strategy for 2016 to 2021: Shaping the Future, was published in May 2016 and set out a vision for a more targeted, responsive and collaborative approach to regulation, so that more people get high-quality care. The changes set out in the strategy impacted on a wide range of the work that the Care Quality Commission (CQC) does as a regulator and, using the principles in the strategy and the learning from inspections so far, the CQC is undertaking further consultation about how the regulatory model develops.

3.2 Between December 2016 and February 2017, the CQC consulted on how it should develop and evolve its approach as it implemented the vision and moved into the next phase of its regulatory approach. This consultation focused on: the principles for regulating new models of care and complex providers; changes to the assessment frameworks; strengthening the guidance on registering services for people with a learning disability; and changes to the way the CQC regulates NHS trusts.

The consultation generated 496 responses from a range of stakeholders and the feedback produced a number of themes across the consultation. These included: the need to ensure clarity, consistency and transparency in implementing the changes; flexibility in approach; proportionate regulation; and closer and more collaborative working with other organisations at local and national level (including involving the public in holding services to account through partners such as Healthwatch).

The full consultation response can be found at www.cqc.org.uk/nextphase1.

3.3 In June 2017 the CQC published a report; 'The state of adult social care services 2014 to 2017: Findings from CQC's initial programme of comprehensive inspections in adult social care'. This report is attached as **Appendix 2**. The report summarises the findings from inspections of adult social care over the last three years, what the sector can learn from those findings and how services have improved, while also considering how poor quality care is tackled and the next steps for regulation.

3.4 The report concludes that high-quality services exist in adult social care, which is positive and to be celebrated, but the variability in services means that too many people are experiencing care that does not meet the 'Mum Test'. The report highlights the difficulties that some providers experience in making improvements and also that some services have deteriorated following initial inspection which points to a fragility in the sector that needs to be addressed. The CQC wants more services to improve so that people's experiences of care continue to rise and for people to be aware that quality is the responsibility of everyone involved in adult social care.

3.5 Alongside this report, a second stage consultation was launched on 12 June 2017 which runs until 8 August 2017. This consultation is focused on how the CQC proposes to:

- regulate primary medical services and adult social care services;
- improve the structure of registration, and clarify definitions of registered providers;
- monitor, inspect and rate new models of care and large or complex providers;
- use their unique knowledge to encourage improvements in the quality of care in local areas; and
- carry out their role in relation to the fit and proper persons requirement.

The consultation document is attached at **Appendix 3**.

4. PROPOSALS

4.1 The consultation sets out some general proposals in relation to:

- registration and accountability (Questions 1 and 2);
- monitoring and inspecting complex providers (Question 3);
- provider level assessment (Question 4); and
- encouraging improvements in quality of care in a local area (Question 5).

4.2 The element of the consultation that relates specifically to adult social care services (see **Appendix 3** pages 47-54) identifies that 'Since October 2014, the CQC has found the quality of care in adult social services to be variable. At the beginning of May 2017, 77% of services were rated as good and just 2% rated as outstanding. The CQC has also found that their ability to influence improvement has been mixed. Over three quarters of services rated inadequate improved on re-inspection, but for services that require improvement the picture is less encouraging, with 38% remaining unchanged on re-inspection and 5% getting worse'.

4.3 The proposals for regulation of adult social care services are summarised by the CQC as aiming to strengthen the use of information and relationship management to support a more responsive and targeted approach to inspection. There will be an increased focus on providers that are unable to sustain improvement, and on recognising providers that have improved but have not yet managed to achieve a better rating.

The CQC proposes to:

- implement a more consistent approach to working with providers and stakeholders to understand quality of care and encourage improvement;
- introduce an online provider information collection and share information with key stakeholders;
- develop a new CQC Insight model that brings together information about all the locations of a provider to help inspectors see the broader context for performance;
- increase the period between comprehensive inspections for services rated as good and outstanding, as our monitoring improves;
- make more use of focused inspections, which will always include an assessment of the well-led key question;
- remove the 'six month limit', which only allows them to change an overall rating if a focused inspection is carried out within six months of the last comprehensive inspection;
- extend the time in which to gather views about the quality of services that provide care to people in their own homes; and
- increase focus on services rated as requires improvement to drive improvement.

4.4 The consultation poses questions in relation to adult services in the following areas:

- monitoring (Question 11);
- inspection and rating (Question 12 and 13); and
- taking action to improve care (Question 14).

4.5 The final two general questions in the consultation (Questions 15 and 16) relate to fit and proper persons requirements.

4.6 It is proposed that the Council responds to the consultation and that the Adult Services Committee provides views on the draft response prepared by officers.

4.7 Information regarding the consultation has also been shared with the Audit & Governance Committee in relation to the regulation of health services. Questions 6-10 relate to the regulation of primary medical services and have therefore not been included in the draft response in respect of adult services.

5. RISK IMPLICATIONS

5.1 There are no risk implications associated with this issue.

6. FINANCIAL CONSIDERATIONS

6.1 There are no financial considerations associated with this issue.

7. LEGAL CONSIDERATIONS

7.1 There are no legal considerations identified.

8. CHILD AND FAMILY POVERTY CONSIDERATIONS

8.1 There are no identified child and family poverty considerations.

9. EQUALITY AND DIVERSITY CONSIDERATIONS

9.1 There are no equality and diversity considerations identified.

10. STAFF CONSIDERATIONS

10.1 There are no staff considerations identified.

11. ASSET MANAGEMENT CONSIDERATIONS

11.1 There are no asset management considerations identified.

12. RECOMMENDATION

12.1 It is recommended that the Adult Services Committee reviews the CQC consultation document and provides views on the draft response, to inform the final response that is submitted on behalf of Hartlepool Borough Council.

13. REASONS FOR RECOMMENDATIONS

13.1 The Adult Services Committee has oversight of adult social care services that are regulated by the CQC.

14. CONTACT OFFICER

Jill Harrison
Assistant Director – Adult Services
Hartlepool Borough Council
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DRAFT CONSULTATION RESPONSE FOR CONSIDERATION:

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?
This proposal will increase transparency and accountability for care delivery, which is to be welcomed. Where there are multiple providers within a group, the proposed changes will ensure that action can be taken across all services / providers where appropriate, while still allowing for very focused local action when this is needed. Clarity about accountability following a change in ownership or change in address is also important so that the history of a service is not lost.

1b: What are your views on our proposed criteria for identifying organisations that have accountability for care?
The proposed criteria capture key areas and would be supported. Applying the criteria to those who are deemed to exert significant influence seems logical and proportionate.

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?
Type of service provided, who it is provided to and any exclusions.
Whether the service is building based (single or multiple sites) or delivered in the community.
Whether the service is part of a group and linked to other services.

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?
Agree

3b: Please explain the reasons for your response.
As provision becomes more complex and providers work across a range of sectors, this will provide a useful tool to map the full range of service areas in which a provider operates. The ability to combine monitoring information across service areas will be helpful in ensuring that the whole picture is considered when services are regulated.

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?
A provider-level assessment for corporate providers of health and social care services, will improve accountability at the highest level, particularly when several services are rated as requires improvement or inadequate and there are potentially serious concerns about the provider's corporate approach. The assessment will need to take into account management structures and use of resources within the organisation and focus on a consistent quality assurance framework.

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

5b: How could we regulate the quality of care services in a place more effectively?
Develop and maintain closer working relationships with commissioners and providers, as well as Healthwatch organisations, to make use of local intelligence and better understand the context and culture within local communities.

NOTE: QUESTIONS 6 – 10 HAVE NOT BEEN INCLUDED IN THIS RESPONSE AS THEY RELATE TO THE REGULATION OF PRIMARY MEDICAL 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?
Strongly agree

11b: Please give reasons for your response.
The proposed approach will allow providers to update their information on a more regular basis, which will enable changes that occur between inspections to be captured more systematically. Sharing of the information with Local Authorities, as key stakeholders, will enhance local intelligence and enable commissioners to be more responsive.

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

12b: Please give reasons for your response.
The proposals allow increased flexibility to use timescales proportionately, which would be welcomed - particularly the ability for a focused inspection to change the overall rating outside of the current six month window. The proposal to continue re-inspecting services that are inadequate every six months, and those that are rated as requiring improvement every year, is supported as it promotes a continuous drive to improve the quality of care and ensures that providers maintain a focus on making and sustaining improvements. The opportunity for concerns to be highlighted outside of routine inspection timeframes, that may then lead to an inspection, needs to be maintained to reflect the fact that events (such as a change in Registered Manager or a rapid increase in occupancy or complexity of residents) can have a significant impact on a service in a short space of time.

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

13b: Please give reasons for your response.
This change in approach will enable people who receive regulated care services in their own homes to make a meaningful contribution to the regulation process. It is vital that this is facilitated for people who wish to contribute, including making

arrangements to support people to do so, e.g. through use of advocates or engaging with family members when people do not have capacity to participate themselves.

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.
The proposal to share examples of good practice is very positive and would be welcomed. This would give CQC a role in relation to provider support and development, which would enhance local arrangements that facilitate joint working and sharing of best practice. It would be particularly helpful if this included a focus on leadership and training, as this could provide valuable links to local initiatives to support and develop the care workforce.

The work with the Department of Health regarding increased transparency when enforcement action is being taken is strongly supported. Local experiences of managing such situations within the current regulatory framework have been very challenging, because it has not been possible to be fully open and transparent with individuals and family members when serious concerns have been raised and enforcement action is being undertaken, which massively impacts on their lives.

15a: Do you agree with the proposal to share all information with providers
Agree

15b: Do you think this change is likely to incur further costs for providers?
It appears that it is unlikely to incur unreasonable additional costs.

16a: Do you agree with the proposed guidance for providers on interpreting what is meant by “serious mismanagement” and “serious misconduct”?
The guidance, by definition, cannot cover all eventualities but it would be helpful if the examples given under 2.10 could be defined as either ‘serious mismanagement’ or ‘serious misconduct’ so that there is a clearer definition between the two.

CareQuality Commission

The state of adult social care services 2014 to 2017

Findings from CQC's initial programme of comprehensive inspections in adult social care

STATE OF CARE

Our purpose

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can

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Foreword from the Chief Inspector

In my first month in post in October 2013, I wrote:

> *"To make sure that our regulatory approach is truly personalised I want us to consider for every service we look at – is this good enough for my Mum (or any other member of my family)? If it is, that is fantastic. If it's not then we need to do something about it."*

The 'Mum Test' has guided our work ever since. I wanted CQC's regulation and indeed, the commissioning and provision of adult social care, to be truly personalised and firmly focused on the people receiving it. After extensive co-production, engagement and testing, CQC formally rolled out its new inspection framework for adult social care in October 2014, when, for the first time, we rated services as outstanding, good, requires improvement or inadequate. By February 2017, we had inspected all adult social care services registered with us in October 2014 – many more than once. That's more than 33,000 inspections of around 24,000 different locations, including care homes, care in people's own homes, Shared Lives schemes and supported living services.

What have we found? Are adult social care services meeting the Mum Test? When we choose care for ourselves or our loved ones, can we be confident that it is safe, effective, caring, responsive to our needs and well-led? The wealth of information gathered from our inspections means that the picture of adult social care – its successes, its failures and the challenges ahead – is clearer. I can say that most of the adult social care sector is meeting the Mum Test, providing safe and high-quality care that we would be happy for anyone we love, or ourselves, to receive.

Over three-quarters (77%) of adult social care services are good – this should be and is celebrated. These are services with leaders who inspire a positive culture focused on providing person-centred care – treating people as people and not just as recipients of care. These leaders motivate, develop and value their staff who work tirelessly and skilfully to support people to live their lives to the full, with dignity and respect. The lives of people using adult social care can be transformed or their final days remembered for the care and compassion they and their families and carers experienced.

However, quality across England is undeniably variable. We have completed our initial comprehensive inspection programme with only 2% of services being rated as outstanding. While we make no apology for setting the bar high, this is considerably lower than we originally expected. It is clear that it is more difficult to achieve this highest standard of quality.

And there is too much poor care: 2% of services are currently rated as inadequate, and 19% of services are rated as requires improvement and are struggling to improve. Through our inspections, we have seen examples of unacceptable care, occasionally resulting in actual harm to people using services.

This is awful for people receiving this care, as well as their families and carers. But it also undermines the public's confidence in the sector as a whole – a sector that we are becoming increasingly reliant on as our population ages and people's needs at all ages become more complex.

Quality regulation is playing its part to ensure people receive the safe, high-quality and compassionate care they have every right to expect. We can see that many providers are responding to our concerns and rising to the challenge. Eighty-one per cent of services rated as inadequate improved their overall rating following re-inspection, which is testament to the commitment of staff to deal with problems and achieve better care. In particular, we have found that having a committed and consistent registered manager can have a big influence on the quality of care that people receive – for example, by making sure staff have training to understand the needs of people in their care.

However, too many services are not improving or seem incapable of improving. Thirty-eight per cent retain their rating of requires improvement following re-inspection, despite knowing from our inspections what needs to change and 5% of these services had deteriorated. Not all services that were originally rated as good maintain quality. Where we have re-inspected them, usually prompted by concerns, over a quarter (26%) have received a lower rating.

In our report *The state of health care and adult social care in England* last October, we gave a stark warning that adult social care in England was 'approaching a tipping point'. This was driven by a growing and ageing population, more people with increasingly complex conditions and in a challenging economic climate a greater demand on services but more problems for people in accessing care, and further issues across the health and care sector. The risk of adult social care approaching that tipping point is still real. We will explore what effect this is having on people using services and the wider health and care landscape in our next report in the autumn.

CQC will keep its relentless focus on quality by sharing successes, identifying failings, taking action to ensure areas in need of improvement are tackled, and at all times, by being transparent and acting in the public's best interests. To achieve this, our regulation of adult social care will become even more targeted, risk-based and intelligence-driven over the next few years.

I hope people using adult social care services, their families and carers will find this report helpful and that providers, commissioners and funders, improvement bodies and the government will use our information to place quality firmly at the heart of the continuing debate about the future of adult social care. There are stories to inspire, lessons to learn and warning signals to heed. With everyone at CQC, I remain committed to shining a spotlight on quality, encouraging and recognising improvement and holding providers to account. But we cannot do it alone. Everyone must play their part in transforming adult social care and making sure that all services pass the Mum Test so that people using services, their families and carers can be confident that **quality matters** and will be delivered.

Andrea Sutcliffe
Chief Inspector of Adult Social Care

1. Introduction

In 2013, CQC set out its plans to radically transform the regulation of adult social care services. A year later, we began our new programme of comprehensive inspections, with ratings to make it easy for people to understand the quality of care and to help them choose care; a focus on identifying, highlighting and celebrating good practice; and a determination to drive improvement and hold providers to account for poor care.

Understanding the experiences of people who use adult social care services is key. They are often in very vulnerable circumstances and their care can affect every part of their lives. Social care supports older people coping with several health conditions; some are living with dementia while others may be isolated and lonely. But adult social care is not just a service for older people; meeting the needs of people with mental health issues, younger people with a disability and people with a learning disability is also very significant. People using adult social care services have different needs, aspirations and circumstances.

This incredible diversity in the adult social care sector means that personalisation is critical so that people can identify their individual needs; be empowered to take control; and make informed choices about the way they live their lives. Good services recognise this by delivering truly person-centred care.

We have now completed this initial programme of comprehensive inspections and ratings – some 33,000 in all across two and a half years. This report sets out what we found: are our adult social care services safe, effective, caring, responsive and well-led?

1.1 How we work

We register providers that apply to CQC when they are able to satisfy us that they meet the requirements.

We make intelligent use of data, evidence and information, including information shared with us by staff and people using services, their families and carers to decide when, where and what to inspect.

Our inspectors use their professional judgement, supported by objective measures and evidence, to assess services against our five key questions. Supported by people who have experience of using care services (Experts by Experience) in the majority of inspections, our inspectors use feedback from people who use services, their carers and families to inform their judgements.

We always ask the following five questions of services.

- Are they safe?
- Are they effective?

- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

We rate services to highlight where care is outstanding, good, requires improvement or inadequate. We rate services at two levels:

1. We rate each one of the five questions.
2. We aggregate these separate ratings to give an overall rating for the location.

This approach to comprehensive inspections was launched on 1 October 2014. It was developed through testing and consultation with the public, people who use services, providers and organisations with an interest in our work. We are continuing to refine our approach and in June 2017 published a new, consolidated assessment framework, which will be adopted from November 2017.

Our enforcement policy sets out what action we take to require services to improve and, where necessary, the action we take to make sure those responsible for poor care are held accountable for it.

1.2 Background to the sector

Adult social care can make a real difference to people's lives. It is the largest sector that CQC regulates, with a large number and range of providers, a strong private and voluntary sector, and wide differences in the size and types of services and care provided. The sector covers:

- accommodation and personal care provided in residential care homes, nursing homes and specialist colleges (around 16,000 locations, with the capacity to provide care for around 460,000 people)
- personal care provided in the community for more than half a million people, of which the majority is care provided in people's homes through domiciliary care services (around 8,500 services), as well as extra care housing, Shared Lives schemes and supported living services.[a]

Adult social care is estimated to contribute £20 billion to the economy[1] and employ around 1.4 million people – 5.3% of the total workforce in England[2]. It can help individuals and the families of people who need care and support to carry on working.
Adult social care services are facing a number of challenges. These include:

[a] We will be publishing a separate report later this year that looks at quality in hospice services. From 2017/18 hospices services be assessed under the healthcare assessment framework. They will therefore become part of the responsibility of the Chief Inspector of Hospitals. Hospice services are included in the data for 'all' adult social care services in this report.

- An ageing population with increasing needs.
  - The number of people aged 85 or over in England is set to more than double over the next two decades.[3]
  - More than a third of people aged over 85 have difficulties undertaking five or more tasks of daily living without assistance, and are therefore most likely to need health and care services.[4]

- Difficulties in recruiting and retaining staff to care for people.
  - In 2015/16 the overall staff vacancy rate across the whole of the care sector was 6.8% (up from 4.5% in 2012/13), rising to 11.4% for home care staff. Turnover rates have risen from 22.7% to 27.3% a year over the same three-year period.[5]
  - Potential changes to immigration policy resulting from the vote to leave the European Union could have serious consequences for the social care workforce. Around one in 20 (6%) of England's growing social care workforce are non-British European Economic Area nationals – around 84,000 people.[6]

- Rising costs of adult social care.
  - In 2015/16, the gross expenditure of all councils with adult social services responsibilities was £16.97 billion. Although this is 18% higher in absolute terms than in 2005/06, after accounting for inflation it is 1.5% lower than in that year.[7]
  - Findings from the most recent Association of Directors of Adult Social Services budget survey have estimated that the National Living Wage will cost councils around £151 million plus at least £227.5 million in implementation and associated costs in 2017/18. This will affect both direct council costs and increased provider fees.[8]

- Concerns about funding to meet these costs and a reliance on those who pay for their own care.
  - Age UK estimates that an additional £4.8 billion a year is needed to ensure that every older person who currently has one or more unmet needs has access to social care, rising to £5.75 billion by 2020/21.[9]
  - Some providers, particularly in domiciliary care, have withdrawn from local authority contracts where they felt there was too little funding to enable them to be responsive to people's needs.
  - Despite additional funding that has been made available for adult social care, only 7% of directors of adult social services are fully confident that savings targets will be met in 2019/20.[10]
  - The public have expressed concerns over the higher charges self-funders tend to pay, compared with state-funded residents. A sample of care home groups operating in 12 English counties in 2015 found self-funders pay over 40% more on a like-for-like basis.[11]

In this challenging context, CQC's role as the quality regulator is ever more important. We have to make sure that we do not compromise on the quality of care and ensure that people using services, their families and carers are at the heart of everything we do.

1.3 This report

This report looks at what we found about the quality of care across the whole range of adult social care services that we regulate.

Our report is based on more than 33,000 inspections of around 24,000 different locations published up to May 2017. It is one of a series of reports across the sectors that CQC regulates, which aim to give an in-depth review of services based on our initial programme of comprehensive inspections. We illustrate the quantitative findings from our ratings data[b] with qualitative information and examples from a sample of inspection reports.

We recognise there is fragility in the adult social care sector influenced by funding and resource pressures. But as the quality regulator, our focus in this report is on the quality of adult social care services and the impact that this has on people who use services.

[b] Although we completed our initial programme of comprehensive inspections in January 2017, we have used data extracted on 5 May to allow time for inspection reports and ratings to be published.

2. What have we found in our inspections?

Key points

- At the end of our initial comprehensive inspection programme, almost four out of five adult social care services in England were rated as good or outstanding overall. Nearly a fifth of services were rated as requires improvement. We are particularly concerned about the 343 locations (2%) that were still rated as inadequate.
- We have observed differences in performance from region to region, with the East of England showing almost 10% more locations rated as good or outstanding than the North West.
- Of the five key questions that we asked all services, safe and well-led have the poorest ratings, with around a quarter requires improvement and inadequate.
- Caring was the best rated key question – 92% good and 3% outstanding.
- Community social care services (such as supported living and Shared Lives) were rated the best overall. Nursing homes remain the biggest concern.
- Generally, smaller services that are designed to care for fewer people were rated better than larger services.
- The public values the information in our inspection reports.

2.1 Introduction

Since October 2014, when CQC completely overhauled and transformed our regulatory approach for adult social care services in England, people have been using our inspection reports and ratings as an important source of information to support their choice of care services.

This was reflected in CQC's 2016 public inspection report survey that showed 90% of people who were looking at residential adult social care reports said they found them useful.

CQC's judgements published in inspection reports are informed by a range of detailed information that we gather from providers, partners, commissioners and, importantly, people's own experiences of care and the views of their families and carers. Our inspection teams are trained and equipped to support a consistent and robust approach to making these judgements by asking five key questions – is this service safe, caring, effective, responsive to people's needs and well-led – so that we are really getting under the skin of care services in a more consistent, detailed and thorough way than ever before.

Our approach not only supports people to make informed decisions about care, but the detail of CQC's inspection reports also highlights shortcomings in the quality of care for providers and commissioners to respond to and act on. If providers do not respond well enough and fail to give people who use their services the standards they have a right to expect, we will take action to enforce improvement.

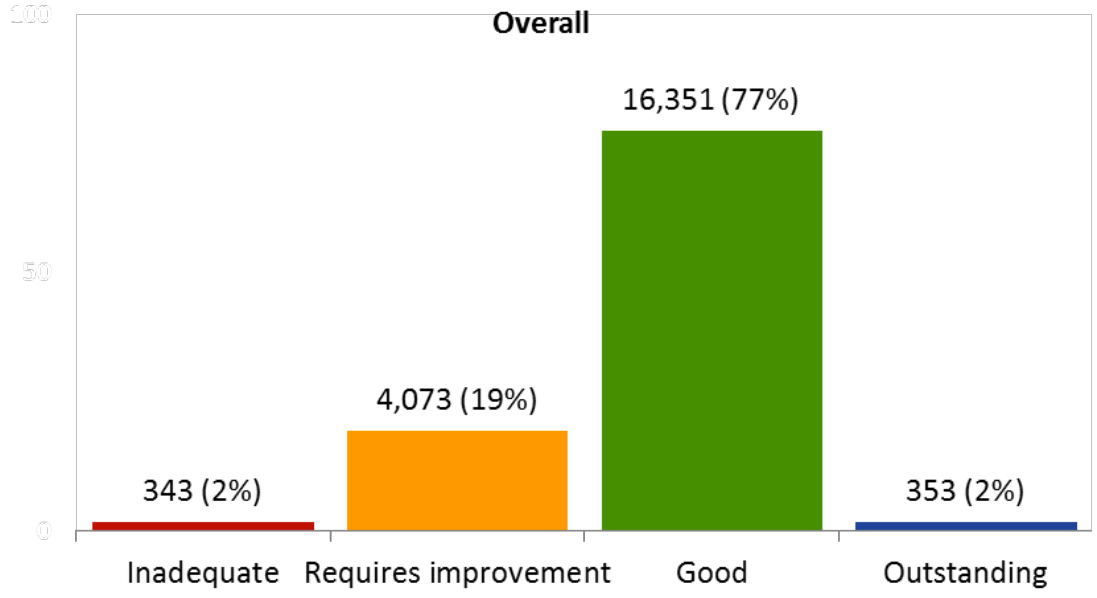
2.2 Overall ratings – all England

A service's overall rating is very visible. All services are required to show it on their websites and in their services. Where services are good or outstanding, many providers have been keen to promote this further – on banners, on literature and through local media. We welcome this; it's right that providers should be proud of their good and outstanding services, and of the staff who help to achieve this.

By the end of our initial comprehensive programme of more than 33,000 inspections, almost four-fifths of adult social care services in England were rated as good (77%) or outstanding (2%) overall. Nearly a fifth of services were rated as requires improvement. This proportion is too high. As part of our next phase of inspections we will target these services to make sure that providers do not view this overall rating of requires improvement as acceptable and, alongside commissioners, they work hard to improve care.

We are particularly concerned about the 343 locations (2%) that are currently rated as inadequate (figure 1). We estimate that these services may collectively have the capacity to care for almost 20,000 people. Since poor care can have such a shocking impact on people's day-to-day lives, it has to be everyone's responsibility to make sure that people's care is safe, compassionate and of high quality. CQC will work with providers and commissioners to ensure the necessary changes to improve care are made.

Figure 1: Adult social care overall ratings



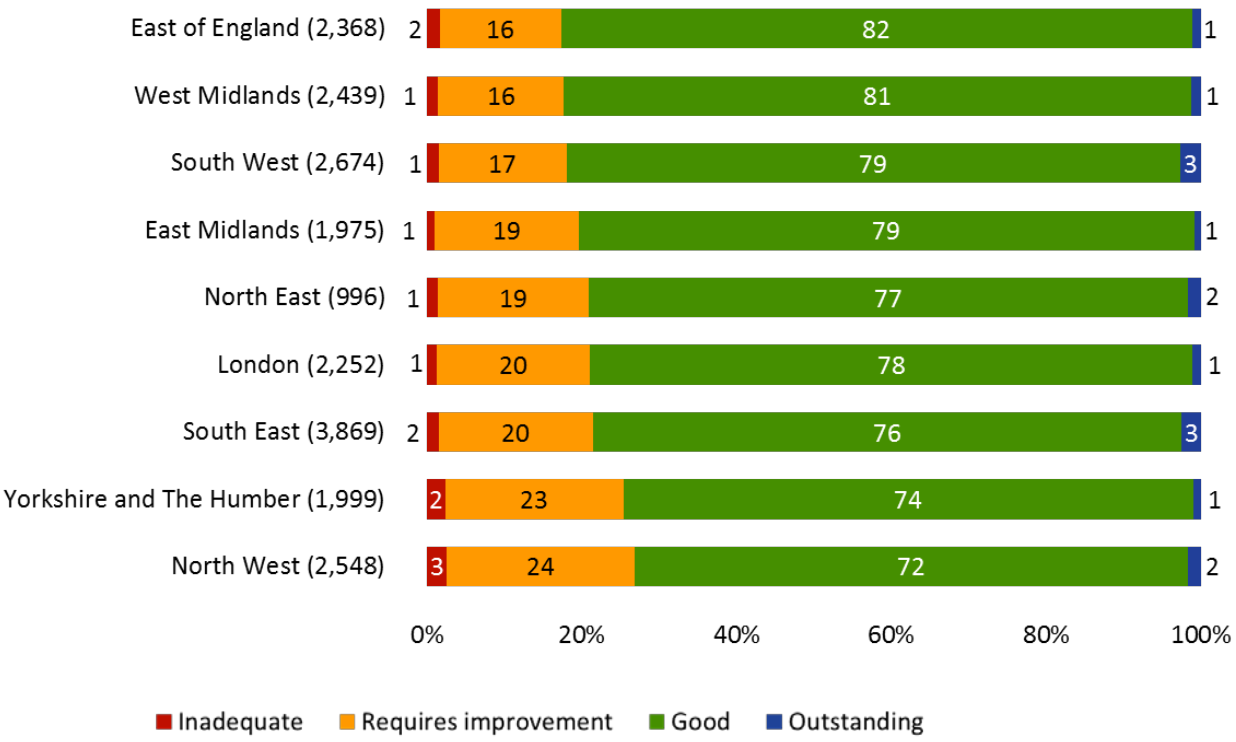
Source: CQC ratings data, 5 May 2017. Numbers above bars show total active locations rated

2.3 Overall ratings – regional breakdown

Completion of our initial comprehensive inspection programme has provided the public with a full picture of performance for their area. As well as detailed inspection reports for each adult social care service – searchable by postcode – there is a map on our website that enables people to see and compare the ratings of services in their area.

Region-by-region analysis shows that there was a difference between the region with the best ratings (East of England, where 82% of locations were rated as good and 1% as outstanding), compared with Yorkshire and the Humber (74% and 1%) and the North West (72% and 2%) (figure 2).

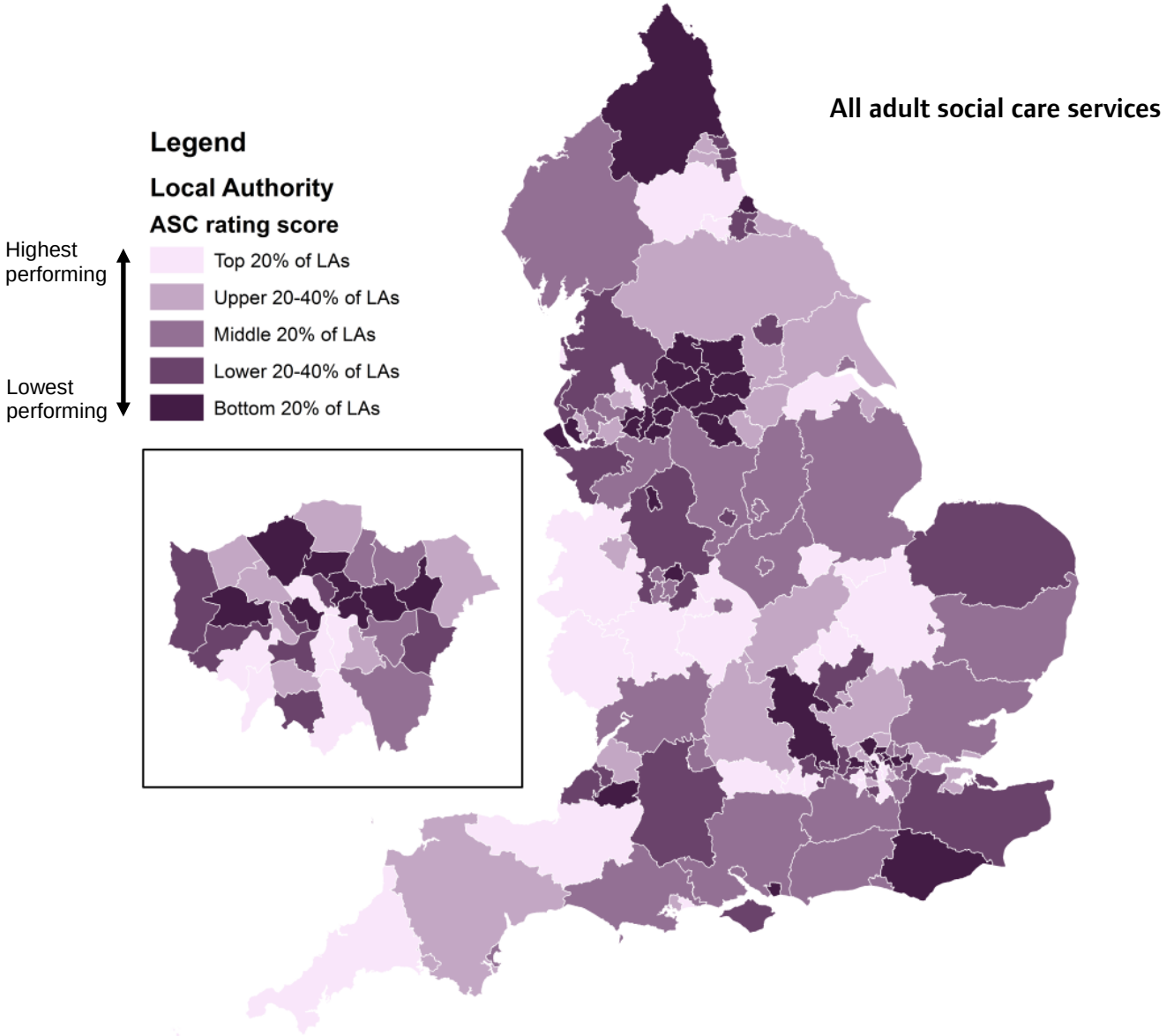
Figure 2: Overall adult social care ratings by region



Source: CQC ratings data, 5 May 2017. Figures in bars are % of rated locations. Numbers in brackets show total active locations rated

Figure 3 maps this regional performance across the local authorities in England. The lighter areas on the map show where, on average, we found the highest rated adult social care services – note the clusters in the midlands. And the darker areas show where the lowest rated services were – note the clusters in areas of the North West and West Yorkshire and some of the London boroughs in the North and East. This map, as well as the other maps and charts in this report, can be viewed in a separate document on our **website**.

Figure 3: Adult social care ratings by local authority area



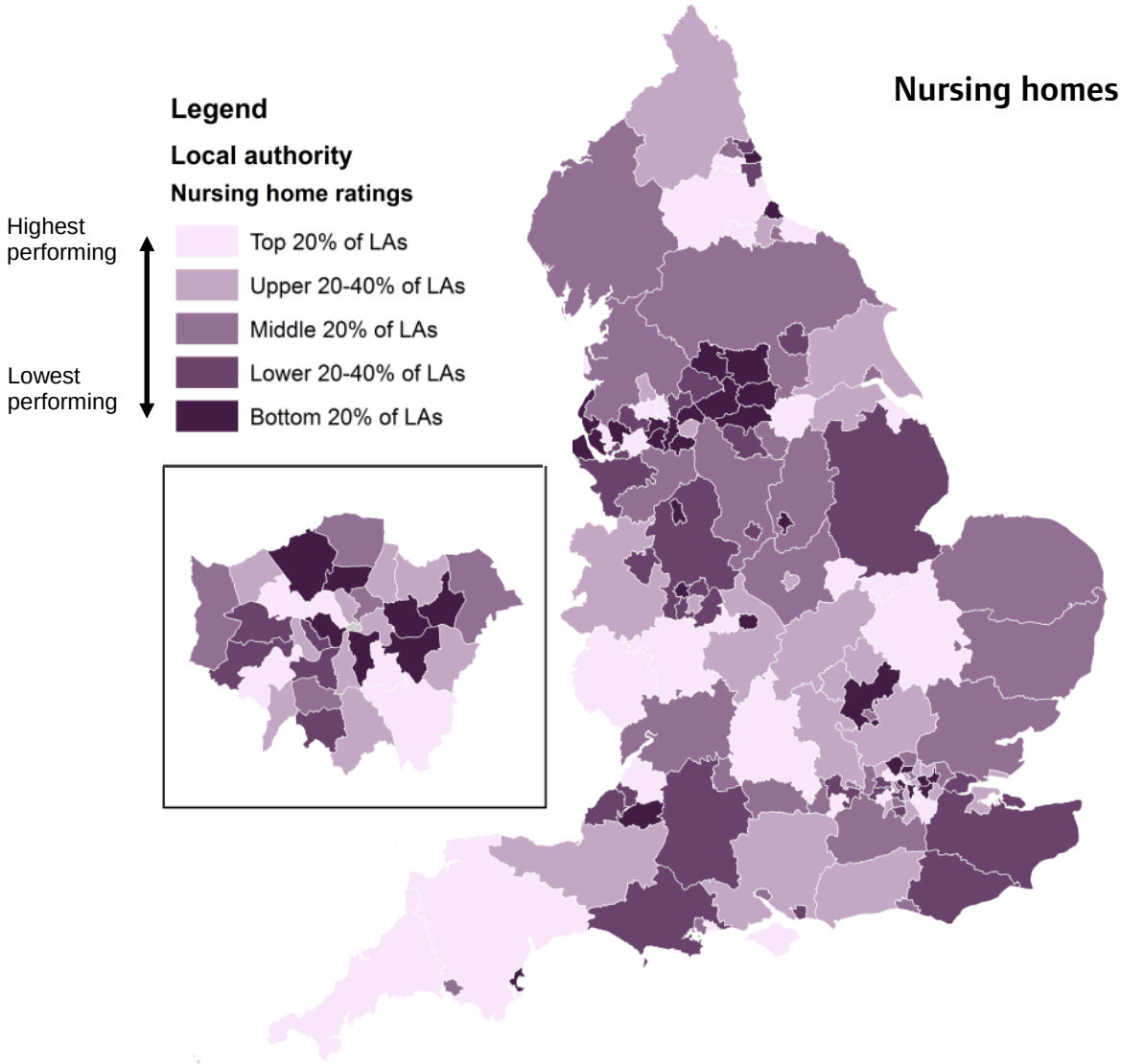
Source: CQC ratings data, 5 May 2017. Quintiles are based on local authority ratings scores, based on all key question ratings for each adult social care location

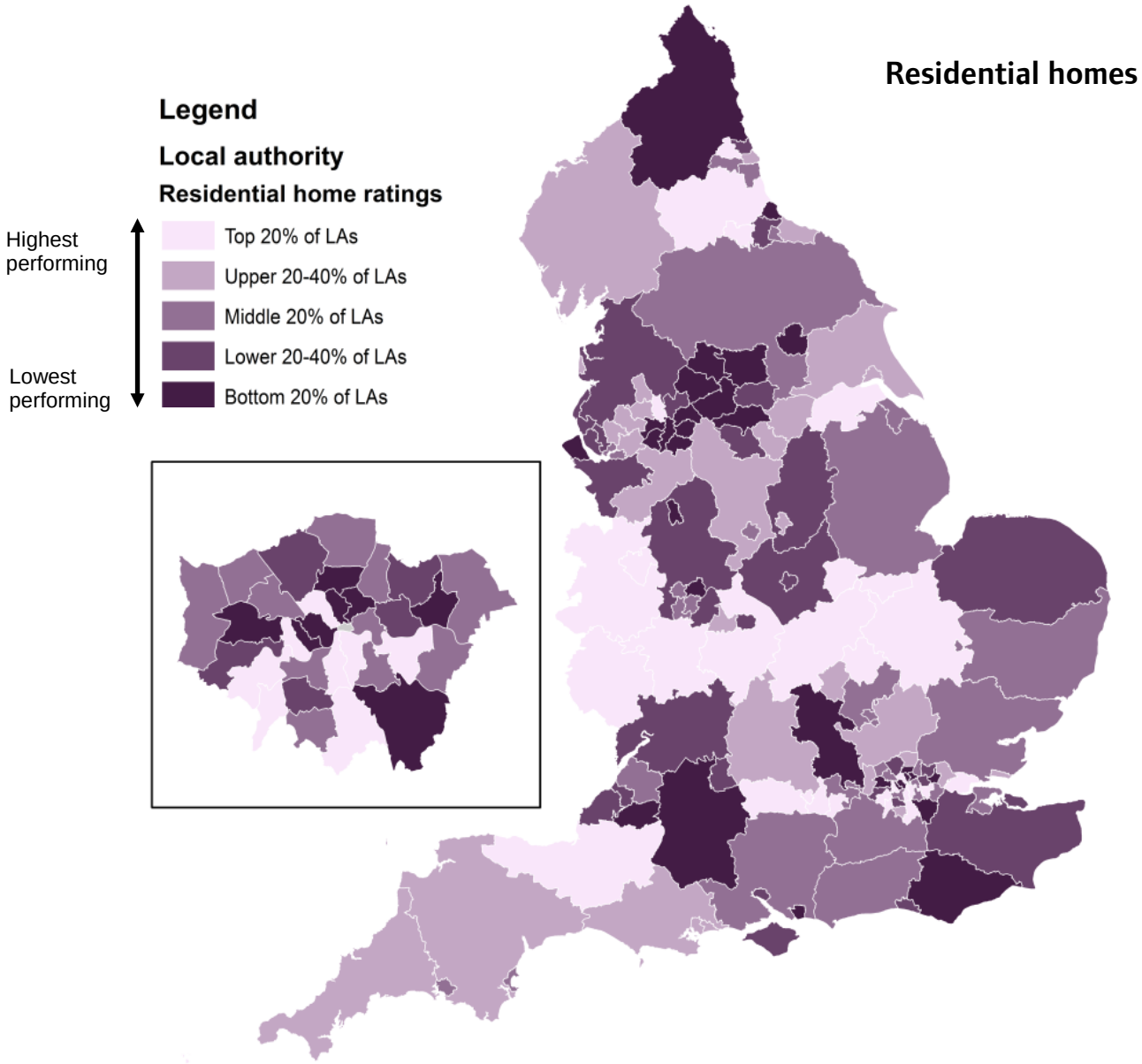
Figure 3 shows average ratings across all adult social care services, but we can look at the three main types of care in more detail. Figure 4 maps nursing home, residential home and domiciliary care performance across local authorities. Compared with all services, the cluster of high performance in the midlands is even more notable in residential homes, and for nursing homes high average ratings are particularly grouped in the far South West. Parts of the North West and West Yorkshire stand out as areas of poorer care, although this is more marked among residential and nursing homes than in domiciliary care. However, it is worth noting the cluster of poorer domiciliary care services in Greater London; 14 London boroughs feature in the lowest fifth of average ratings for domiciliary care, compared with eight boroughs for residential homes and seven boroughs for nursing homes.

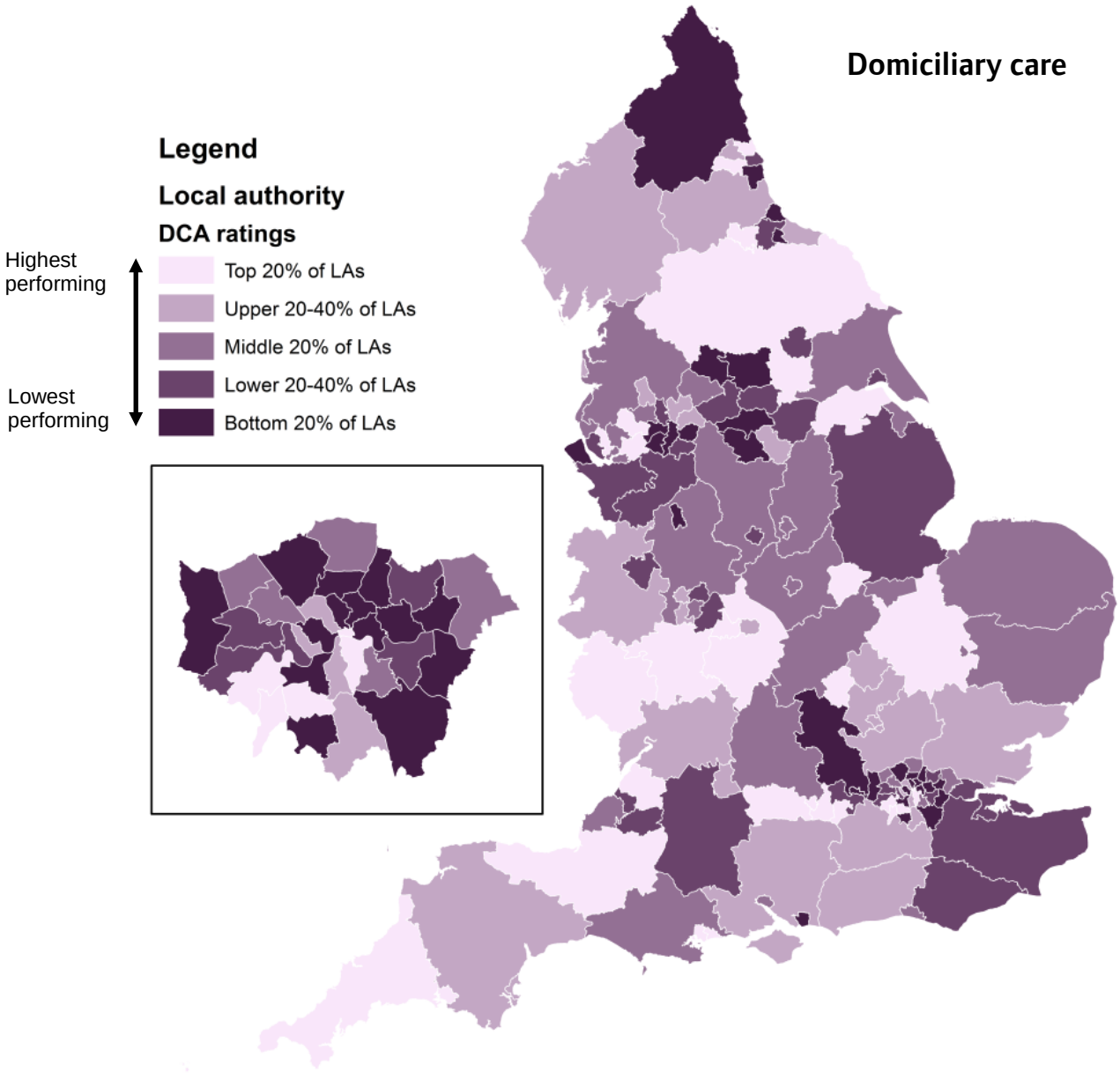
Beyond the clusters of patterns in performance, the maps below show many examples of variations in types of service within the same local authority. For example, Northumberland is in the highest performing 20-40% of nursing home provision, whereas it is among the lowest performing authorities in its residential home and domiciliary care provision. At the other end of the country, the London Borough of Bromley shows a similar pattern of performance.

We continue to observe these geographical differences in quality, and while the differences on average between the poorest fifth and best fifth of areas is not enormous, we are seeing that there are parts of the country where good quality adult social care may be harder to access. We will continue to analyse this data in discussion with partner organisations to see if we can explain the variation we observe.

Figure 4: Nursing home, residential home and domiciliary care ratings by local authority area




Residential homes
Legend
Local authority
Residential home ratings
Highest performing
Lowest performing
Top 20% of LAs
Upper 20-40% of LAs
Middle 20% of LAs
Lower 20-40% of LAs
Bottom 20% of LAs



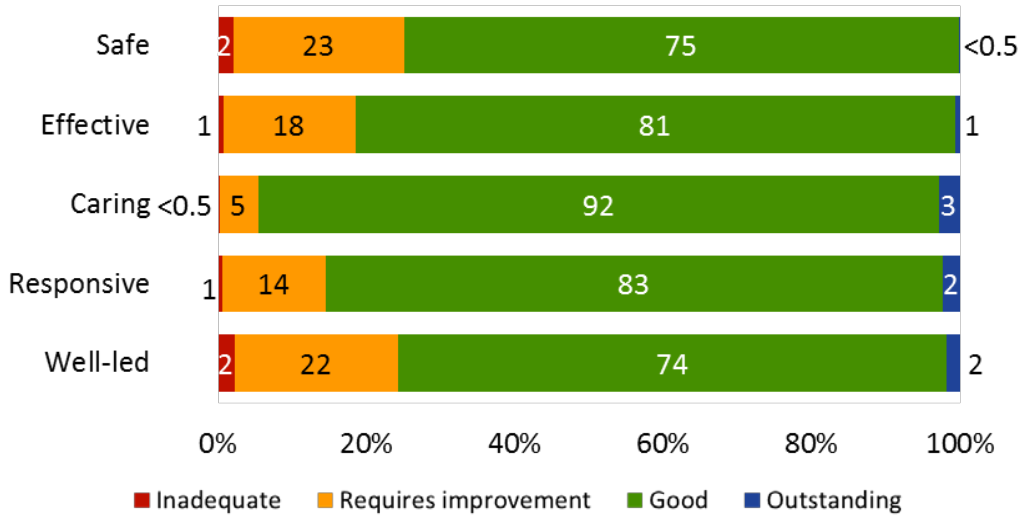
Source: CQC ratings data, 5 May 2017. Quintiles are based on local authority area ratings scores, based on all key question ratings for each adult social care location

2.4 Ratings by key question

As well as the overall rating, we give all adult social care services a rating for each of the five questions we ask of all care services. These allow us to look into greater detail at the issues that matter to people: are services safe, effective, caring, responsive to people's needs and well-led?

Figure 5 shows how all adult social care services were rated against the five key questions.

Figure 5: Adult social care ratings by key question



Source: CQC ratings data, 5 May 2017. Figures in bars are percentages

Safe

When we ask whether a service is safe, we find out if people are protected from abuse and avoidable harm.

SAFE IN AN INSPECTION REPORT

'One member of care staff told us, "We try to build a trusting relationship so if people had any problems or concerns they would come to us and tell us." One person told us, "If anyone hurt me I would talk to the staff about it."'

However, of the five key questions that we asked all services, safe had the poorest ratings, with 23% rated as requires improvement and 2% as inadequate.

Low ratings are concerning and indicate poor quality that can have a real impact on people using services. For example, poor safety can mean systems and processes that are not adequate for managing medicines or determining staffing levels. This can result in people not getting their prescribed medicines to help keep them well. In domiciliary care agencies, for example, staff that do not have enough time on home visits to have meaningful discussions with people about their needs and preferences will not be able to give them good person-centred care.

Effective

When we ask whether a service is effective, we find out if people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

EFFECTIVE IN AN INSPECTION REPORT

'Care workers were proactive in identifying if people's needs changed. For example one person told us, "I usually make all my medical appointments, but one day the carer noticed something wrong with my ankle and called in the district nurse for me."'

More than four out of five services were able to show that their care was effective and that people's care, treatment and support enables them to have a good quality of life. This has been achieved, for example, by involving people in training, to help staff understand the needs of those in their care. Eighty-one per cent of services were rated as good and 1% as outstanding for the key question 'are services effective?'.

Caring

When we say that a service is caring, we find out if staff involve and treat people with compassion, kindness, dignity and respect.

CARING IN AN INSPECTION REPORT

'People who used the service and their relatives confirmed they were treated with dignity and respect by carers who empathised with them. One person said, "I'm very slow on my feet now and they know that – they never rush me." Another person told us how their carer, "always helps me do as much as I can – they're very tactful". In a questionnaire returned to CQC one relative stated, "The carers and managers have provided an excellent service underpinned by total respect and dignity."'

In the majority of cases, our inspectors have seen and heard that staff involve people in their care and treat them with compassion, kindness, dignity and respect. When people may not be able to fully describe this themselves – for example, people with a learning disability and those living with dementia and other conditions that may affect their ability to communicate – our inspectors have used our Short Observational Framework for Inspection, which helps us to analyse how well staff interact with and support the people they are caring for. People using services were often very keen to tell us of the close relationships built up over time with staff who know their likes and dislikes. These factors led to 'caring' being the most highly rated of all the questions we ask services. More than nine out of 10 services were rated as good (92%) or outstanding (3%) for caring.

Responsive

When we ask whether a service is responsive, we find out if services are organised so that they meet people's needs.

RESPONSIVE IN AN INSPECTION REPORT

'All staff went out of their way to maintain family lives and relationships. Relatives' comments included, "I'm always made to feel welcome anytime", "I bring the grandchildren in to visit, we sometimes go in the garden or just spend time in their room, there is plenty of space".'

Our reports show that in high-performing responsive services everyone has equal access to care, regardless of their particular characteristics. Eighty-five per cent of services were rated as good or outstanding for responsiveness, while 14% were rated requires improvement. One per cent of services were rated as inadequate for responsiveness.

Well-led
When we ask whether a service is well-led, we find out if the leadership, management and governance of the organisation assures the delivery of high-quality, person-centred care, supports learning and innovation, and promotes an open and fair culture.

WELL-LED IN AN INSPECTION REPORT
'The registered manager and provider had developed an open and inclusive culture by meeting and working with people's relatives, staff and external health and social care professionals. A comment from a relative read, "The kindness, patience and care shown to my relative is wonderful. The team is led by a truly marvellous manager whose standards are the highest possible."'

Like the safe key question, our assessment of whether services are well-led shows relatively poor performance, with 22% of services rated as requires improvement and 2% as inadequate. Our data shows that if a service is rated as good or outstanding in well-led, it is more likely to be rated as good or outstanding overall, compared with any other key question.

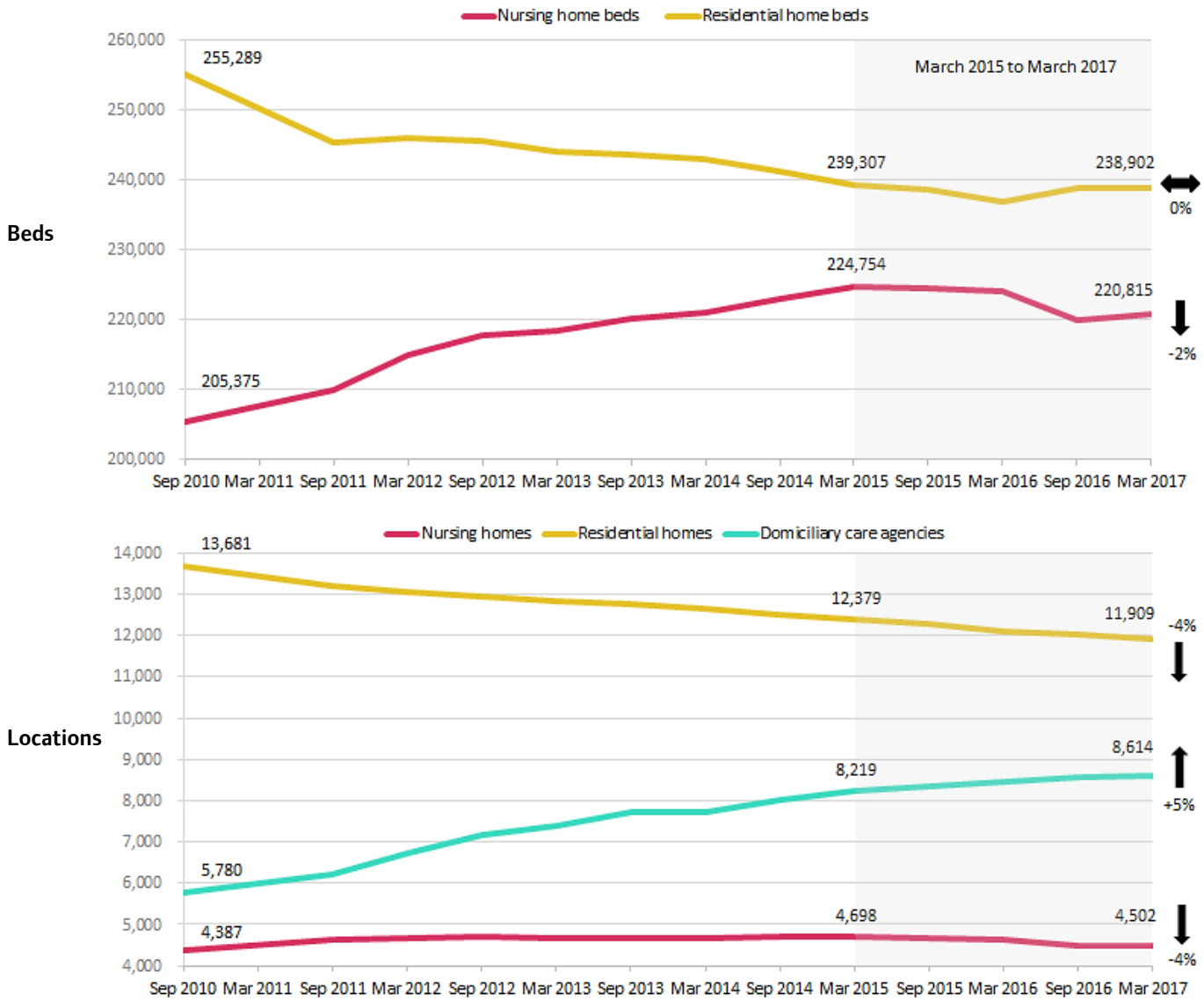
Services that are rated as requires improvement or inadequate in their well-led rating can indicate that staff are not being adequately supported or that people who use services, their families and carers are not being taken seriously if they raise a concern.

2.5 Types of services

People who use services, their families and carers can use these different types of adult social care service, depending on their needs. By looking at the registration data that we collect we can see how provision has changed over the last seven years as different providers enter and leave the market. By following the historical patterns, we get an idea of how services are responding to needs of local populations, and how they are balancing this with financial and resource pressures.

Figure 6 shows a pattern of decreasing numbers of residential homes and increasing numbers of domiciliary care agencies of various sizes. It also shows a long-term trend of increasing numbers of nursing home beds and decreasing numbers of residential home beds. However, we flagged in *The state of health care and adult social care in England* last year that the increase in nursing home beds came to a halt around March 2015. Since then, the provision of nursing home beds has declined and there are nearly 4,000 fewer nursing home beds open than there were at the peak in March 2015. This decline in nursing home beds may have abated; the latest data shows a small rise in bed numbers. As demand increases it will be important for CQC nationally and commissioners locally to monitor the availability of services and understand the reasons for changes.

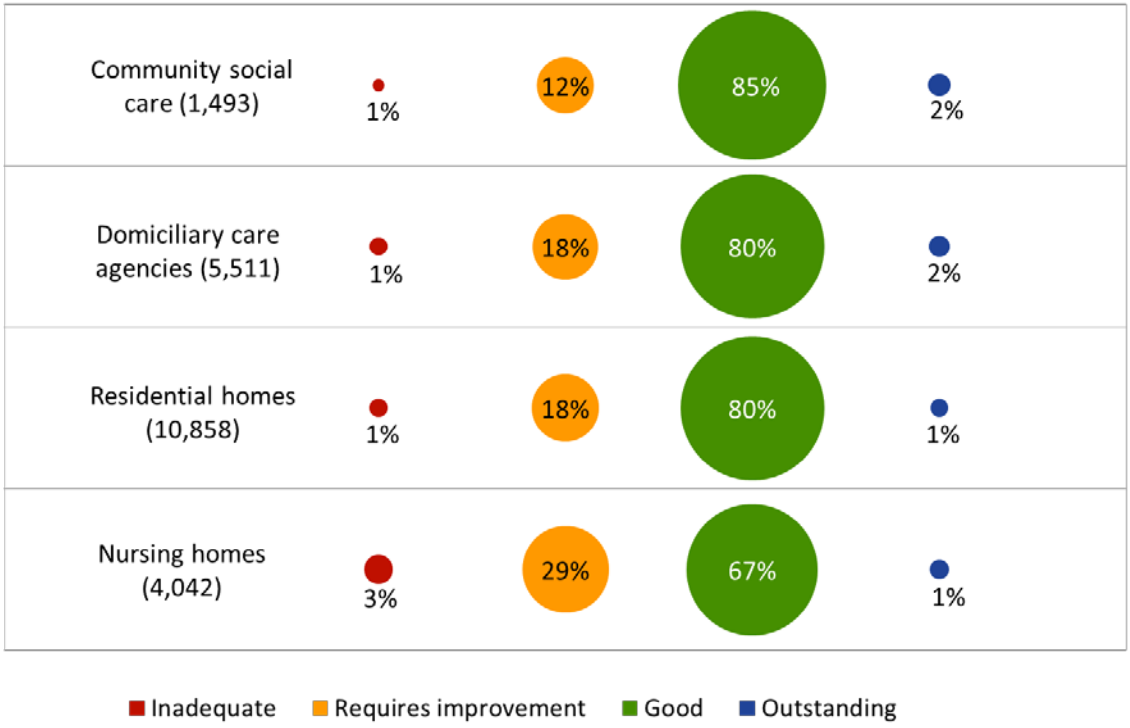
Figure 6: Adult social care market trends



Source: CQC registration data, March 2017. Arrows show movement since March 2015

There is considerable variation if we look at the ratings across different types of services. Community social care services (for example supported living and Shared Lives) were rated the best overall when compared with other services. Domiciliary care services and residential homes received similar ratings, with four out of five services being good. It is nursing homes that remain the biggest concern – 67% were rated as good and 1% as outstanding, with 29% rated as requires improvement and 3% as inadequate (figure 7).

Figure 7: Current overall ratings by service type



Source: CQC ratings data, 5 May 2017. Numbers in brackets show total active locations rated.

2.6 Size of services

Our analysis of our inspections shows that there is variation in performance depending on the size of services. Figure 8 shows that, in both nursing and residential homes, there is a trend that smaller homes are rated better than larger homes, with 89% of both small nursing and small residential homes rated as good or outstanding, compared with just 65% of large nursing homes and 72% of large residential homes. This pattern may be partly because many smaller homes are for people with a learning disability, and these services tend to perform well (see section 2.7). To give an idea of the numbers of people experiencing these levels of care, the 4% of large nursing homes rated as inadequate can provide services for around 5,500 people.

We have found that services that care for smaller numbers of people often found it easier to demonstrate a good level of responsiveness – for example, by being able to offer activities that are based on people's individual interests. This may be a challenge for larger services, but can be achieved as the example below shows.

Figure 8: Current overall ratings by size and type of care home

Source: CQC ratings data, 5 May 2017. Figures in brackets are numbers of locations rated.
Small = 1-10 beds, Medium = 11-49, Large = 50+

EXAMPLE OF PERSON-CENTRED CARE IN A LARGE SERVICE

Deerhurst Care Home is a care home with nursing care for up to 66 predominantly older people in Bristol.

A relative said:

- *"As my mother's needs have changed the staff have changed the way they look after her. Nothing seems to faze them and they always keep us informed [about] what is happening."*

Deerhurst has a 'homemaker' role, which staff take it in turns to fill. They are an extra dedicated member of staff to support and reassure people, and also to monitor what people are eating or drinking.

The service went the extra mile in caring for people when it arranged for a specially adapted

double bed to be provided for one of its residents. This was because the resident had always shared a double bed and missed the cuddles with their loved one. The person was able to spend time with their loved one, watching television, lying on the bed until falling asleep in each other's arms. The relative then returned to the family home knowing their loved one was settled for the night.

Read the whole report at www.cqc.org.uk

When looking at domiciliary care services, our data shows that locations providing care to a smaller number of people were also performing better than larger services. Our ratings data shows that 85% of small services (for one to 50 people) were rated as good or outstanding, whereas only 73% of larger services (for 101 to 250) achieved the same results (figure 9).

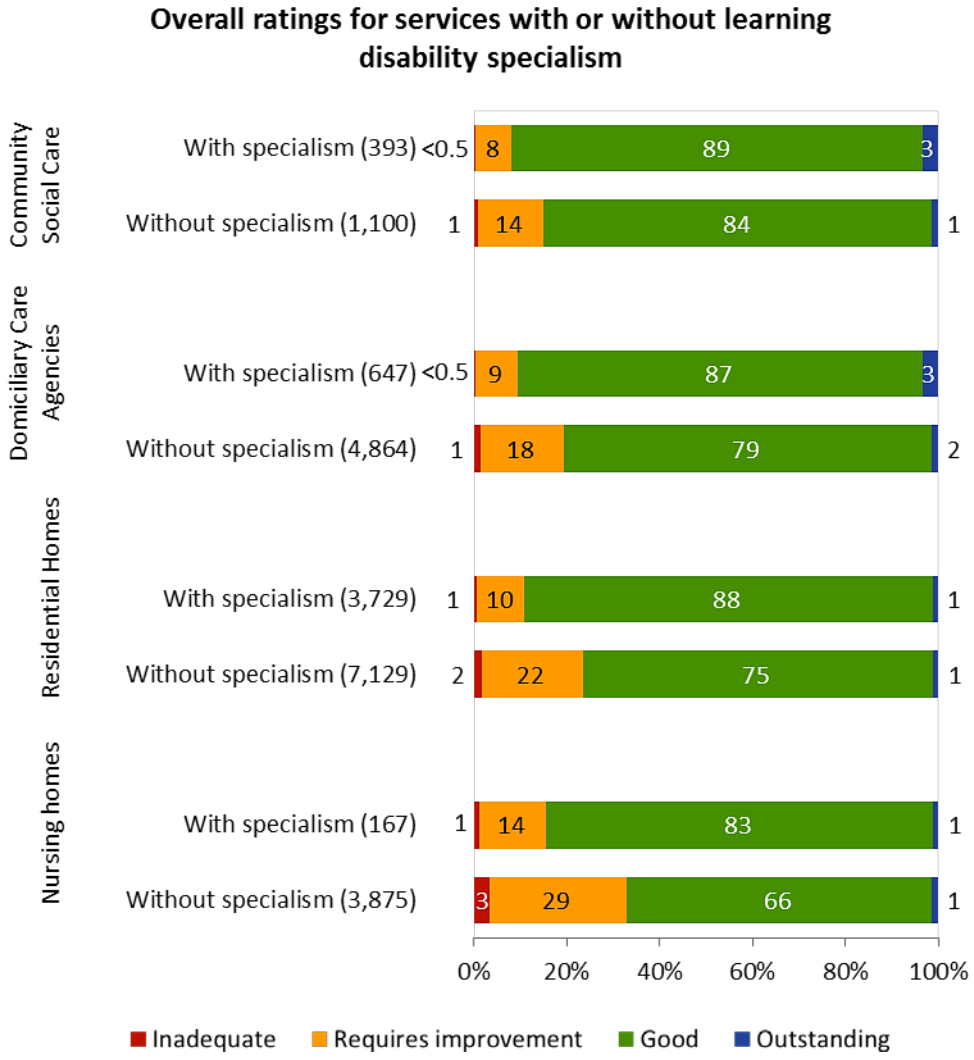
Figure 9: Current overall ratings by size of domiciliary care service

Source: CQC ratings data, 5 May 2017. Figures in brackets are numbers of locations rated

2.7 Learning disabilities

We can see variations in performance when we compare ratings for adult social care locations that specialise in the care of people with a learning disability against those that do not (CQC also inspects learning disabilities services as part of our mental health hospital inspections). Figure 10 shows that across all types of adult social care learning disability services have around half the proportion of inadequate or requires improvement overall ratings compared with services without a learning disability specialism. The caring and responsive key questions were particularly strong for learning disability services, showing that providers are organising their services to meet people's needs, and staff are involving people in their care and treating them with compassion, kindness, dignity and respect.

Figure 10: Current overall ratings by services with and without a learning disability specialism



Source: CQC ratings data, 5 May 2017. Numbers in bars are percentages and figures in brackets are numbers of active locations rated

EXAMPLE OF A CARING SERVICE FOR PEOPLE WITH A LEARNING DISABILITY

Mill Green provides accommodation and personal care for people who may have physical disabilities or long-term conditions, acquired brain injury and cognitive or learning disabilities.

One person said:

- *"Staff here are great, but they have a lot to do. I do a bit of washing and drying up. It feels more homely if I help."*

The provider's emphasis on person-centred care was understood by all staff. Staff saw beyond people's medical conditions, and encouraged and supported them to 'be themselves'. One person, who was not able to walk independently, had spent their morning happily painting the garden shelter with staff, while sitting in their wheelchair. People and relatives told us they had noticed a difference in the way people used the garden since a care coordinator had taken ownership of the 'garden project'. People also enjoyed an outdoor exercise class to music because all the staff, including the manager, housekeeper and senior manager joined in, which made them feel less self-conscious.

People were supported to maintain their independence with eating and drinking. Sometimes people chose to eat out and sometimes people chose to buy their own meals to re-heat at home, which promoted their independence.

Staff were committed to personalising the way they communicate with people. For example, one person with limited speech and mobility liked staff to walk in front of them, so they could hold their shoulders while they walked round the home.

Read the whole report at www.cqc.org.uk

3. What can the sector learn from our inspections?

Key points

- All providers can learn from high-quality care services and should know what to do to avoid poor care.
- Strong leaders had a pivotal role in high-performing services. This was seen at registered manager and provider level, where strong vision and values were communicated to all staff, encouraging a culture of openness and transparency.
- Positive and supportive cultures are characterised by staff who were well-trained, caring, skilled, dedicated, enthusiastic and focused on positive outcomes for people.
- A key theme that shone through in terms of high-quality services and improvement was a clear focus on person-centred care. In these services, staff really get to know people as people, understanding their interests, likes and dislikes.

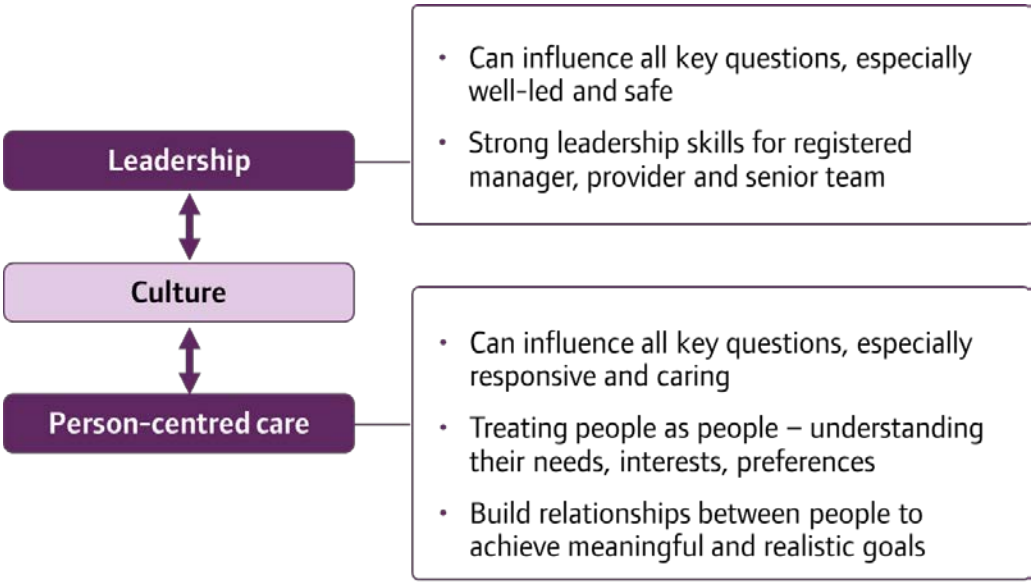
In this section, we focus on the main features of high-quality care that we have seen during our initial comprehensive programme of inspections, illustrated with examples from our inspections of high-performing providers. All providers can learn from each other – especially those that are rated as inadequate or requires improvement. Good and outstanding providers can also learn from the best practice and, as can be seen in the next section, quality in even the highest rated services can decline, so a focus on continuous improvement is vital to maintain quality care for people.

3.1 Characteristics that have led to high-quality care

Good leaders, both at registered manager and provider level, have a big influence on the quality of adult social care that people receive. They have an important role in shaping a positive culture in a service – including creating a supportive environment for staff, listening to their concerns, and communicating well with them, other professionals, and people who use services and their families and carers. They also genuinely appreciate diversity and seek ways to meet equality, diversity and human rights.

Leaders in the highest performing services also inspire a culture where people are at the centre – treating people as people, as opposed to just recipients of care. Staff sought to build relationships with people to find out what works for them. We found that good leadership, based around person-centred care inspired a positive culture (figure 11).

Figure 11: Characteristics of high-quality care



Leadership

Strong leadership has a pivotal role in both high-performing services and bringing about improvement in adult social care. At registered manager level strong leadership was characterised by individuals with an innovative, outward or forward looking approach who were open to feedback and actively sought out best practice to steer improvement. Managers were visible in the service, and known to staff, people using the service, carers and families, for example by sharing an office with all levels of staff and working closely with them.

Good managers truly valued their staff, supporting them to maintain their knowledge of best practice and person-centred care through training and establishing 'champions' in different areas of care.

Strong leadership was not restricted to registered manager level. Managers were supported by providers to communicate a strong vision and values to all staff, encouraging a culture of openness and transparency.

Good and outstanding services were supported by quality assurance systems and processes to monitor standards, such as quality audits and surveys. In well-led organisations leaders would ensure these systems and processes were embedded across the organisation, with clear lines of accountability.

We have also seen that leadership has an impact on the other questions as well as asking if the service is well-led. If a location was not performing well in other areas it was very unlikely to be rated as good or outstanding for well-led. There is a particular link between inadequate for safe and inadequate for well-led.

Innovation was identified as a characteristic of outstanding services, with good leaders described as being 'innovative' or 'creative', especially when adopting really person-centred practice and solutions to individual care needs, instead of simply seeing the risks or barriers.

EXAMPLE OF VALUING STAFF AND INDIVIDUALISED CARE IN A HIGH-PERFORMING SERVICE

Care By Us is a large organisation that offers personal care and other related services in East, West and North Hertfordshire, Essex and North London. They provide a wide range of care services in people's own homes. They serve around 1,600 people, employing about 500-600 staff.

People who used the service said:

- *"Staff do very well at lifting my mood if I'm feeling a bit bad. They are very caring."*
- *"They [staff] are so gentle when they get me out of bed, they don't rush me or seem keen to go. I feel like they're looking after me ever so well. Fantastic service!"*

Beyond the necessary mandatory training, such as safeguarding and food hygiene, a lot more core training was given to staff – especially in their first weeks. For example, staff attended cookery lessons where they learnt basic cookery skills and how to promote healthy eating for the people they were supporting.

Training was supported by appointing Champions across the organisation – for example, for dementia, falls prevention, nutrition and medication. The Champions actively trained and coached staff. One staff member said, "We are learning a lot about safe handling of medicines and what best practice means. If we are unsure we have our Champions, they know how to guide us."

The provider had a very personalised approach to care planning that sought to enable people to live as long as possible in their own home. They sat down with each person and looked at what good care looked like for them. There was a team who went out to talk to people who were not happy with the initial assessment of their care – for example the number or timing of the calls. This team of managers met with people and laid out all the options, talked about these and adapted the plan of care. Staff adapted to the people, not people to the staff. One person told us, "Care by Us came and discussed it [care needs], they did suggest three times a day but we have chosen to have mornings and evenings." One relative told us, "Yes, it was the senior management who came to discuss the care plan and care needs. I was there; it was very professional and very understanding of my [relative's] needs."

Care By Us have their own IT department, which developed technology for their own use. They were using telecare equipment, for example a GPS watch for people who cannot find their way home, so that the service could locate them and pick them up.

Read the whole report at www.cqc.org.uk

Culture

Positive culture was something that characterised good performance and improvement, and the links to the leadership finding outlined above are clear. Both staff, people who use services and inspectors commented on particularly positive and supportive cultures characterised by staff who were well-trained, caring, skilled, dedicated, enthusiastic and focused on positive outcomes for people. The cultures of the services were also highlighted as being open and transparent, with a culture of improvement based on good practice and feedback.

A review of CQC inspection reports carried out by Skills for Care highlighted the importance of creating and maintaining an inclusive culture. It also identified a link between organisational vision and values and quality. It found that in the majority of CQC inspection reports reviewed from services rated as requires improvement or inadequate, there was little or no evidence of the organisation's vision or values. By comparison, it was rare to find an inspection rated as good or outstanding that did not include some positive evidence of how vision and values have helped the service to achieve high standards of care.[12]

Practical examples of how a positive culture was created included:

- Staff not wearing uniforms in recognition that they were in people's home and viewing themselves as 'guests'.
- Involving people who use services in training.
- Staff designated as 'champions' in particular areas.

Person-centred care

The third key theme that shone through in terms of high-quality services and improvement was a clear focus on person-centred care. Good leadership that generates a positive and inclusive culture leads to genuinely person-centred care. These vital characteristics can have a real impact on the lives of people using services, their families and carers.

In high-quality services, staff really get to know people as people, understanding their interests, likes and dislikes. This supports relationships where staff and people who use services work together to set and achieve meaningful and realistic goals. The way these services engaged with and supported carers and family members also showed an inclusive approach to care.

Good person-centred care was achieved through people using services and their carers and families being fully involved in all areas of their care, such as writing care plans. Our report, *Better care in my hands*, used analysis from a literature review and from CQC inspections of outstanding services, and evidence from our national thematic reviews to identify a common set of achievements that have helped services to ensure people are involved in their care (box A).

BOX A: The importance of involving people in adult social care to achieve person-centred care

1. I am involved in discussions about my care, treatment and daily life as I want to be
How is this achieved?
By involving people in all aspects of care is a priority for the organisation and managers take a leadership role, encouraging staff to involve people

Inspection report example
"We saw that people's preferences and views were reflected, such as the name they preferred to be called and personal care preferences such as, 'I like to have a shower every day.' We spoke with this person and they confirmed that they had a daily shower."

2. My wishes and preferences are respected
How is this achieved?
There are management systems in place to monitor how people's wishes and preferences are being acted on

Inspection report example
"The main emphasis was that people were at home; they dressed in their preferred clothes and continued to undertake their individual hobbies. We observed people were able to do what they wished, making their own decisions helped and supported by staff. A member of staff we spoke with told us, 'The residents are not pushed to have a certain routine; we go with the flow so people live the life they choose.'"

3. My family and loved ones help me plan my care and support
How is this achieved?
Services coordinate how they involve people and their families in their care

Inspection report example
"I am always consulted about everything. The manager and staff keep me informed and we always have a six monthly review meeting when we discuss every aspect of my mother's care. I find communication to be excellent." (Relative of a care home resident)

4. Staff in different services work with me to adapt my plans as my needs change
How is this achieved?
Key staff work together across services to coordinate people's involvement in their care

Inspection report example
"A hospital passport was completed for each person. If a person needed to go into hospital other professionals would be made aware of people's preferences regarding their care, support needs and their current treatments that were best for them."

5. I am offered appropriate information, support and advocacy about key decisions for my care and treatment
How is this achieved?
Tailored and timely accessible information is used to support discussions and the involvement of people and their families

Inspection report example
"We observed a member of staff sitting next to a person who had no verbal communication. The staff member was holding the person's hand and pointing out the various picture meal options available for lunch."

6. I am involved in daily life choices in care settings
How is this achieved?
Services are organised to provide continuity of staff working with people using services over time

Inspection report example
"Care staff worked with Mr J and his wife to understand his life story and find out what would make him happier. Mr J had been a firefighter and relished the responsibility of keeping people safe. Care staff supported Mr J to check the environment for safety and standards and also involved him in practical daily tasks."

7. My capacity to be involved is taken into account – wherever I receive care
How is this achieved?
There is flexible advocacy provision as people use different services (when people lack capacity to make a decision or need support to represent their interests)

Inspection report example
"One 17 year old had a continuing healthcare assessment which was very person-centred. His support needs were clearly outlined and recorded in simple language and using his own words. It had a strong focus on his likes, dislikes and wishes. His father told us, 'The team have worked creatively to expand and enrich his social and practical skills. As a result his ability to join in and socialise with his siblings and peers has grown significantly.'"

Adapted from: CQC: *Better care in my hands: A review of how people are involved in their care*, May 2016

Tailoring activities to individuals' likes and interests was an important way of achieving person-centred care. This often involved using the arts to find creative ways of enhancing people's quality of life. For example, there is building evidence[13] that music and singing interventions work to improve the wellbeing of adults living with diagnosed conditions or dementia:

- Targeted, culturally relevant music and singing interventions can enhance mental wellbeing and decrease depression in older people with chronic conditions in residential and community settings.
- Participation in individual personalised music listening sessions can reduce anxiety and/or depression in nursing home residents with dementia and that listening to music may enhance overall wellbeing for adults with dementia.
- Participation in extended (12 months) community singing programmes can improve quality of life and social and emotional wellbeing in adults living with chronic conditions.

Practical examples of how person-centred care was achieved included:

- Staff actively supporting links with the wider community and involving volunteers in day-to-day activities.
- Arranging the environment so it provided positive living, learning and social experiences. For example placing objects around the home that were meaningful to people and that they could interact with. One home used iPads to engage with and create a stimulating and fulfilling environment for people living with a learning disability and dementia. This meant that one person, who had no verbal communication, was able to build up a picture/video diary and could tell their family what they had been doing during their visits.

EXAMPLE OF PERSON-CENTRED CARE IN A HIGH-PERFORMING SERVICE

Mary & Joseph House is a care home in Manchester, providing accommodation and personal care to adult men with enduring mental health needs.

A person who used the service said:

- *"The staff here know what they are doing. They have supported me so well, I was close to death when I first arrived, now I am strong and feel great."*

Mary and Joseph House are careful about people having realistic aims and objectives. They want to make sure that, if people are moving out, they have their finances sorted out correctly. There was an example of a person who was due to move out back into his own family home. The service was supporting him over a number of months, to visit his home regularly, to try and build up links with the community, to find new volunteering opportunities, and to know that he can still come back to Mary and Joseph House informally for a cup of tea or have a meal.

Arts and creativity were an integral part of the service provided at Mary and Joseph House:

- The service had a choir and an instrumental band which had been organised by the staff and people.
- A therapeutic gardener and art teacher were employed. The gardening team have worked with the art group to achieve Gold Awards in various Royal Horticultural Society competitions.

We saw one example of a person living with dementia who started a project five years ago to make a ceramic picture of what the home did. He took pictures to show where he was up to with the project. The home continually supported him to finish the project. It was a massive achievement for him.

Read the whole report at www.cqc.org.uk

3.2 Focus on Shared Lives

CQC regulates, inspects and rates Shared Lives services, which match adults who have care needs with approved carers. Shared Lives carers accept people into their own homes and provide care, support and mentorship to people.

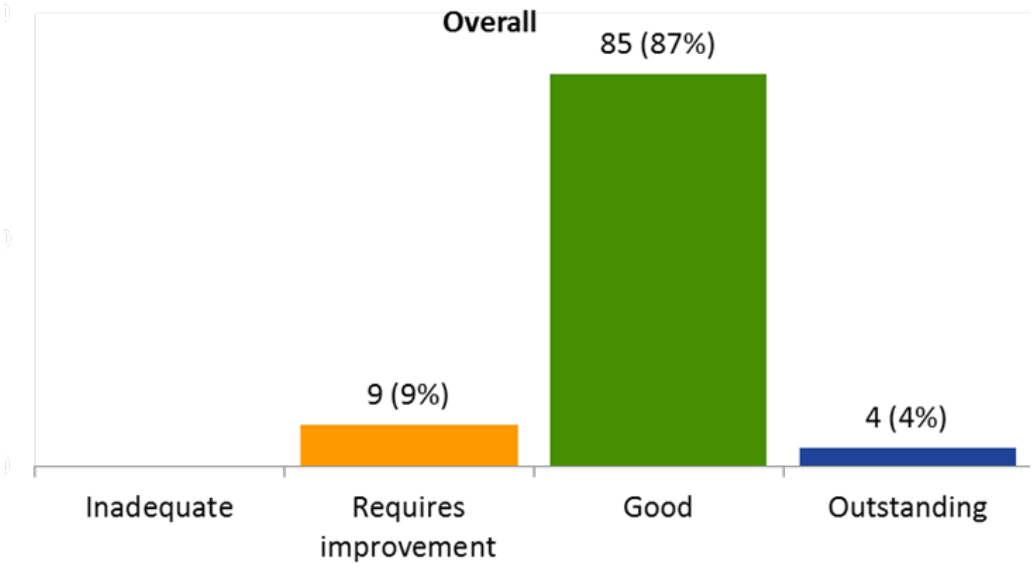
The Shared Lives model of care is geared towards achieving positive outcomes for people who use the service. The placement of people in a family home with carefully selected and screened carers helps create a supportive family environment, which helps to ensure person-centred care that is focused on independence and positive risk taking.

Shared Lives represent a small proportion of the services we regulate. Between October 2014 and May 2017, we inspected and rated 98 Shared Lives services.

According to Shared Lives Plus, this form of care is less expensive than other forms of care, while achieving good outcomes for people. Half of the 12,000 people using Shared Lives are living with their Shared Lives carer as part of a supportive household; half visit their Shared Lives carer for day support or short breaks. Shared Lives is also used as a stepping stone for someone to find their own home.[14]

CQC ratings data shows that they perform very well; over 90% are rated as good or outstanding and there are currently no locations rated as inadequate (figure 12). The key questions of caring and responsive are rated particularly highly compared with all adult social care services (for example, there are no locations rated as requires improvement or inadequate for the caring key question). This reflects the personalised approach of Shared Lives services that can bring positive results for people using them (see the example below).

Figure 12: Shared Lives overall ratings



Source: CQC ratings data, 5 May 2017. Numbers above bars show total active locations rated

The characteristics that have led to high ratings and remarkable support to people using services as shown in the case study below are:

- Strong leadership features again, with managers who maintained strong relationships with other local health and local authority services, who were forward looking and focused on solutions to maintain placements.
- Positivity of staff reflects strong leadership and careful recruitment. Staff were dedicated, enthusiastic and motivated by achieving positive outcomes for people using the service.
- Carers were carefully selected, screened and assessed, ensuring that people were highly suited to the role and able to demonstrate the necessary skills and qualities required. This was followed by a robust process for matching a person with a carer, which took into account a wide range of aspects to ensure that the needs of the person were catered for.
- People who use services, carers and staff were all well supported through effective communications, the availability of training, and monitoring processes to proactively identify areas for support.
- An open and transparent culture was present, which meant that issues could be highlighted and addressed.

EXAMPLE OF A HIGH-PERFORMING SHARED LIVES SERVICE

The Shared Lives Service in Lancashire provides long-term placements, short breaks, respite care, day care and emergency care for adults with a range of needs, within carers' own homes. It is the largest Shared Lives provider in England.

A person who used the service said:

- *"Shared Lives are amazing. This is my home and I am made to feel part of the family. Staff are really nice and friendly."*

One carer said:

- *"We wanted to see what [the person's] potential could be. They have gone from doing almost nothing to being outgoing and making decisions for themselves, including where they want to go and who they want to see. It's been amazing to see the transformation."*

Person-centred model

- One person we spoke with showed us photographs of themselves when they had moved into their Shared Lives home a few years ago to show us they had lost a significant amount of weight. They were proud of this achievement and it was obvious they had been given a lot of support from their carer and support officer to eat well and lead a healthy and active life.

Read the whole report at www.cqc.org.uk

4. What do we do about poor care?

Key points

- When we find poor care, we take action to make sure providers and managers tackle their problems and put things right for the benefit of people using services, their families and carers.
- Adult social care providers say that our enforcement regime encourages services to make sure they meet fundamental standards.
- Poor quality can have a real impact on people using services, particularly in the areas of staffing and medicines management.
- The areas of the regulations that we have taken the most enforcement actions relate to a lack of good governance, and issues with safe care and treatment, staffing and person-centred care.

CQC understands there are financial pressures facing the adult social care sector, but this does not mean that we will compromise on our purpose of ensuring people receive care that is safe, effective, compassionate and high-quality. Our inspections show that services of all types and in all circumstances can provide high-quality care for people. Where there is poor care, we will encourage improvement but if we need to take action that stops unsafe care and protects people from abuse and avoidable harm, then we will do that.

If, during our inspections, we identify aspects of care that need to improve, we ask the provider to evidence how they are going to make sure people receive the care and support that meets the standards they have a right to expect. We go back to inspect to find out whether they have kept to their commitments and if these have had the required effect. If they have not, we will use the enforcement powers we have available to take appropriate action. Our focus is always on the people using services – they have a right to receive safe, compassionate and effective care. When this does not happen we will take action on their behalf.

Our most recent annual provider survey, due to be published in the autumn, showed that providers think that our enforcement regime encourages services to meet fundamental standards that people have a right to expect whenever they receive care. Of the three main care sectors that we regulate, adult social care had the highest results in this area – with 74% agreeing that the prospect of enforcement action is an effective deterrent to encourage services to make sure they meet fundamental standards.

4.1 Characteristics that have led to poor-quality care

Of the five key questions that we asked all services, safe had the poorest ratings, with 23% rated as requires improvement and 2% as inadequate.

Poor quality can have a real impact on people using services, particularly in the areas of staffing and medicines management.

Staffing

Staffing levels were a key factor in providers rated as inadequate or requires improvement for safety. Our inspectors look at safe staffing levels in terms of whether people's needs were being responded to in a timely manner. They do this by talking to people using services and their families and visiting professionals, observing whether people's needs are met and they are safe, checking systems for assessing staffing levels, and talking to a range of staff to hear their views on the staffing at the service. In care homes, for example, inadequate staffing levels led to alarm calls not being responded to promptly, which meant that people did not get the support they needed when they needed it.

The layout of a home and peak times affected the number and deployment of staff. This could have an impact on whether people's needs were responded to promptly, whether medication was given, whether staff were able to spend time in communal areas, and (considering people with challenging needs) ultimately that people were safe. Rotas had shown care staff being deployed to assist in the kitchen for example, during lunch time, when staff were required to safely assist people to the dining room.

The impact of inadequate staffing on care provided for people receiving help from a domiciliary care agency was that they would receive rushed one-to-one assistance instead of the two-to-one support required, and this could be provided by a different carer every day.

Even where appropriate numbers of staff were in place, if they did not have the necessary skills this could have an impact on safety. During one inspection of a service that was rated as inadequate, we found that the manager did not know what skills their agency workers had, and we found that they did not have the skills needed to support the people with complex needs.

Staff training was also a factor on safety, particularly in areas such as infection control, risk assessments, safeguarding and medicines.

We also found shortfalls in staff understanding of the training, with no evaluation of staff competency after the training or practical supervision.

Medicines management

Medicines management was a key factor associated with unsafe care. Specific issues included:

- Medicines not being administered properly

- Staff lacking knowledge of medicines and their side effects
- Issues with record keeping, including timeliness
- A lack of medicines audits
- Medicines being out of date and not being stored correctly.

In some cases poor medicines management were described as having extremely serious consequences, with failure to check that a member of staff was able to administer medicines on an ongoing basis leading to actual harm to people using services. Conversely, staff that have an understanding of the medicines they were administering were able to talk to people about any possible side effects.

The next section discusses what we do when we find poor-quality care, with examples of some of the poor care described above, and what providers have done to make improvements.

Information and resources to support improvement can be found on Care Improvement Works, which is a free online tool developed by Skills for Care, the Social Care Institute for Excellence and the National Institute for Health and Care Excellence.

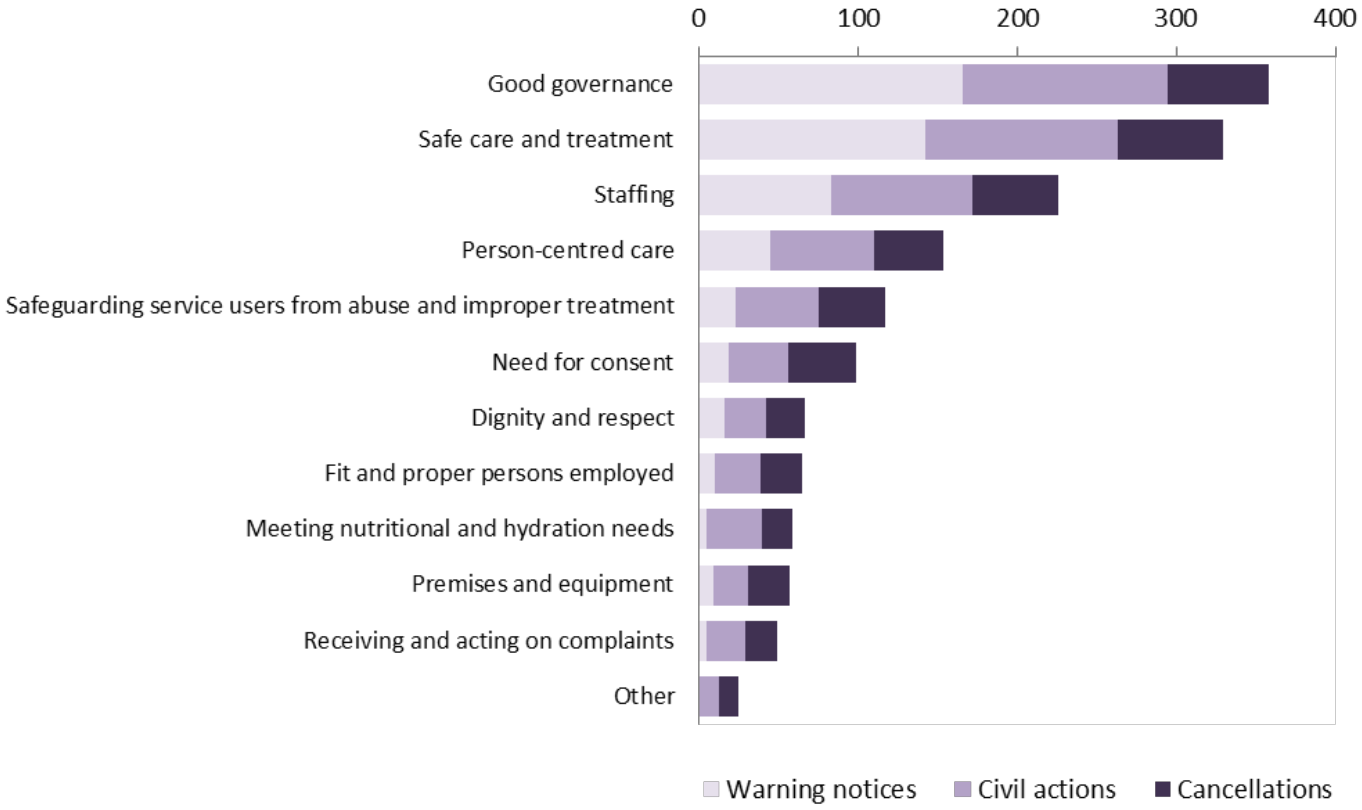
4.2 Using our civil enforcement powers

Where we identify poor care, or where registered providers and managers do not meet the standards required in the regulations, we have a wide set of enforcement powers that allow us to protect the public and hold those responsible to account.

The actions we take depend on how serious the problems we have identified are and how they affect the people who use the service. Actions range from giving providers notices setting out what improvements they must make and by when, to placing them in 'special measures', which gives them a clear timetable within which they must improve the quality of care they provide. If providers do not improve we will take further action (for example, cancelling their registration). The example on page 38 shows the work that is done to ensure continuity of care for people when a registration is cancelled.

Figure 13 shows the number of breaches in each area of the regulations that contributed to inadequate ratings. The enforcement actions we took ranged in severity from warning notices through to cancellation of registration. The most common breaches relate to the issues we have highlighted in this report. In these services there was a lack of good governance, and issues with safe care and treatment, staffing and person-centred care. This may mean that providers and leaders were failing to check the quality of their care, seek the views of people using the service, administer medicines safely, and make sure that staffing levels are adequate to provide care in a person-centred way. A similar pattern emerges for enforcement actions against locations rated as requires improvement, although with fewer civil actions and cancellations.

Figure 13: Enforcement actions against locations rated as inadequate



Source: CQC ratings and enforcement data, 5 May 2017. The numbers relate to regulations breached, not total numbers of locations (which will be fewer as a number of locations breach more than one regulation)

4.3 Using our criminal enforcement powers

Since 1 April 2015, enforcement responsibility for health and safety incidents in the health and social care sector transferred from the Health and Safety Executive and local authorities to CQC. We have subsequently prosecuted five providers using these powers (figure 14). While all prosecutions so far have related to a breach in safe care and treatment requirements, the cases have covered a wide range of safety issues, including medication errors, uncovered radiators and use of bed rails. Recurring themes, which have been highlighted in legal analysis,[15] included:

- Issues with documentation: for example, errors regarding medication dosages and strengths and timings not being accurately recorded.
- Risk assessments: for example, one care home was found to have no proper system for assessing the risks to the health and safety of people using services (including failing to prevent a blind resident repeatedly falling in her room and a resident repeatedly choking).

- Equipment: for example a person living with dementia suffering burns after falling against a radiator through lack of radiator covers or pressure sensor mats to alert staff to the person getting out of bed.
- Staff training: for example, a person fell out of a shower commode chair because staff did not know about a national safety alert about the importance of safety/posture belts and did not understand how to fit chair straps safely.

Figure 14: Successful CQC prosecutions of adult social care services

June 2016	St Anne's Community Services	Prosecution following the death of a 62-year-old man who broke his neck in a fall from a shower chair at a nursing home in West Yorkshire. The provider was fined **£190,000**.
September 2016	Cotton Hill House care home	Prosecution following the death of a resident at Cotton Hill House care home following errors with the administration of his anti-coagulant medication. The provider was fined **£50,000** and the former manager, was fined **£665**.
February 2017	Manor Residential Home	Prosecution following an incident when a 79 year old woman fell against an uncovered radiator and suffered serious burns. The provider was fined **£24,600**.
March 2017	Mossley Manor Care Home	Prosecution following 14 offences for failing to provide safe care and treatment; failure to notify CQC of the deaths of ten residents; and failure to notify CQC of three serious incidents. The provider was fined **£82,430**.
April 2017	Lamel Beeches Care Home	Prosecution following two offences with one resulting in avoidable harm to a resident who died in hospital after falling out of bed at the home and re-fracturing his hip. The provider was fined **£163,185**.

To illustrate the terrible cases of neglect and abuse that are behind these prosecutions, the following example gives the detail of the Mossley Manor Care Home case.

EXAMPLE OF A CQC PROSECUTION

As a result of concerns from the family of a prospective resident, we inspected Mossley Manor Care Home during May and June 2015 and were appalled at what we found. Some residents were unkempt and smelled strongly of urine or body odour, having not received a bath or shower in the previous three weeks. Bedrooms were not being cleaned regularly and some contained mouldy and congealed tea and coffee cups. Carpets were dirty and dusty. Communal toilets did not contain soap, hand towels or bins. When there was no hot water staff had to boil pans of water in the kitchen to wash residents.

The care home had also failed to control risks of serious injury. There was no proper system in place for assessing the risks to the health and safety of individual people. One woman who was blind and had a history of falls was found injured on the floor of her room on three occasions but the provider failed to take action to stop it happening again. A 77-year-old man who was at risk of choking was twice taken to hospital – but there was conflicting advice for staff on how they should support him to eat and drink safely.

Initially we gave the owners 24 hours to submit an action plan to make urgent improvements. On visiting again a few days later to check if this was being implemented there were still serious concerns. CQC applied to Liverpool Magistrates to urgently cancel the provider's registration and close Mossley Manor. We worked closely with Liverpool City Council at the time so that people living at the home could find alternative accommodation.

The registered providers were fined £60,000 for failing to provide safe care and treatment and £20,800 for the 13 offences of failing to notify CQC. They were also ordered to pay the prosecution costs of £1,510 and a £120 victim surcharge.

Taking criminal action and prosecuting providers is a detailed process that involves the care and comprehensive collection of evidence. We test each case on whether there is sufficient evidence to secure a prosecution and, if so, is it in the public interest to prosecute. We currently have two prosecution cases that have been listed for a magistrates' court hearing, and six cases that are likely to be listed for a magistrates' court first hearing by March 2018.

5. Have adult social care services improved?

Key points

- Adult social care providers say that our inspections encourage improvement.
- More than four-fifths (81%) of locations that were initially rated as inadequate have improved their rating after a CQC inspection.
- Only 56% of locations that initially required improvement have improved their rating after a CQC inspection.
- Committed managers, who are supported by the provider, can drive improvement in a previously failing service.

The previous section of this report describes how we use our enforcement powers when we find poor care. It is our expectation that providers should take responsibility for the quality of the care they provide. We expect them to use our findings and reports as an opportunity to tackle their problems and put things right for the benefit of people using services, their families and carers, so that we should not have to resort to the more severe actions in our enforcement policy.

Our most recent annual provider survey showed that providers think that our inspections encourage improvement. Of the three main sectors that we regulate, adult social care had the highest results in this area – with 80% agreeing that inspections help them to identify areas of improvement.

This section focuses on how services have responded to our initial programme of comprehensive inspections in terms of improvement.

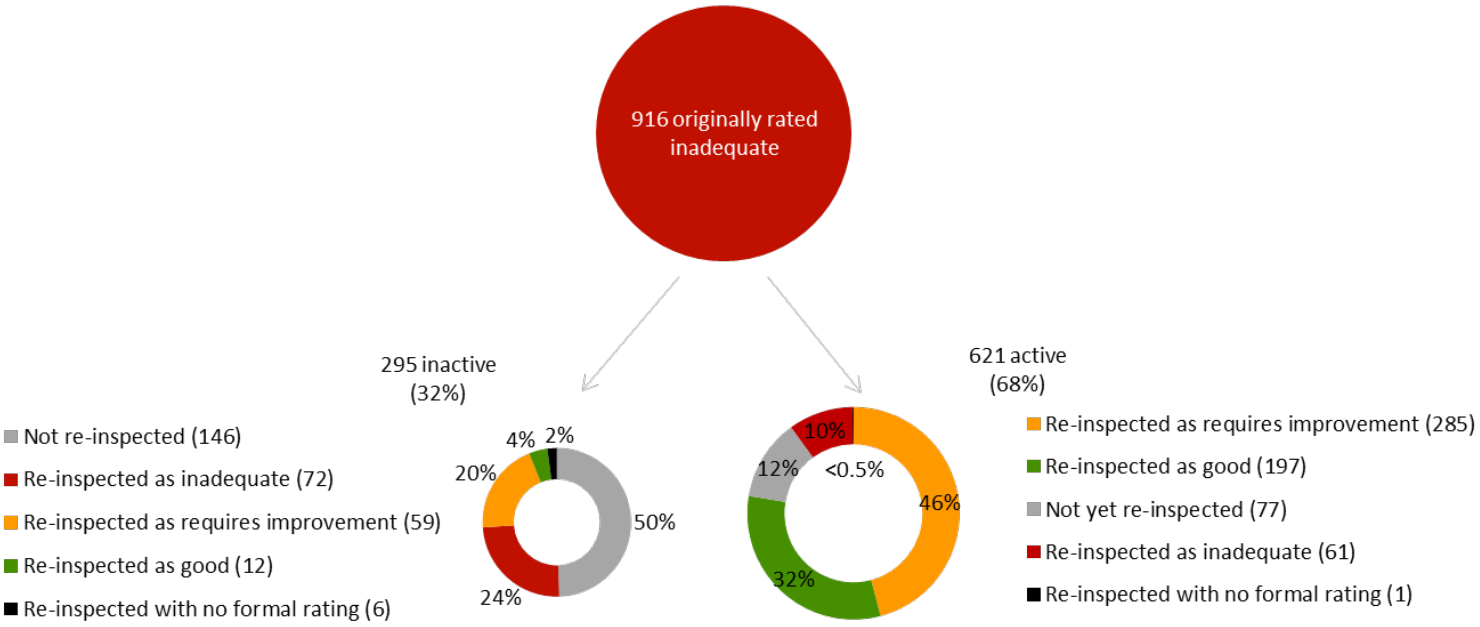
5.1 Inadequate services that improve their quality

Throughout our initial programme of comprehensive inspections in adult social care we have seen improvements across all types of services. This improvement is most evident in services that originally had the poorest quality, and were rated as inadequate. These services may not be keeping people safe – there may be widespread and significant shortfalls in the care, support and outcomes people experience; staff may not treat people with respect, and may sometimes be unkind and lack compassion; people may not be involved in the development of their care; and these things may stem from a lack of good leadership. Whatever factors have contributed to poor care, it is important that providers take action to protect people, improve their service and deliver on the legal obligations they accept when registering with CQC.

Figure 15 shows what has happened to the 916 services where we gave a first rating of inadequate. Almost one-third (295 locations) are no longer active; many of these will be locations that were deregistered by their providers before we could take further action – half of them became inactive before we were able to re-inspect them. Nearly a quarter of the 295 locations (24%) remained inadequate on re-inspection before they became inactive. A small number of locations are now inactive because CQC cancelled their registration – see page 35.

Of the 68% of services (621 locations) that were initially rated as inadequate and continued to provide services, over three-quarters improved (482 services). We continue to monitor the progress of the remaining 22% to make sure that people are protected and will take further action as necessary.

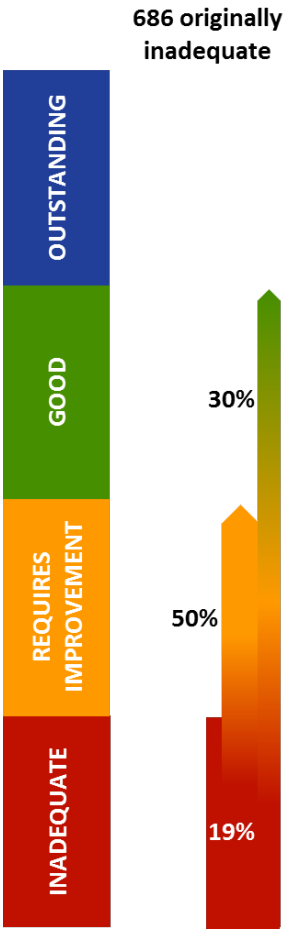
Figure 15: What has happened to services first rated as inadequate?



Source: CQC ratings data, 5 May 2017

Figure 16 shows a simpler picture of performance for those services that were first rated as inadequate and only includes those that have been re-inspected. It is encouraging to see that many providers are responding to our concerns. Eighty-one per cent improved their inadequate overall rating following re-inspection; 50% to requires improvement and 30% moved two ratings to good. We will continue to focus on those services that continue to be rated as inadequate (19%).

Figure 16: Re-inspection of services rated as inadequate – all providers



Source: CQC ratings data, 5 May 2017. Percentages do not add up to 100% due to rounding.

EXAMPLE OF IMPROVEMENT THROUGH LISTENING TO CQC AND PEOPLE WHO USE SERVICES

In November and December 2015, a domiciliary care service was inspected and rated as inadequate overall.

Six months on, in June 2016, the service was re-inspected and 'significant improvements' were found. The service was rated good overall and good in all the areas we assessed. Seventeen people were receiving support from the service at this time.

The first inspection identified a range of issues and risks across the five areas we look at, relating to recruitment, medicines management, staff training and supervision, poor assessments of people's needs and records management. Some people using the service and their relatives also highlighted issues about the delivery and continuity of care.

In preparation for the second inspection, the service had carried out another quality survey, which received positive feedback. When we talked to people using the service and their

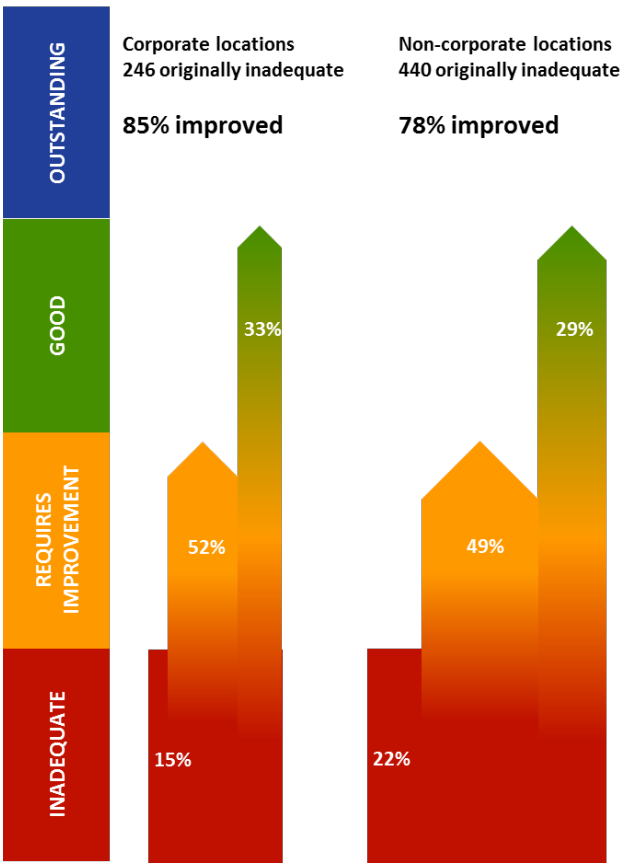
relatives, they confirmed they were now involved in care planning and staff were described as very caring and friendly and found to be proactive in supporting people and their relatives.

Both the registered provider and registered manager remained in post throughout the process, but a fundamental change to the service led to the improvements.

When we look at the overall ratings of corporate providers (a provider with 20 or more locations), they are very similar to the ratings of all providers. For example, 80% of corporate-owned locations were rated good or outstanding overall, compared with 79% of other locations.

Corporate providers, however, have been better at improving since a first rating of inadequate; of the locations originally rated as inadequate, only 15% of locations owned by corporate providers remained inadequate at their last rating, compared with 22% of non-corporate locations (figure 17). This might suggest that corporate providers are more equipped to step in to support any of their locations that are performing poorly and we are aware of larger corporate providers establishing quality turn-around teams to address problems at individual locations. It is important to ensure that the immediate action taken to address problems is sustained once the turn-around team has left. There is also a key role for local commissioners to consider what support they may be able to provide to smaller providers to help them improve.

Figure 17: Re-inspection of services rated as inadequate – corporate locations and non-corporate locations



Source: CQC ratings data, 5 May 2017

Impact of registered manager on improvement

It is clear from section 3 of this report that good leaders have a big influence on the quality of care that people receive. This applies not only to high-quality services, though, but also to services that have improved between inspections.

A committed registered manager, who is supported by the provider, can drive improvement in a previously failing service:

- The presence and capability of the registered manager was key to improvement. One of the examples in this section shows that improvement can be achieved by a consistent manager who is supported to bring about fundamental change. In the other example, improvement was brought about through recruiting a new registered manager who was quickly able to address staff issues by providing training that helped them understand the needs of the people in their care.
- Similarly, acceptance and ownership of the issues raised by CQC by the registered manager and provider was highlighted as important.
- The improvement driven by the registered manager involved moving to a more person-centred approach and culture, for example by involving people more in their care.

EXAMPLE OF IMPROVEMENT THROUGH A CHANGE IN MANAGER

The first inspection of a 58-bed residential care home, providing care to older adults with a range of support and care needs, in December 2015 revealed that the manager in place was not knowledgeable, approachable or responsive. Staff were process driven and did not support people in caring way that protected their dignity and privacy. The combination of these two aspects led to the service being rated as inadequate.

After this first inspection, the acting manager left their post and a new manager was appointed. At the second inspection the manager, with support from the owner, had been able to achieve a great deal of improvement in a short period of time. This included:

- Staff teams were mixed up so that "problematic cliques" could be broken up and staff could be exposed to best practice at other parts of the service.
- Person-centred caring training for staff. This included dignity challenges that aimed to give staff a better understanding of how it feels to be cared for, for example being fed by another person while wearing a blindfold. At the second inspection, staff also commented on how important the training had been for their role.
- More frequent staff meetings and weekly memos to improve communications between staff and the manager.

The overall rating of requires improvement reflected the work that the manager had been able to achieve, but still showed there was more to do.

At the third inspection the inspector saw improvements in the areas identified at the previous inspection and no new issues were identified and was able to rate the home as good.

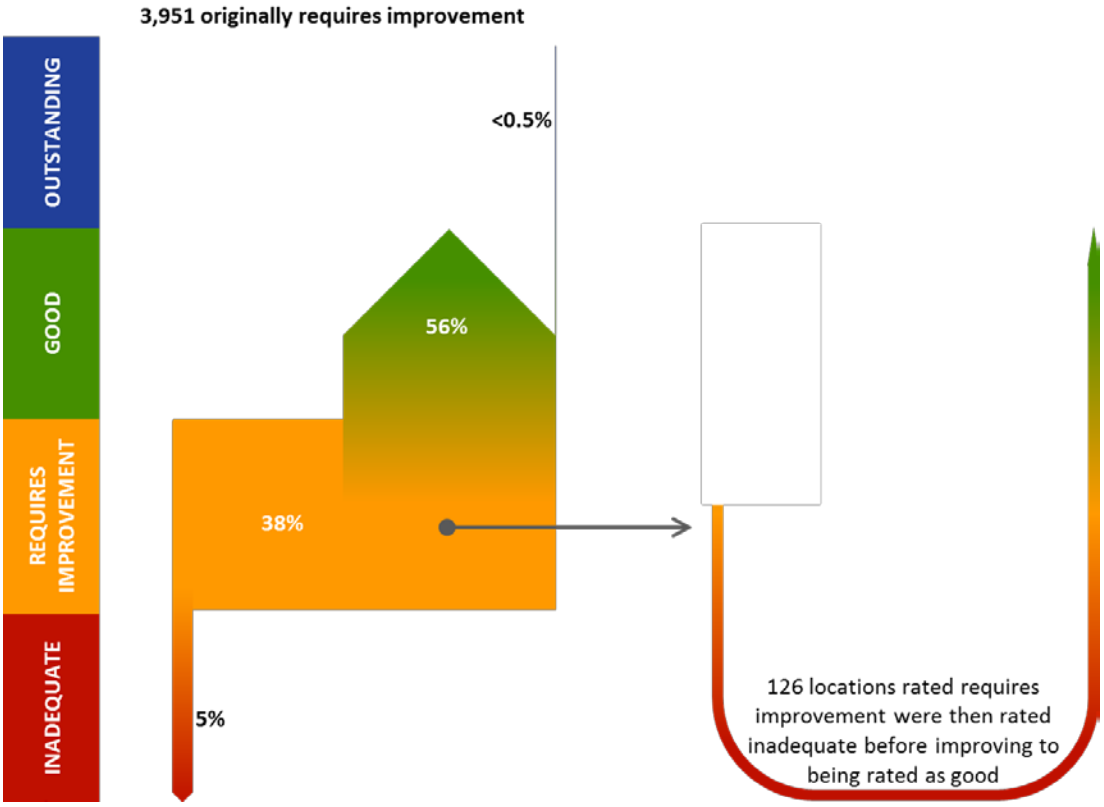
5.2 Services that fail to improve their quality

Although it is very encouraging to see so much attention given to inadequate services that has enabled them to improve, we have not seen the same rate of improvement in services that have been rated as requires improvement. We are clear that providers and commissioners must work to improve services rated as requires improvement to good and outstanding as well.

Of the 3,951 locations originally rated as requires improvement that were re-inspected, 56% (2,211 locations) had improved to a rating of good (figure 18). Of these, 6% (126) first deteriorated to a rating of inadequate, before improving to a rating of good.

However, in 38% of cases, there had been no change, and in 5% of cases, quality had deteriorated, resulting in a rating of inadequate. This means locations that require improvement have improved at a much lower rate than inadequate locations.

Figure 18: Re-inspection of services rated as requires improvement



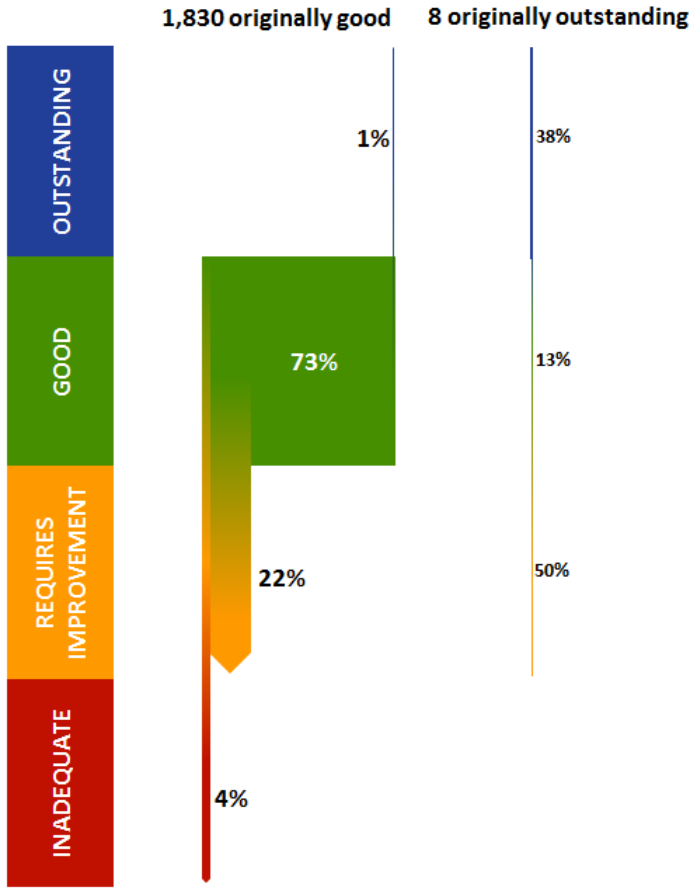
Source: CQC ratings data, 5 May 2017.

5.3 Services where good quality deteriorates

It is important that even good services maintain their focus on quality. Having completed our initial programme of comprehensive inspections, we are now looking at the movement in quality, not only of services rated as inadequate or requires improvement (which we check more frequently), but also those that at first inspection we rated as good. Although these are smaller in number, and the re-inspections are likely to have been prompted by concerns from staff, people using services and their families, or notifications from the provider itself, analysis is beginning to show that even those services that have provided the highest quality can deteriorate.

Of the 1,830 originally good locations that we have re-inspected (some planned as part of our timetable for return inspections but mainly prompted by concerns), only 1% had improved to outstanding. In 73% of cases, there had been no change, but in 26% of cases, quality had deteriorated, resulting in a rating of requires improvement (22%) or inadequate (4%). Even people who use the services of outstanding services can experience a decline in their care – of the eight services originally rated as outstanding that we have re-inspected, half of these have deteriorated by two ratings to requires improvement (figure 19).

Figure 19: Re-inspection of services rated as good or outstanding



Source: CQC ratings data, 5 May 2017

This early information shows that the sector continues to be fragile. Providers cannot afford to be complacent and need to monitor the quality of their services constantly, particularly when there are changes, for example the departure of the registered manager, to maintain a culture of person-centred care supported by well-trained, confident staff.

These findings from our inspections of services originally rated as good mean that we are not as confident as we need to be that services can always sustain their good practice. As we move into a more responsive and targeted phase of our inspections we will keep this under close review. We need to continue to improve the way we listen to and respond to the vital information that alerts us to poor performance, even among those services that have formerly been the best.

6. What is next for the regulation of adult social care services?

6.1 Improving how we work

In *A Fresh Start for the Regulation and Inspection of Adult Social Care* in 2013 we set out how we would change the way we do things – developing our regulatory approach, including ratings, and supporting our staff to deliver a programme of inspections that would build confidence among people who use services, their families and carers; providers; and commissioners.

We have now completed this initial programme of inspections, and we are able to take what we have learned to strengthen our assessments of adult social care services to make sure we continue to find out whether services are safe, effective, caring, responsive and well-led.

In line with our strategy for 2016 to 2021, our regulation of adult social care will also be more targeted, responsive and collaborative so that more people get high-quality care. A new, consolidated assessment framework for all of adult social care was published in June 2017 that reduced duplication between the key lines of enquiry and made more explicit the characteristics of inadequate, requires improvement, good and outstanding services. The consultation also launched in June 2017 seeks your views on the proposed further changes to help us realise our strategy, improve what we do, and to help us adapt to a changing adult social care market.

6.2 Improving services

This report has shown that high-quality services exist in adult social care, and all providers can use the examples here and on our website to strive for excellence. This is positive and to be celebrated but the variability in services means that too many people are experiencing care that we would not want for anyone we love. The difficulties some providers experience in making improvements and the deterioration we have seen in services originally rated as good or outstanding, point to a fragility in the sector that needs to be addressed.

We want more and more services to improve so that people's experiences of care continue to rise. CQC has been working as part of a collaborative group with sector leaders and people using services, their families and carers to create a shared commitment to high-quality, person-centred adult social care – *Quality matters.* This initiative aims to make a difference in care services by working across the sector with people who use these services, carers and families.

One of *Quality matters* central messages is that quality is the responsibility of everyone involved in adult social care. Ensuring people are at the heart of everything we do will help all of us who work in adult social care make a difference for people using services, their

families and carers. This is what CQC will continue to focus on by setting clear expectations; monitoring services, inspecting and rating them; celebrating good care and sharing good practice; ensuring providers know what action they need to take to improve; and taking action if they do not.

The conclusion of our initial programme of comprehensive inspections shows that there is much for the adult social care sector to be proud of but there is still much more for us all to do to ensure the public can have confidence that every service meets the Mum Test.

Acknowledgements

CQC would like to thank the stakeholders in the adult social care sector who have helped us develop this report. We particularly appreciate the support given by the Editorial Panel, which included Ruth Iveson, Jennifer Pearl and Julie Thorpe. They represented the Experts by Experience who have been an important element in our initial programme of comprehensive inspections.

We are grateful to the providers, managers, staff and people who use services that have provided the feedback and practice in our examples in this report that illustrate the very good work that is seen across England in adult social care.

And we would like to thank the CQC inspection staff who have worked hard to complete the initial programme of comprehensive inspections. They have provided a wealth of information, not only for this report, but for individuals looking to choose care and to providers to bring about improvement.

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CQC-377-072017

Consultation 2

Our next phase of regulation

A more targeted, responsive and collaborative approach to regulating in a changing landscape of health and social care

Cross-sector

Primary medical services

Adult social care services

June 2017

Contents

Foreword

As a result of CQC's inspections, England has, for the first time, a comprehensive baseline of information about quality in every NHS trust, primary care and adult social care provider. We know that many services are good and outstanding and we have evidence that, with the right leadership and support, services can improve.

Now that we have established this quality baseline we want to focus more on understanding how services improve and using our insight and regulatory approach to strengthen how we encourage improvement. We know that some services struggle to improve and this can be a particular problem for some of the adult social care services that we have repeatedly rated as requires improvement. We want to develop a consistent approach across all sectors and make sure that our approach to registration enables us to always hold the right people to account.

Our strategy for 2016 to 2021, published in May 2016, set out an ambitious vision for a more targeted, responsive and collaborative approach to regulation, so that more people get high-quality care. Using the principles set out in our strategy and the learning from our inspections, we want to continue the discussion about how we should develop our approach further and move into the next phase of our regulatory model.

We want your views on how we should respond to our changing society and the care environment in a way that supports improvement and sustainability, and that continues to make sure people have access to safe, effective, compassionate, high-quality care.

We started these detailed discussions about our regulatory model in December 2016, when we published *Our next phase of regulation*. This proposed principles for how we will regulate new models of care and complex providers, and changes to our assessment frameworks for health and social care and how we register services for people with a learning disability. It also detailed changes to our approach to regulating NHS trusts.

This second consultation also has proposals that apply to all regulated sectors, including how we register, monitor, inspect and rate new models of care and large or complex providers; how we use our unique knowledge and capability to encourage improvements in the quality of care in local areas; and how we carry out our role in relation to the fit and proper persons requirement.

Our other proposals focus on changes to how we regulate primary medical care services and adult social care services.

Throughout the development of our regulatory approach, we want to keep the elements that we know people value and to improve what people tell us we can do better. We will continue to work with people who use services, providers, professionals and our other local and national partners to co-produce what we do.

Thank you for giving us your views on how we can continue to develop a more targeted, responsive and collaborative approach to regulating in a changing landscape of health and social care.

Sir David Behan CBE
Chief Executive

Introduction

CQC's purpose is to make sure health and social care services provide people with safe, effective, compassionate high-quality care and to encourage care services to improve. Our strategy, *Shaping the future*, set out a vision for a more targeted, responsive and collaborative approach to regulation, and outlined four strategic priorities, which are to:

1. Encourage improvement, innovation and sustainability in care.
2. Deliver an intelligence-driven approach to regulation.
3. Promote a single shared view of quality.
4. Improve our efficiency and effectiveness.

In December 2016, we published a consultation *Our next phase of regulation*. It proposed principles for how we will regulate new models of care and complex providers, changes to consolidate our assessment frameworks for health and social care, our approach to regulating NHS trusts, and how we register services for people with a learning disability. Our response is published alongside this new consultation. We also published a joint consultation with NHS Improvement about our approach to assessing leadership and use of resources in NHS trusts.

In this second consultation, we continue to describe how we are developing our regulatory approach in line with the direction set out in our five-year strategy. We provide further information about how we are adapting to a changing landscape of care and how we propose to regulate providers that deliver care across sectors. We seek your views on specific proposals for how we will:

- register, monitor, inspect and rate new models of care and large or complex providers
- use our unique knowledge and capability to encourage improvements in the quality of care in local areas
- regulate primary medical care services and adult social care services
- carry out our role in relation to the fit and proper persons requirement.

These proposals have been informed by what we have learned during the past four years and the feedback we have received from the public, people using services, providers and other stakeholders, including feedback from our December consultation. The proposals build on our knowledge of specific sectors and our specialist expertise, and enable a more flexible and joined-up approach.

The *Next steps on the NHS Five Year Forward View* sends a clear signal about the increasing importance of system-based transformation of care built around local populations. In July 2016, we outlined our own intention to support innovation in health and social care, and we have spent much of the past year listening to, and learning alongside, those providers who have been developing new models of care within and across the NHS, and in primary care and

adult social care. We have worked with our partners to consider how we need to respond to changes in the way care is provided and to support improvement in a time of financial constraint. We will continue to develop our relationships with providers and other stakeholders so that our knowledge about service provision and the quality of care across the country is up to date. We will also continue to share good practice and to use our independent voice to encourage improvement.

In our December consultation, we asked for feedback on our principles for regulating in a complex, changing landscape. A summary of this feedback and our response is published alongside this consultation, and we have updated the principles in light of this. We will now use these principles to support a more targeted, responsive and collaborative approach to regulation, with greater emphasis on integration and leadership. They are:

1. We will always take *action* to protect and promote the health and wellbeing of people using services.
2. We will hold to *account* those responsible for the quality and safety of care.
3. We will be *transparent* about our approach, our regulatory decisions and how our actions support improvement.
4. We will work closely with our *partners* so that we take a coordinated approach to quality assessment, assurance and improvement.
5. We will be *proportionate* by using information about an organisation's structure and track record to determine when and how to inspect.
6. We will *simplify* our inspection process, where possible, to minimise complexity for providers that deliver more than one type of service.
7. We will deliver a *comparable* assessment for each type of service, regardless of whether it is inspected on its own or as part of a complex provider.
8. We will rate and report in a way that is *timely* and *meaningful* to the public, people using services, carers, providers and commissioners.
9. We will be *fair* to providers by not penalising them when they have taken on a service in order to improve it.
10. We will bring together inspectors who have *specialist* knowledge of different sectors to inspect jointly, where this is most appropriate for the provider.

These principles underpin the proposals that we describe throughout this consultation.

We are grateful for your feedback on this consultation, which closes on **Tuesday 8 August 2017**. See page 58 to find out how to respond.

PART 1: REGULATING IN A COMPLEX CHANGING LANDSCAPE

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

Introduction

In this section we set out our proposals for how we will develop our approach to registration and how we will change the CQC register in the future.

CQC has a statutory duty to maintain a register of who is legally able to deliver regulated activities. This register shows the public what services are available, who they are for and where to find them. The register also provides information that supports our regulatory functions to monitor, inspect and report on what we know about the quality of these services, and to take enforcement action where necessary.

In our five year strategy we proposed moving towards registering all organisations that are accountable for the quality of services to make sure that we can monitor quality across an organisation and hold the right people to account. By 'accountability', we mean:

> Accountability (either directly or through other legal entities or contractual arrangements) for the carrying on of regulated activities, where that direction or control has the effect of rendering the organisation accountable for the quality and safety of those activities, even where responsibility for delivering care sits with others.

We also propose changes to the way we structure the information we hold on our register of services to give the public a more accurate reflection of how care is delivered now, and to make sure that we can identify and adapt to future changes.

Summary of proposals

We propose to:

- develop our register so that it properly informs the public about ownership of providers, what services are provided, to whom and where to find these services
- clarify who is required to register with us so that we can hold to account all of those who are accountable for quality and make sure they improve quality across their services
- improve our understanding of large and complex organisations so that we can take a more targeted and responsive approach to regulation

- re-structure our approach to registration so that we hold more information about different types of services and so that we can make it easier to register new organisational forms and innovative types of services.

The changes we propose for registration

The scope of registration

Limitations of our current approach

Section 10 of the Health and Social Care Act (2008) requires that any person 'carrying on' a regulated activity must be registered with CQC. Until now we have interpreted this as meaning the legal entity that has ongoing direction and control of the regulated activity and which delivers the service day-to-day.

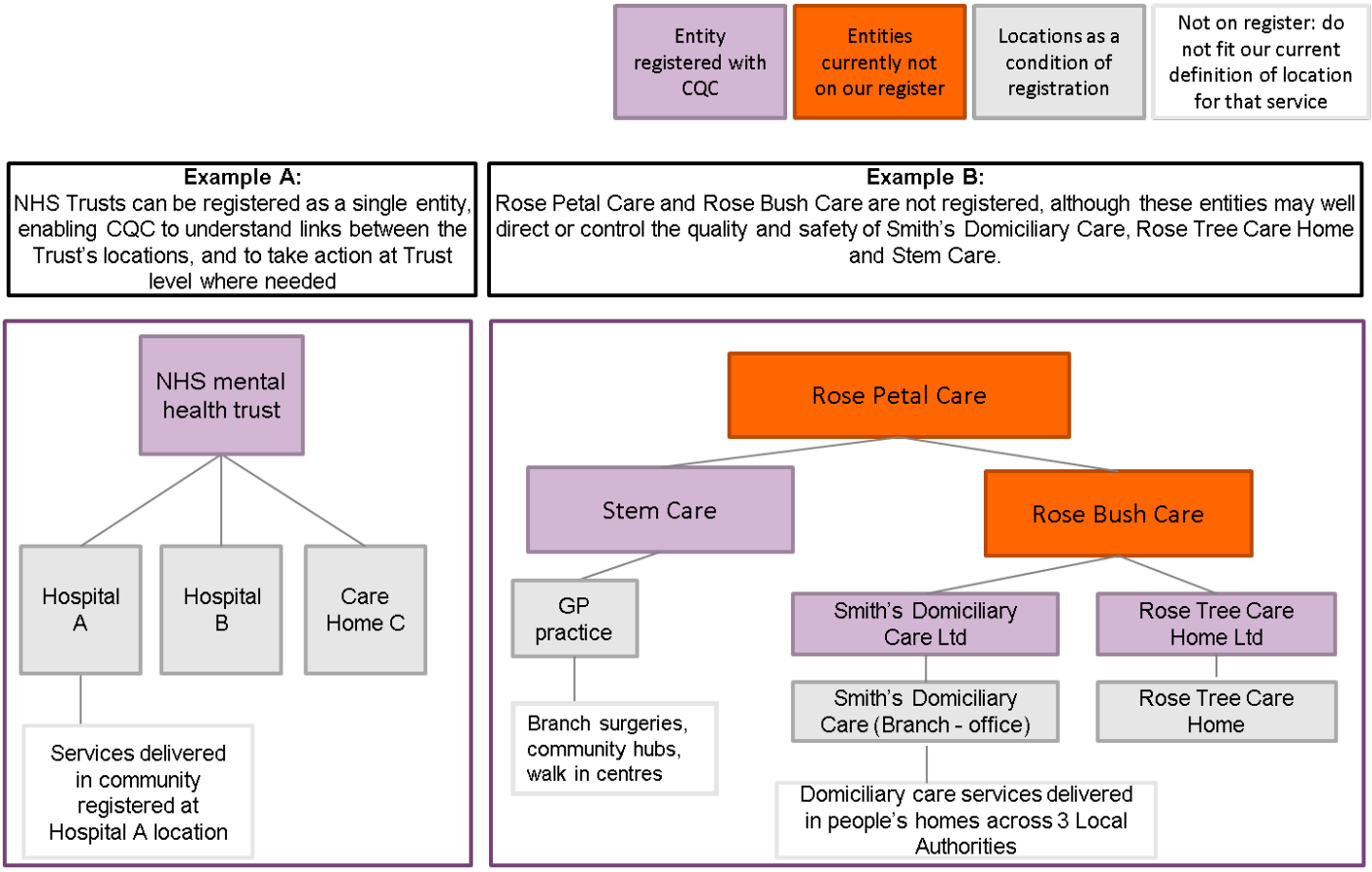
Where care providers are subsidiaries within wider groups, this means rather than registering the group as a whole, we have in most cases registered:

- the entity that is directly above the location (where regulated activities are provided or managed) in an organisational structure, and
- each provider individually.

At the beginning of June 2017, there were 30,868 providers registered with CQC delivering services across 49,394 locations. We estimate that 2,300 of these providers are part of around 350 wider groups, for example 'corporate providers' (including approximately 50 that are subject to Market Oversight Regulations). These wider groups run services from approximately 11,300 locations and own around a third of all care homes in England. We do not currently register at the corporate or group level for the majority of these services.

Here are two hypothetical examples of how this currently works in practice (figure 1).

Figure 1: Hypothetical examples of how CQC currently registers providers



We know that good leadership and accountability are crucial in ensuring that people receive safe, high-quality care in a way that is sustainable. This is not just about leadership at the local level but about recognising that leaders at the top of organisations also play a vital role in ensuring the quality of care. Our current approach to registration means that we have not been able to fully take account of this influence on quality, or to reflect the ways that many providers structure themselves and run their businesses.

Our new approach

Any providers that are currently registered with us will remain registered. We will also register any related organisations, such as parent companies, that also have accountability for quality. This means that these organisations will also appear on the CQC register, and the public will be given information about who is accountable for the care being provided.

By making changes to who is required to register, we will be able to monitor and inspect at provider level and, if necessary, require organisations to take action to improve quality using our enforcement powers (see the following table). These changes will mean that we can take action against those that are accountable for the failings. This may be the providers already registered with us, or it might be other related organisations, such as those owning and directing the provider. In the example in figure 1, this means that if there are failings in Stem

Care or Rose Bush Care we could take action against each provider. However, we could also take action against Rose Petal Care if this company was accountable for the poor quality of care across the two providers.

We want people to be able to see the history of a service where they come under new ownership, new contracting arrangements or if there is an administrative change such as change of address. In making decisions about registering providers we intend to take more account of this history.

When a person checks the register using our website to look at an individual care service, they will see a list of all the providers that are involved in delivering and are accountable for regulated care.

	Current approach to registration	New approach to registration
Register	• The CQC register shows the organisation directly delivering care day to day, but not other organisations that have some accountability for that care • We may know when separate providers are linked by common ownership and/or management, but legislation does not require registered providers to tell us about these links • The registered provider is as close as possible to delivering day-to-day services • Where services change owners, or where existing owners change the legal entity of the provider, the regulatory history and previous rating and enforcement actions do not continue, and are not displayed on our website.	• The CQC register will show all organisations based in England that are accountable for care being provided • We will have oversight of how providers fit into wider organisations and who is influencing or directing the quality of that care • We will continue to register the entity that is as close as possible to delivering day-to-day services, but we will also register organisations that are accountable for delivering these services above this level • Where services change owners, or where existing owners change the legal entity of the provider, the regulatory history stays with a service. This includes the ratings and any enforcement action. The information will be displayed on our website and will remain part of the CQC register
Monitor	• We can see a provider's strengths and weaknesses but cannot always identify systemic issues across	• We will know about the quality of care across the full range of a group's services sharing common ownership or

	providers, which may be linked by ownership or management	management. This will allow us to make much more informed decisions about how to respond to poor care and where to appropriately target our engagement or regulatory action to improve services
Inspect and rate	• We can target inspection activity but have limited scope to make the links where we have concerns across different services. This can delay inspections and duplicate effort both for our inspection teams and for providers • We have limited ability to carry out focused inspections at the overall leadership level for all health and social care providers, or to rate them; we can currently only do this in NHS trusts • We cannot use our findings to encourage improvement by recommending or requiring a provider to take action across all of its services • We are not able to inspect at relevant headquarters for organisations owning multiple providers	• We will retain the ability to inspect and rate at local service level • We will have a much more joined-up approach to providers that share common links. This will enable us to target inspections more effectively, with the option of assessing and rating the overall leadership of the organisation • We will be able to use inspection findings as a basis for more effective interaction with leadership, drawing together all we know and setting out what action we want the provider to take • We will be able to undertake inspection at relevant headquarters for organisations owning multiple providers where this is appropriate
Enforce	• We cannot always hold to account those ultimately responsible for care, as we can only carry out enforcement against legal entities that are registered with us • We risk having to hold lower levels of provider organisations to account even though true accountability does not sit at that level (for example, the fit and proper persons requirement for directors)	• We will still be able to focus enforcement action at any level of a group or organisation, but will also be able to hold overall leadership to account • We will have an enhanced ability to identify those ultimately accountable for delivering care

Independent voice	• We can't be fully confident that the information we publish in the register and in inspection reports and national publications reflects all the facts about the provider's structure and the health and care market • People choosing and using care services will not know that their local service is owned or operated by a company other than that shown on our website	• We will have a definitive register and greater confidence in the findings that we report • We will be transparent about the links between local services and organisations that are responsible for the quality of care. We will be able to report on the quality of care across these groups and organisations to enable people to make more informed judgements and choices

Defining who is accountable for the quality of care

Our proposal brings all those accountable for care onto our register. We know that different organisations are structured and run in a variety of ways and we will need to consider each provider individually. However, we believe we can define some criteria that will help us determine when an entity has responsibility for quality and so should be registered with us. These criteria would include whether the entity:

- Manages and delivers assurance and auditing systems or processes that assess, monitor and drive improvement in the quality and safety of the delivery of regulated activity and to which entities delivering that activity are accountable.
- Has the right to require providers of regulated activity to submit consolidated annual budgets in advance for approval.
- Has the right of veto such that entities providing regulated activity will only be entitled to carry on their business in accordance with financial plans that have been signed off.
- Directly develops and enforces common policies on matters such as staffing levels, clinical policy, governance, health and safety, pay levels and procuring supplies that must be adhered to by entities providing regulated activity.
- Has the right to make employment decisions concerning:
    - People who work or are seeking to work in support of the delivery of regulated activity
    - People who run or who seek to run individual care settings that deliver regulated activity
    - Board membership where the board is responsible for holding to account services or entities delivering regulated activity.

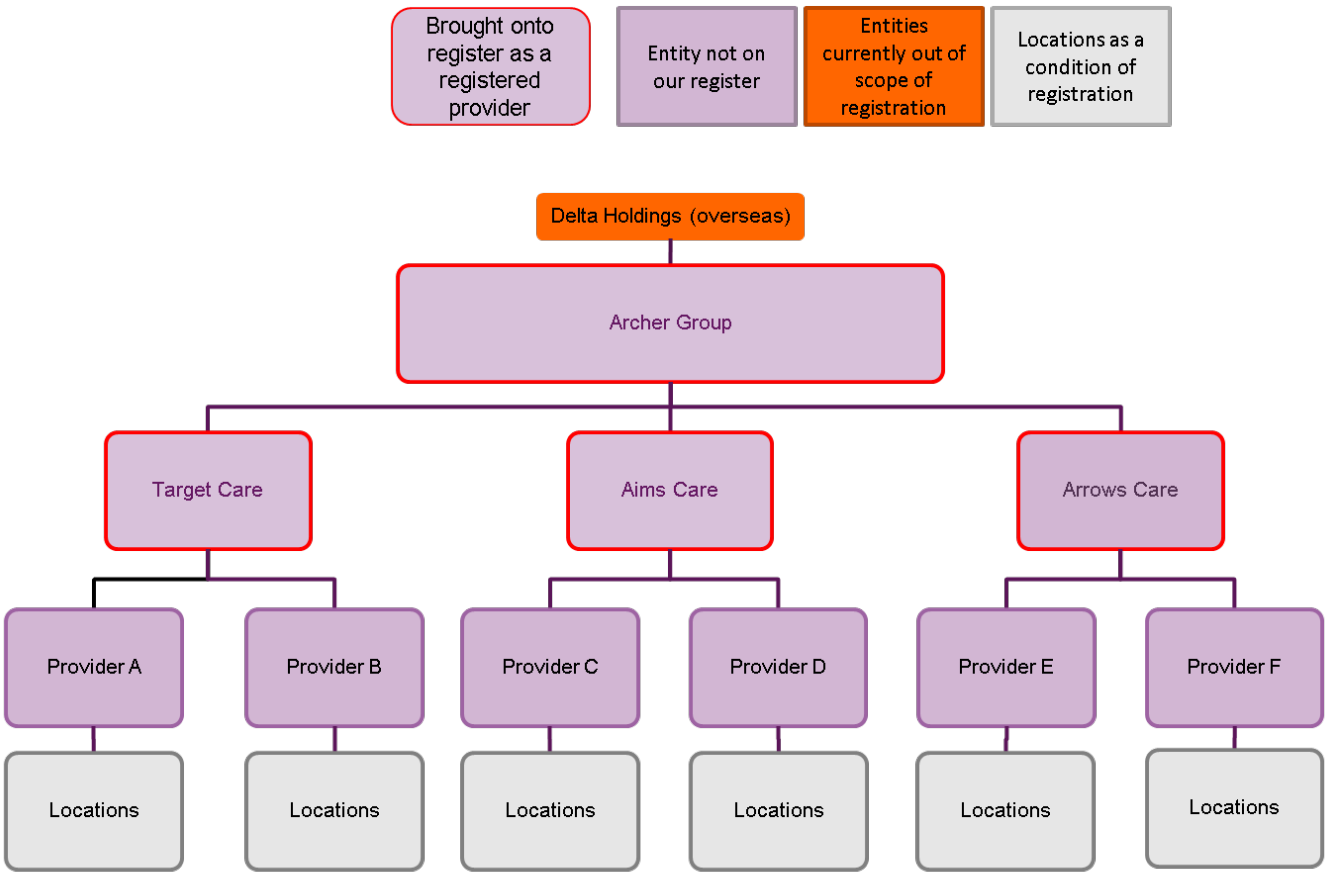
In all cases, we will only be interested in those parts of an organisation that exert significant influence over the quality and safety of services. Organisations such as hedge funds and other

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.

CQC was established to regulate health and social care in England, and cannot carry out enforcement action against companies that are not based in England. Therefore, we will not seek to register those that are not based in England. However, we will require providers to inform us of owners that are not based in England and will use this information to link together what we know about providers with common ownership and publish this on our website.

Figure 2 shows how this would look in practice. In this hypothetical example, we would bring four additional entities into registration as they meet the test for having sufficient direction and control over the delivery of regulated activities. In other words, they meet the definition of a 'service provider'. This would mean that when somebody used our website to look up Provider A on the register, they would also see that Target Care and the Archer Group have an influence on the quality of care provided by Provider A. If we needed to take enforcement action, we could take this against whichever organisation was accountable for the regulatory breaches.

Figure 2: Hypothetical example of the effects of our registration proposals



Consultation questions

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?

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

Changing the structure of the register

Limitations of our current approach

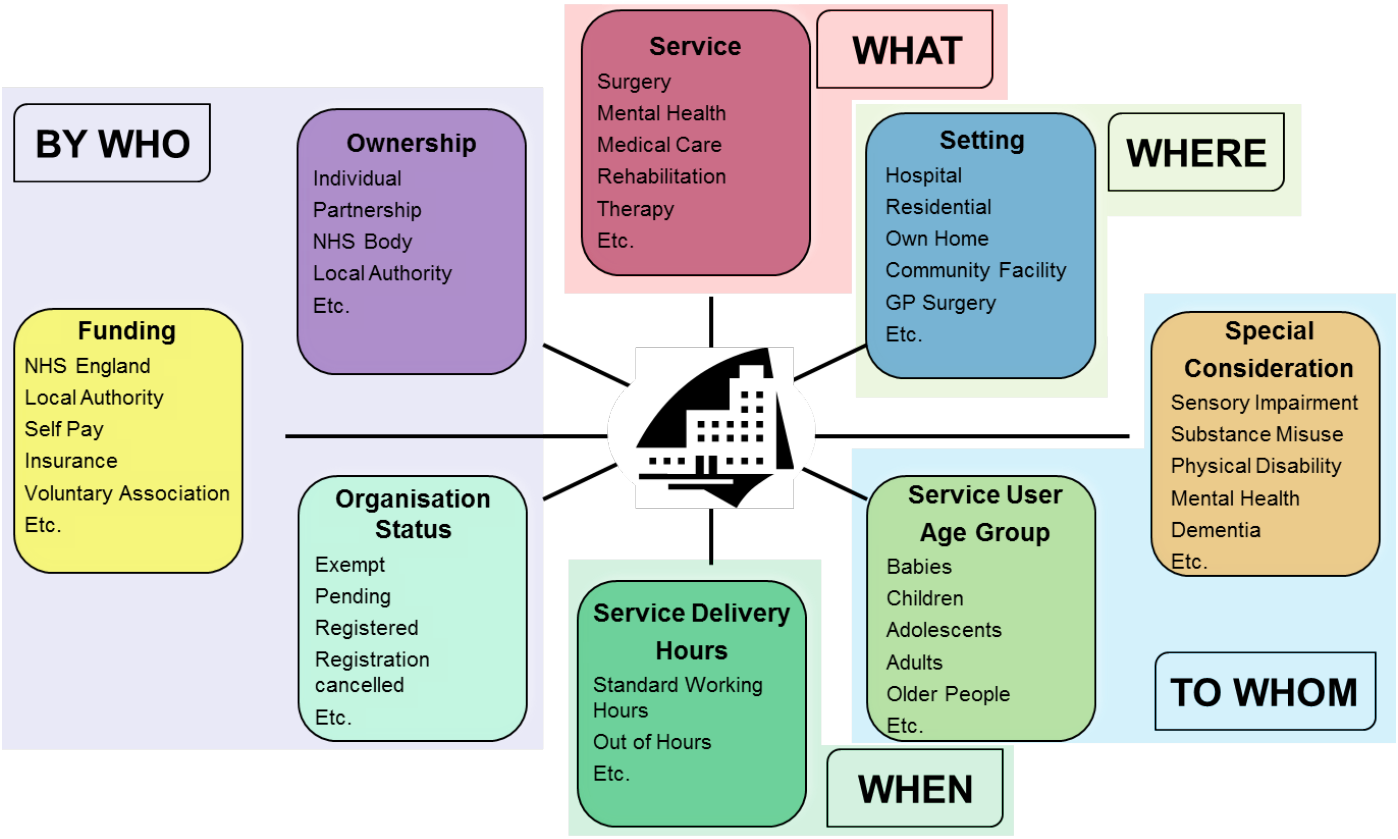
The CQC register currently displays the provider, the regulated activities and the locations from which the provider can carry on those regulated activities. The way our register is currently organised restricts providers to deliver specific regulated activities only at, or from, specific buildings defined by our 'location rules'. This means providers need to apply to us before they can change the address of buildings they manage or deliver care from (as well as to change or add regulated activities). This works where a service is delivered in a single building (such as a care home), but is less effective when services are delivered across multiple sites, in communities, in people's homes, or digitally, such as through online GP services.

We propose to change how the register is structured so that it provides a more useful record of not only who is providing care, but also how, to whom, where and when.

A new structure

We propose to use the information that providers record in their statement of purpose so that the register will include **what** type of services are provided, **who** the service is for, **what** type of setting it is provided in, **where** the service can be found and, where relevant, **how much** care is provided. Figure 3 illustrates this with some examples.

Figure 3: Example information to support a new register structure



By collecting this more detailed information we will be able to describe services in a way that is meaningful to the people who use them and to providers themselves. It will also enable us to be more responsive to innovation, as this approach will allow us to register new types of services in line with changes in health and social care.

Current structure of the register	New structure of the register
• The CQC register shows a provider, their regulated activities and the locations from which they are registered to carry these on	• The CQC register will give more detailed information about what services are provided, including the type of service, who it is for and the type of setting
• We register providers and registered managers for the regulated activities they deliver	• We will continue to register providers and managers against the same set of regulated activities
• Records the locations at which a provider carries on regulated activities, based on specific buildings and our location rules	• We will retain buildings as a core feature where appropriate (for example, care homes or hospitals) and continue to record where services are located. However, we

	will have a wider set of criteria to describe a service. Location will be only one attribute of that description
• Places limits on how much care a provider can deliver on the basis of the number of buildings it operates from	• We will have a wider set of criteria that we can use to set the limits within which a provider can operate (for example, the geographical area a domiciliary care agency can cover)
• Does not reflect the size of services, where the public can access them, and where they are provided (online, in communities or people's homes). This is because the provider may register one office (a location), but deliver care in a different area or across the country. This is particularly relevant when care is delivered in the community or in people's homes	• We will have a more accurate picture of what the service delivers, where, to whom and when
• Does not make enough use of information in a provider's statement of purpose because of the limitations of our current systems and processes	• We will make more use of the valuable information in statements of purpose by developing our systems and processes
• Applies the location rules differently for each type of service. This makes it more confusing when services are being combined in new ways, such as in new models of care	• We will understand a provider in terms of the description of its services, and reflect this in the register

Consultation question

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?

Implications for our fees policy

From 2017/18, we will receive around 90% of our funding from providers. We define our fees as a charge for entering and remaining within a regulated market, and we then adapt this to account for provider type and size. We do not intend to change this approach, but changes to

the level at which we register providers and the structure of the register will have implications for our fees scheme and income. This will provide better information and enable us to be clearer with providers about how we calculate their fees using information in the register. The overall cost of regulation will not increase as a result of this work. We will ensure that the fees scheme aligns to this work so that our fees remain proportionate.

We are required to consult on any changes to our fees scheme, and any proposals to charge a fee for registration applications. We will ensure that the registration timetable aligns with our fees timetable, taking into account our duty to consult providers and seek the approval of the Secretary of State.

Timetable for implementation

We recognise the importance of a phased, well-managed transition for providers. We also need to allow sufficient time to develop and test new information systems, policies and procedures.

We will engage with providers whose registration will expand to include other companies within their wider group in order to identify the appropriate level to register.

Any changes to the way we record services on the register will affect all providers. We plan to test the core dataset for registration using provider information collections before applying it to providers' registrations.

April 2017 to March 2018:

- Develop, plan and assess the impact of our proposed changes.

April 2018 to March 2019:

- Start live testing, continue to engage with stakeholders and begin phased implementation.

April 2019 to March 2021:

- Continue phased implementation and engagement with stakeholders.

1.2 Monitoring and inspecting new and complex providers

Introduction

Since we introduced our new approach to regulation three years ago, we have seen an increasing number of providers operating across multiple sectors, and we expect to see many more new and complex models of care emerging over the coming years, including accountable care organisations and systems.

In this section, we describe our approach to monitoring and inspecting 'complex providers', by which we mean:

> Organisations that deliver services across more than one sector. For example, NHS trusts that provide GP services or care homes, independent community health providers that deliver NHS 111 services, or 'new models' and 'accountable care organisations (ACOs)', such as fully integrated multi-specialty community providers (MCPs) and integrated primary and acute care systems (PACS).

We also describe how we will combine our regulatory approaches for NHS trusts, primary medical services and adult social care and how we will build on our experience of regulating existing complex providers to monitor and inspect services in a more streamlined and coordinated way.

Summary of proposals

We propose to:

- identify a single CQC relationship-holder for each complex provider, who will work alongside named leads for each type of service to coordinate our regulatory activity for that provider
- align the way we collect information from providers and combine our monitoring information to inform a single regulatory plan
- coordinate our inspection activity within a defined period, except for any focused inspections in response to concerns about quality in individual services
- assess leadership and governance across all services when we assess the well-led key question in NHS trusts, and in any future provider-level assessments in other sectors (see section 1.3)
- test this approach, including with a small number of accountable care organisations and systems.

The changes we propose to monitoring and inspecting complex providers

Monitor

In our proposals for NHS trusts, GP and adult social care services, we describe how we will place more emphasis on monitoring to enable a more intelligence-driven approach to regulation. We commit to working closely with providers and other stakeholders and making better use of information throughout the year.

For complex providers, we will coordinate our monitoring activities and combine information about their services. We will identify a single CQC relationship-holder who will be the main point of contact between CQC and the provider. They will have responsibility for coordinating and planning all aspects of the provider's regulation, and will work alongside the named CQC lead for each type of service. In most cases the relationship holder will be from the CQC directorate that inspects the majority of the provider's services. For example, if an NHS trust is operating a number of care homes, the relationship holder will be from our Hospitals directorate, and they will work with our inspectors from the Adult Social Care directorate.

We want to make sure that we continue to collect the information we need about individual services but that we do not place additional burden on providers by sending multiple requests for information. We will build on our experience of regulating existing complex providers and will develop an approach to collecting information that also helps us understand any changes they are making or propose to make in the future. We will review how we engage with local partners, the public and other stakeholders, to make sure that we can capture their views on all services and, where relevant, the organisation as a whole. This will include speaking to people using services about how well care is coordinated to meet their needs.

We will strengthen our internal cross-sector risk and planning arrangements to improve how we coordinate our regulatory activity for these types of providers. Each year we will hold an internal regulatory planning meeting where we will review the information we hold about a provider and its services, and agree an appropriate inspection schedule. This will inform which services we need to inspect, when and how.

As well as this annual regulatory review, we will continue to respond to alerts and concerns about individual services in line with the approach set out for NHS trusts, primary medical care and adult social care services. When inspectors identify the need to carry out a focused inspection in addition to the planned inspection schedule, they will liaise with the relationship holder.

Current approach to monitoring	New approach to monitoring
• A separate approach to Intelligent Monitoring for each sector • Different approaches to provider information collection in each sector • Stakeholder engagement before inspection for each type of service • Named inspectors for each service but no overall relationship holder	• Coordinated approach brings together monitoring information for all services • Provider information collections are aligned across sectors • Single relationship holder for each provider with named CQC leads for each type of service • Annual internal regulatory planning meeting involving all CQC sector leads

Inspect and report

The relationship holder will work with the named leads for each of the services to develop a single regulatory plan, with inspections scheduled, wherever possible, within a defined period. This will help to avoid multiple inspections and help to simplify our inspection process. The plan will take into account the range of services provided, the inspection frequencies set out for each sector, and the risks identified through monitoring. Inspections will be conducted by one or more sub-teams, as needed, with expertise that reflects the scope and configuration of services. We will use the relevant key lines of enquiry from the assessment frameworks for health care and social care services.

When assessing the well-led key question at NHS trust level, we will look at how well the trust is working with its partners and how well it is integrating services across the sectors, where this is relevant. CQC staff from all inspection directorates will be involved in the quality assurance process. In section 1.3 we discuss how we might assess quality at provider level for other types of organisation, subject to the changes to registration described in section 1.1.

We will improve our website to make it easier for people to see the links between services and the overall provider.

Current approach to inspection	New approach to inspection
• Separate inspections for different services and sectors • Single provider-level assessment for combined trusts only	• Coordinated schedule of inspections • Assessment of well-led key question at a provider level reflects leadership across all the services that the provider delivers • Inspections will be carried out by teams of hospital, primary care and adult social care

Integrated health and care systems

We are also seeing an increasing number of organisations developing partnerships to deliver care as part of more integrated health and care systems. These include accountable care systems (ACS) that receive more control and freedom over a local health economy in order to provide joined-up, better coordinated care that keeps people in their local population healthier for longer.

In most of these cases, given that there is no change to the legal responsibilities of each organisation working as part of the ACS, we expect to continue to register and regulate each organisation as a separate legal entity. This means that we can hold the right people to account for the quality of care they provide. However, we recognise that there could be benefits in taking a coordinated approach to monitoring and inspecting these services, in a similar way to that described above. This would help us understand the structure and aims of the model, and enable us to provide an independent assessment of how well the individual providers and services are working together to meet people's needs.

This could include a single relationship holder for a group of providers, a coordinated planning review and inspection schedule, and potentially an assessment of leadership, governance and integration across the whole model or system. We propose to test this in a small number of areas during 2017/18. Our approach will be shaped through discussion with local providers and stakeholders, as well as with our system partners, such as NHS England, NHS Improvement and the Local Government Association.

Timetable for implementation

April 2017 to March 2018:

- test a coordinated approach to monitoring, inspecting, rating and reporting on health and social care services in a sample of areas, with a focus on evolving accountable care organisations and systems.
- identify relationship holders and introduce joint regulatory planning meetings and joint inspections for existing complex providers
- begin using provider information collections to identify complex providers and links between services.

April 2018 to March 2019:

- continue using provider information collections to identify complex providers and links between services
- test approach with independent health and social care led organisations, alongside live testing of provider-level registration

- test approach to provider-level assessment and, if appropriate, ratings for complex providers, in line with proposals set out in the next section
- agree approach to regulating accountable care organisations and groups of organisations in accountable care systems.

Consultation questions

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]

3b Please explain the reasons for your response.

1.3 Provider-level assessment and rating

Introduction

In this section we set out proposals to assess the quality of care at provider level and consider options for how this might work across health and social care sectors, including where providers deliver more than one type of service. By provider level, we mean:

> The highest level at which we register any organisation that delivers more than one service. This would include the board level of an NHS trust or independent sector provider, or the management level of a GP federation or care home group.

We explain how we will develop and test our approach with different types of organisation alongside the proposed changes to the scope of registration discussed in section 1.1.

Summary of proposed changes

We propose to introduce a provider-level assessment and/or rating for providers across all the sectors we regulate, subject to the proposed changes to registration.

We will:

- continue to rate NHS trusts at provider level in 2017/18 based on our assessment of the well-led key question and use our aggregation principles and professional judgement to rate the other four key questions
- develop a new provider-level assessment for NHS trusts, corporate providers of health and social care services, large-scale general practices and other complex providers
- work with providers and other stakeholders from across the sectors that we regulate to develop and test the assessment
- introduce our assessment in phases to reflect the organisational context of providers, including where registration changes are needed.

What we propose for assessing and rating at provider level

Provider-level assessment in all sectors

During our first phase of comprehensive inspections, the only type of provider that we registered and rated for the quality of care at provider level was NHS trusts. This year, we will continue to rate NHS trusts at provider level for all five key questions. The rating for well-led

at trust level will be determined through our assessment of the well-led key question. Provider-level ratings for the other four key questions will be determined using our ratings aggregation principles and the professional judgement of our inspection teams, as outlined in our guidance for NHS trusts, published alongside this consultation.

Where trusts deliver services across sectors, for example GP services or care homes, these services will be inspected and rated in line with the approach described in Part 2 of this consultation document, and will be coordinated in line with our approach to complex providers described in section 1.2. The quality of these services will be considered in the trust-level assessment of well-led, and our inspection teams will work together to agree how their ratings should be reflected in the trust-level rating.

To ensure that we make consistent decisions, we follow a set of 16 ratings principles when rating core services, locations and providers. We may use professional judgement and deviate from the principles when aggregating ratings to ensure they are proportionate to all available evidence and the specific facts and circumstances. This includes when a provider has taken on new services or where a service or location significantly differs from the other services – for example in the type and mix of service (including other than hospital care), or the size of a service, its type of setting, or the population groups it serves. We will consider any concerns we have identified, such as the potential impact on people who use services and the risks to quality and safety. We will then consider how confident we are in the service's ability to address these concerns.

We can already comment on the overall quality of care in large provider groups in other sectors, using the findings of our service-level inspections. However, we propose to develop a provider-level assessment for all sectors, including NHS trusts, corporate providers of health and social care services, large-scale general practices and other complex organisational forms. This will enable us to hold them to account more effectively at this level, including when we have rated several of their services as requires improvement or inadequate.

We will introduce provider-level assessments as we start to change the way we register providers, in line with our approach to registration described in section 1.1. We will test this with providers that are already registered at this level, for example some corporate providers of independent healthcare. This assessment will be in addition to our inspection and rating at service level, which will continue as set out in our proposals for regulating hospitals, primary medical services and adult social care.

Rating at provider level

Since the introduction of our ratings approach, we have seen that ratings can have different purposes for different audiences at provider and service level (summarised in figure 4).

In taking forward our proposals, we need to make sure that we continue to give people the information they need and that we can continue to encourage improvement. We will need to consider whether we should rate providers of health and social care at the highest level, as we

already do for NHS trusts, and whether this would be effective in encouraging improvement and providing accountability to the public, people who use services, and commissioners of care. We may introduce provider-level rating across some or all sectors.

As new models of care evolve, we will also need to consider how we can develop a more consistent approach across different types of organisation, including NHS trusts and providers in the independent sector.

Figure 4: Purposes of CQC ratings for different audiences

Purpose of ratings	Audience
Help people to choose services	Commissioners, people who use services , the public (but limited at provider level)
An incentive to improve performance in delivering safe, high-quality care	Health and care providers and their staff
Increase accountability and transparency about quality of care	Commissioners, public, people who use services
Enable comparisons of performance over time and between organisations	Commissioners, public, providers, national bodies including CQC, NHS Improvement, NHS England

Developing our approach

We plan to involve providers and stakeholders from across all sectors in developing our approach to an assessment at provider level. We will consider the scope of the assessment and the benefits of rating, and will test and evaluate the effectiveness and affordability of our proposals with different types of organisation.

We have been exploring a number of possible options for our provider-level approach, including:

1. **Developing a new provider-level assessment framework**, where the scope of the assessment would reflect those elements of the existing five key questions which are most relevant at the provider level.
    - Bespoke assessment framework
    - KLOEs reflecting what good looks like at provider level; these would combine parts of the five key questions with other factors which influence care at this level
    - A provider inspection team would undertake the provider-level assessment

- It would result in a narrative report, and potentially a single rating for quality and safety could be awarded for some or all provider types.

2. **Assessing well-led only at the provider level**, using a single well-led assessment framework, based on the existing frameworks. The other four key questions would not be assessed or rated at provider level.
    - A single well-led assessment framework, based on the existing healthcare framework
    - A provider inspection team would undertake an assessment of well-led using the existing framework
    - Outcome would be a narrative report, and potentially a rating for well-led could be awarded for some or all provider types
    - No ratings for the other four key questions at this level.

3. **Assessing up to five key questions at provider level,** using a single well-led assessment framework, based on the existing healthcare framework, plus assessment frameworks for some or all of the other key questions applied at provider level.
    - A well-led assessment framework, based on the existing healthcare framework.
    - Bespoke assessment frameworks for four key questions to ensure they can be applied at provider level.
    - A provider inspection team would undertake an assessment of all five key questions at provider level
    - Outcome would be a narrative report, and potentially a rating for all five key questions could be awarded for some or all provider types
    - Where five ratings are awarded, these could be aggregated into a single provider level rating for some or all provider types.

4. **Adopting the current approach in NHS trusts for other types of provider**, with an assessment and rating for the well-led key question at provider level, and rating of the other four questions based on aggregation and professional judgement.
    - A well-led assessment framework, based on the existing healthcare framework
    - A provider inspection team would undertake an assessment of well-led using the existing framework
    - Outcome would be a narrative report. A rating for well-led would be based on the assessment, and the provider rating for the other four key questions would be based on aggregation and professional judgement for some or all provider types
    - Where five ratings are awarded, these could be aggregated into a single provider level rating for some or all provider types.

Figure 5: Options for our provider-level approach

Option	Assessment framework	New or existing framework?	Ratings	Assessment or aggregation?
1	Provider level assessment	New	One provider rating	Assessment
2	Provider well-led	Existing	One well-led rating	Assessment
3	Provider five key questions	New	Five key questions and overall ratings	Assessment, with aggregation for overall rating
4	Provider well-led	Existing	Five key questions and overall ratings	Assessment for well-led/aggregation and professional judgement

With NHS Improvement, we plan to introduce an assessment of an NHS trust's use of resources. This is for acute trusts initially and then for all NHS trusts. We will develop and test options for combining use of resources and quality ratings, and will consult on options later this year.

We will develop our provider-level assessment approach in parallel with our approach to assessing use of resources, and the development and testing will continue as we make changes to the scope of registration.

Current approach to provider-level assessment	New approach to provider-level assessment
• NHS trusts only	• A wider range of providers including corporate providers, NHS trusts, large-scale GP services, new care models
• Includes an assessment of well-led and rating at provider level • Ratings for other four questions aggregated using professional judgement	• Assessment likely to include well-led • Could go beyond well-led to reflect other aspects of quality and safety. May include an assessment or aggregated rating for other questions • Will include a use of resources rating for NHS trusts
• Core services and hospital ratings based on aggregation	• Core services and hospital level ratings continue to be determined through aggregation

Timetable for implementation

April 2017 to March 2018:

- Consultation on more detailed proposal, informed by the current consultation, (Winter 2017/18)
- Development of operational approach (Spring 2018).

April 2018 to March 2019:

- Pilot assessments alongside live testing of registration approach
- Publish final assessment approach
- Begin provider-level assessment in line with registration timetable.

Consultation questions

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]

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

1.4 Encouraging improvements in the quality of care in a place

Introduction

As the regulator for the quality of health and adult social care in England, we are responsible for the regulation of providers. This helps ensure that people receive safe, effective, compassionate and high-quality care. But we know that people's experiences are also affected by how well services work together and that quality can be influenced by factors that are outside a provider's direct control.

We need to make sure that we are able to understand and assess quality in a way that remains meaningful to the public, that we can always tell who is accountable for quality locally, and that we offer a proportionate approach that supports providers and commissioners to deliver the aims of the Five Year Forward View.

In this section we describe how we will use our unique knowledge and influence across the health and social care sector to work with our national and local partners, to encourage improvement, innovation and sustainability beyond the boundaries of individual providers, in line with the direction set out in our five-year strategy.

When we refer to quality of care in a place, we mean:

> The quality of health and social care services within a geographical area and their collective impact on people's experiences and outcomes. For example, the quality of care provided within local clinical commissioning group or local authority commissioning areas, within sustainability and transformation plan areas, or nationally in England.

Summary of proposals

We propose to:

- use our monitoring and inspections of individual providers to assess how well services are working together and to understand the impact on people's experiences
- use our insight about quality in a place to help us understand the context in which providers are working
- use our independent voice and relationships with national, regional and local partners to share our view of quality across health and social care and to highlight cross-system issues
- undertake a small number of targeted reviews that look at how health and social care work together and identify improvements that benefit people that use services

- work with local providers and commissioners, and national oversight bodies – such as NHS England and NHS Improvement – to coordinate what we do to make best use of our respective powers in order to overcome barriers to improvement.

Understanding how providers work together to improve quality

In our December consultation we proposed aligning our assessment frameworks for health care and social care and strengthening our focus on leadership, partnership working and integration. This will help us to look more closely at the ways in which providers are working together in a local area and the experiences of people moving within and between services. This may include, for example, looking at how:

- GPs refer people to acute or mental health services and support people living in care homes
- acute services liaise with GP, social care and community care teams and discharge people out of hospital
- adult social care staff assess and support people's healthcare needs and coordinate care with healthcare services.

We propose to:

- develop CQC Insight – our new approach to monitoring data in each sector – to include information about quality in local areas and, where relevant, about the quality of a provider's different services, so that our inspectors have a better understanding of the context in which services are working
- use our new cross-sector risk and planning and scheduling arrangements (described in Section 1.2) to identify, share and follow up information about quality in the area, including the views of people using services, their families and carers, about their experiences across different services
- develop inspection prompts for hospital, primary medical care and adult social care services that enable us to assess the interactions between providers and the impact on people using services
- report our findings about local partnership working and integration in our provider inspection reports and share with local partners and other stakeholders (as set out below).

Using our independent voice to encourage improvement, innovation and sustainability

We will make more effective use of our knowledge and our independent voice to encourage improvements and inform sustainability and transformation plans (STPs). We will bring together the information we hold about quality in a local area, highlight changes in quality and priorities for improvement, and share examples of good practice and innovation. We will continue to provide a national view of quality across the health and social care system and the development of integrated models of care.

We propose to:

- develop CQC Insight products that draw on the information we hold, including information about people's experiences of care, our inspection findings and local knowledge, to provide a view of quality across national, STP and local commissioning area footprints
- share information with our national partners, local commissioners and other stakeholders, including Quality Surveillance Groups, to help them identify priorities for improvement and agree where further monitoring, inspection or other activity may be required by CQC or others
- use our independent voice, including our national State of Care report, to comment on the changing landscape of care provision, how providers are working together, and the quality of care for local populations.

Helping local partners identify opportunities for improvement

In recent years we have tested different ways of looking at the quality of care across a place. We have provided views of quality in Salford, North Lincolnshire and Tameside, and we have looked at urgent and emergency care networks in the Bradford and Airedale area and in South Warwickshire. This work has developed our understanding of quality across a system. We have built on this learning to test a more targeted approach to place-based activity in Cornwall and the London Borough of Sutton. In 2017, the Secretary of State for Health also asked CQC to carry out targeted reviews across a small number of areas to look at how health and social care work together and what improvements could be made to benefit people who use services.

We will develop a framework that supports local inspection teams to identify and respond to system-wide issues that we identify as part of our internal cross-sector conversations and risk meetings. This may inform what we look at when we carry out our routine inspection activity. In more exceptional circumstances, we may agree with our partners about the benefit in using our review powers to help local stakeholders understand the issues affecting quality and to identify opportunities for improvement.

We propose to:

- develop a framework to enable us to assess quality across a local system, with a focus on leadership, governance and collaboration between providers and commissioners across sectors
- work with our system partners, NHS Improvement, NHS England and locally with Quality and Surveillance Groups, to ensure that we are making the best use of our respective powers, coordinating our activity and sharing what we find in a way that is meaningful to people using services and local stakeholders.

Timetable for implementation

April 2017 to March 2018:

- publish findings from our work in Cornwall and the London Borough of Sutton (Summer 2017)
- develop and test prompts to assess integration as part of our service-level inspections
- continue to develop and test area data profiles and engage with partners to shape the data that we can offer for external use
- carry out targeted reviews in a small number of areas, as requested by the Secretary of State.

April 2018 to March 2019:

- continue to develop our approach to sharing insight and agreeing action with our national and local partners
- agree a programme of reviews using our section 48 powers, as required.

Consultation questions

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]

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

PART 2: NEXT PHASE OF REGULATION

2.1 Primary medical services

Introduction

In this section we describe how we propose to develop our approach to regulating primary medical services in the context of a changing landscape of care and in line with the direction set out in our new five-year strategy. We describe how we will monitor, inspect, rate and take action to encourage improvement in GP services. We highlight key aspects of our approach to regulating independent sector primary care services, NHS 111, GP out-of-hours and urgent care services, primary medical care delivered online, and large scale models of primary care provision such as GP federations, super practices and multi-speciality community providers.

The majority of GP practices are currently rated good or outstanding (91%), based on inspections we have undertaken since October 2014. We have also seen that, with the right support, practices found to be providing poor care have improved significantly. This means that we can build on the aspects of our current approach that have worked well and have encouraged improvement, and can also take a more proportionate, targeted and responsive approach. One aspect of our approach that we want to review in light of experience is the way that we inspect and rate against the six population groups.

We are reviewing our approach to dental regulation and will consult in autumn 2017 if any substantive changes are proposed. We are not proposing to change our approach to regulating health and justice services at this time.

Summary of proposals

Information will be at the centre of our approach and we will strengthen how we manage our relationships to support more responsive and targeted inspections.

We propose to:

- implement a more consistent approach to working with providers and other stakeholders to understand the quality of care and to encourage improvement
- introduce an annual online provider information collection to allow providers to tell us about the quality of care they provide
- introduce a new Insight model to alert our inspectors to changes in the quality of care

- explore information about the quality of care in local areas or within large-scale models of primary care
- focus our inspections on the issues highlighted through our monitoring or identified as part of our cross-sector planning
- increase the period between inspections for services rated as good or outstanding
- continue to carry out comprehensive inspections for new providers and for practices that have been rated as requires improvement or inadequate
- review how we assess and rate the quality of care for different population groups, to focus on how effective and responsive practices are to the different groups.

We will continue to develop our approach in response to changes in the primary care landscape, and in line with the changes to registration and regulating complex providers outlined in Part 1.

The changes we propose for general practices

Monitor

Our monitoring function will play a greater role in how we regulate. Our new CQC Insight model, strengthened relationship management, and online provider information collection will enable us to monitor potential changes in the quality of care. We will use this intelligence to target our activity and encourage improvement.

Provider information collection

We will replace the existing provider information return with an annual online information collection. We will ask providers for information every year rather than as part of the preparation for an inspection, and will encourage them to keep it up to date. This is one way that providers can demonstrate an open culture and that they are taking responsibility for assuring the quality of care they provide.

We will ask providers for information including:

- what has changed about the quality of care provided over the last year and what plans they have to improve
- examples of good practice
- how they provide effective and responsive care to each of the population groups.

Over time, the annual information collection will be aligned with requests from other organisations to reduce duplication and the burden on providers. For example, we are working with the General Medical Council and NHS England to streamline and align our requests (including the Annual Electronic Declaration – eDEC). We will work with our

regulatory partners to ensure that practices only need to provide a single description of their quality, based on the five key questions.

CQC Insight

CQC Insight is a tool that presents practice-level data against national comparators and identifies potential changes in the quality of care. In time, it will include more information about quality within a clinical commissioning group, including outcome indicators that can provide a better measure of effectiveness within the area than we can accurately measure at practice level. If a practice is part of a GP federation or other organisation, CQC Insight will include information about the performance of other services in the group.

Our analyses will be updated throughout the year and will provide our inspectors with more timely information. We will use this information to plan when and what to inspect and include it as part of the evidence in our inspection reports. We will continue to develop the model and work with stakeholders on future updates. Analyses from CQC Insight will include information from people who use services and national and local partners, as well as from the new provider information collection.

Strengthened relationship management

We already work closely with providers and national, regional and local partners. We will continue to strengthen these relationships to share information, reduce duplication and coordinate action where support is needed to improve, for example from the Royal Colleges and professional regulators, NHS England, the GP Regulatory Programme Board, local and national Healthwatch, clinical commissioning groups or local medical committees. Our inspectors will also work with colleagues in CQC's Hospital and Adult Social Care directorates to review information about quality across the local system and to share this with quality surveillance groups and those developing sustainability and transformation plans.

Our inspection teams will communicate with local stakeholders and gather information about the providers in their area throughout the year, rather than focusing their engagement activity around an inspection. This will help us understand how the delivery and quality of care is changing and make decisions about what, if any, action to take.

Planning our regulatory response

Every year we will formally review all of the information we have about a provider. This will ensure that our monitoring and planning decisions are made clearly, consistently and transparently.

Our inspectors will consider whether there have been any changes to the quality of a provider's care since our last inspection or if the available evidence still supports the rating. This will include reviewing the annual provider information collection, CQC Insight and information from stakeholders.

During this review, we may need to contact the provider to clarify an issue. If information indicates that the quality of care has improved or deteriorated since the last rating, we may decide to inspect. If we don't need to take any action, we will tell the practice that we have carried out the review.

Current approach to monitoring	New approach to monitoring
• Intelligent Monitoring indicators used as part of a wider approach to gathering information before an inspection • Indicators updated periodically • Provider information request sent when inspection announced • Short turnaround time for providers	• Ongoing monitoring will identify potential changes in the quality of care • CQC Insight indicators will be updated frequently. Insight will focus on changes since the previous rating (improvements and areas of risk) and include data about quality in the area • Every year providers will tell us about changes to the quality of care provided, improvement plans, and examples of good practice • Providers can update at any point during the year

Where a service is provided by an NHS trust or other complex provider, our inspectors will work with our hospital and/or adult social care inspectors to plan a joint inspection schedule, as set out in Part 1.

Consultation questions

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.

Inspection

Scope of inspections

Inspection remains an important part of our regulatory approach. It enables us to gain an in-depth understanding of the quality of care and to identify and encourage improvement. In all sectors we ask five key questions: is care safe, effective, caring, responsive and well-led? In general practices we also assess quality for six population groups: older people; people with long-term conditions; families, children and young people; working age people; people whose circumstances might make them vulnerable; and people experiencing poor mental health.

Comprehensive inspections will continue to address all five key questions and all six population groups. We will always carry out a comprehensive inspection for providers rated as inadequate or requires improvement, or that have not been inspected before. However, we propose to change our approach to assessing care for population groups (see the ratings section below).

We will carry out more focused inspections for providers rated as good and outstanding. These will follow up any potential changes in the quality of care indicated by our monitoring activity, or will focus on a specific population group or care pathway when this is highlighted in the data for the local area. We will develop criteria to help our inspectors decide which key questions or issues to focus on. We will always inspect the leadership, governance and culture of the practice under the well-led key question.

All of our inspections will include a site visit. Our inspection teams will still involve specialist advisors and, where appropriate, people who have personal experience of using services. The size and composition of our inspection teams will depend on whether it is a comprehensive or focused inspection and the type of services being inspected, and will include hospital or adult social care inspectors where services are provided in an integrated or complex model.

Inspection scheduling

If we have concerns about services, we will inspect them more frequently than those where we receive assurance that they are maintaining a good quality of care.

We will continue to inspect providers with an overall rating of inadequate every six months and those rated as requires improvement every 12 months, until they improve. For providers rated as good or outstanding overall, we will move to an inspection interval of up to five years, in line with our commitment in our strategy and NHS England's General Practice Forward View.

We may bring forward an inspection when:

- our monitoring information indicates a potential improvement or deterioration in the quality of care
- practices are part of a larger or complex provider and we have chosen to carry out a coordinated inspection, for example alongside our hospital and adult social care inspectors
- we are undertaking a place-based review, as described in section 1.4.

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.

We may inspect any service at any time, irrespective of rating, where this is appropriate.

There will be greater flexibility around inspection notice periods. For example, inspectors may give longer notice periods where we are focusing on specific themes or carrying out an area-based or complex provider inspection. Or we may carry out short notice or unannounced inspections where we have concerns.

Current approach to inspection	New approach to inspection
• All providers inspected at least once during our first programme of inspections • Inspections usually announced • Fixed notice periods for inspection • All providers receive at least a 'baseline' comprehensive inspection (all key questions) • Focused inspections for follow-up of concerns or risks	• Maximum inspection intervals determined by rating and monitoring information • Greater flexibility to use announced, short notice and unannounced inspections • Inspections alongside our adult social care and hospitals colleagues when we inspect more complex models • Focused inspections based on CQC Insight for providers rated as good and outstanding – may focus on key questions, population groups or care pathways

Reporting

Our inspection reports enable us to give the public a better understanding of what they should be expecting from their local care services. They also encourage improvement by sharing examples of outstanding and innovative practice and highlighting areas that need to improve.

Our reports will be shorter and less repetitive, and will use language that is more accessible for the public. They will include a summary report and a more detailed 'evidence table' – which will set out in more detail the evidence we have used to make our judgements. Both sections will be structured around the key lines of enquiry (KLOEs). We will streamline our internal quality control and assurance processes to speed up the publication of reports. We are committed to publishing 90% of reports within 50 days of the inspection taking place.

Current approach to reporting	New approach to reporting
• Report includes all evidence, findings, ratings, contextual information and any enforcement action we have taken • Presented in a narrative style	• Report includes summary of findings, contextual information and ratings • Appendix includes all the evidence presented factually

Rating

Ratings are an important indicator of quality for patients and the public, enabling people to make choices. They increase accountability and transparency and help services and others compare performance between organisations, to identify good practice and incentivise improvement.

We will only change a rating on the basis of evidence from data and inspections. Currently we do not update overall ratings following focused inspections carried out more than six months after a comprehensive inspection. However, in future we propose to remove this rule and to update ratings any time following an inspection.

Ratings for population groups

We currently inspect and rate the quality of care for each of the six population groups against each key question and provide aggregated ratings for each population group, each key question, and for the practice overall. This results in 43 separate ratings for each practice, and means that where practices have developed specific initiatives for particular populations, their achievements are not always discernible in their overall rating. For example, a practice could be rated as outstanding for providing responsive and effective care for people experiencing poor mental health, but not have this recognised because their overall performance on safety or well-led is not good. We want to simplify this by reducing the overall number of ratings we give.

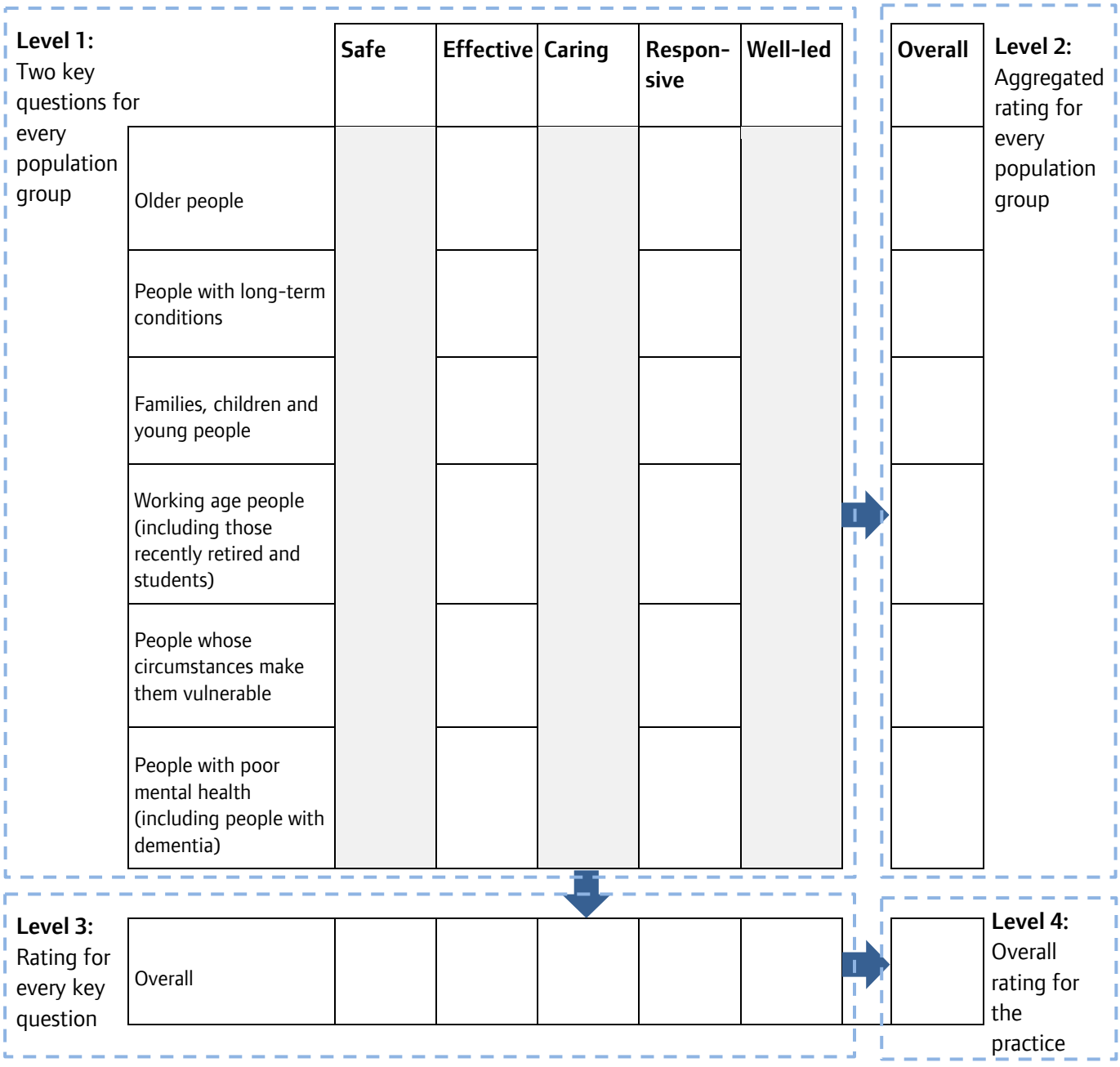
During our full programme of inspections in general practice over the last three years, we have learned that the most significant differences in quality between the population groups are in the effective and responsive key questions. We find that our ratings for caring, safety and well-led are broadly consistent for each of the population groups and at overall practice level.

We want to make our judgements on the quality of care provided to population groups more transparent and easy to understand. We could achieve this by only rating population groups using the effective and responsive key questions. If we make this change, we would instead assess caring, safety and well-led at practice level, highlighting any population-specific issues that we find. In addition, we would continue to inspect a practice's safeguarding arrangements for children and adults as a key line of enquiry under the safety question and

report this at practice level. These changes would not affect the way we look at safeguarding issues or the way we calculate overall ratings for the practice. We would continue to give each of the key questions equal weighting.

The grid below sets out the ratings we give for a practice on a comprehensive inspection. The shading shows the ratings we are proposing to no longer provide.

Figure 6: Proposed ratings grid for a comprehensive inspection of a GP practice



Current approach to rating	New approach to rating
• An overall rating and a rating for all key questions at practice level • An overall population group rating and ratings for each key question across all population groups • Focused inspections more than six months after a comprehensive inspection do not update the overall rating	• Continue to give an overall rating and a rating for all key questions at practice level • Ratings for effectiveness and responsiveness for all population groups • Ratings can be changed after a focused inspection at any time

Consultation questions

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.

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.

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.

Taking action to improve care

Services that repeatedly require improvement

In general practice, we have found that the majority of services rated as requires improvement take timely action and improve. Our regulatory response will therefore always take into account whether a service has breached any regulations, its track record on quality and plans for improvement.

We will continue to engage with partners to highlight examples of improvement, and promote good practice and available sources of support. We will also monitor services more closely to identify any changes or deterioration in quality, so that we can respond more quickly if necessary.

There are occasions when services are unable to demonstrate that they have the necessary leadership or governance processes to assure and improve quality, and this may represent a breach of Regulation 17 (good governance). We will always consider this when a provider has received an overall rating of requires improvement more than once, and we may ask the provider for a written report to set out how they will assess, monitor and improve the quality and safety of their services. This improvement action plan will need to be agreed with their commissioners. If they are rated as requires improvement for a third time, we will hold a formal management review meeting (MRM) to consider the next steps and the potential use of our enforcement powers. As with the current framework, if one or more key questions is rated as inadequate in two consecutive inspections, the provider will enter special measures.

Where we register larger primary care providers, we will monitor quality across all their services. Where there are concerns across the group, we may consider taking action to hold the provider to account, for example by using our enforcement powers.

More effective and consistent enforcement

We cannot currently publish information about enforcement activity in inspection reports until the period in which providers may submit representations and appeals has closed and the outcome of these has been decided. In future, we want to be more transparent with the public when we are taking enforcement action by publishing the details sooner. We are working with the Department of Health on this issue.

Independent sector primary care – overview of proposed approach

In 2015, we consulted on our approach to regulating and inspecting primary care services in the independent sector and we tested our approach in pilot inspections of 40 independent doctor services. Feedback from providers and those involved in the pilots was positive, and has informed our next phase approach.

We propose to no longer separately categorise services provided in the NHS or independent sector. Independent sector services will instead be categorised in line with similar types of services provided in the NHS. The majority of the services will be categorised as primary medical services. In some cases providers may also deliver services that are not defined as regulated activities and therefore fall outside the scope of regulation. Where this is the case, we will make this clear on our website so that the public can understand what we are unable to inspect.

We will assess independent sector primary care services using the approach set out for general practice. For providers offering private GP services, we may also consider how they care for population groups. Where necessary, we will develop sector-specific guidance and inspection prompts. The size and composition of our inspection teams will depend on the kind of services being inspected, and will involve specialist advisors with relevant experience.

We are looking to include these services in the scope of our ratings powers but, in the meantime, we will make judgements about whether care is safe, effective, caring, responsive and well-led, based on whether the relevant regulations are being met.

NHS 111, GP out-of-hours and urgent care services – overview of proposed approach

We face two challenges when regulating NHS 111, GP out-of-hours and urgent care services – by which we mean walk-in centres, minor injury units and urgent care centres:

1. These services can be provided, or hosted, by primary care providers, as well as secondary care providers (including acute and ambulance trusts, and community providers).
2. There is no national data available for urgent care services.

We recognise that, regardless of commissioning arrangements or whether it is a primary care location or part of a trust, these services are doing the same things. Therefore, we will be consistent in our assessment of these services, across the different sectors, regardless of who is providing or hosting these services.

For NHS and foundation trusts that provide NHS 111, GP out-of-hours and urgent care services, we will tailor how we inspect and report on these providers, while being consistent in the assessment we use. This will enable us to take account of the complexity, scale and scope of these providers, and be responsive to the different provider arrangements that we are seeing in the sector.

The key changes we make to our approach for those services provided by primary care providers will be consistent with the model for general practice, as set out above. In summary, we will:

- Strengthen our relationships with providers and our partners (including commissioners) to help us understand service provision, accountabilities and responsibilities. This will help ensure we involve the right people with the right expertise on our inspections.

- Align the provider information collection with requests from other bodies, including NHS England – the collection will tell us about the services being provided, and any changes happening within providers.
- Align our CQC Insight model with NHS England's Integrated Urgent Care Key Performance Indicators.
- Continue to carry out comprehensive inspections of these services, with an increased focus on issues highlighted through our monitoring, or identified as part of our cross-sector planning arrangements.
- Where possible, try to inspect NHS 111, GP out-of-hours and urgent care services at the same time, where a provider is delivering these services across an area.

We are aware that providers of NHS 111, GP out-of-hours and urgent care services are working within the context of greater integration, under new commissioning arrangements and new care models. For example, urgent and emergency care services are working together under 'alliances' to provide more coordinated care and support across local areas. We will improve how we coordinate our regulatory activity across local providers so that we may conduct a series of inspections, across a range of providers within a local area at the same time – sometimes as part of a place-based review of care. We will also use the new assessment framework to strengthen our focus on how these services are working with each other, and other providers, to share information and coordinate care.

Primary care delivered online

In March 2017, we published information to clarify how we propose to regulate digital primary healthcare providers. These are services that provide a regulated activity online. Examples include providers prescribing medications or delivering GP consultations over the internet. Our methodology will include the standard key lines of enquiry, supplemented by sector-specific prompts.

We do not currently have the legal powers to rate most digital healthcare services due to the type of provider and the contracts they hold but we are looking to bring them into the scope of rating. Until then, we will make judgements about whether the care provided is safe, effective, caring, responsive and well-led, based on whether the relevant regulations are being met. We will take action where care is not safe.

Where GP practices also offer online consultations, inspection teams will use the specific digital healthcare prompts, together with the standard KLOEs and prompts in the assessment framework for health care services. Our aim is to ensure that the same safeguards are in place during those consultations as we would expect in exclusively online providers.

Primary care at scale – overview of our proposed approach

Primary care is evolving and the way care is organised is changing. Many GP practices are joining federations, super-partnerships, multi-site practice organisations or other new models of care, including GP-led multi-speciality community providers (MCPs) which we refer to as large-scale general practice. We anticipate that we will continue to inspect the majority of GP services as part of our GP inspection programme. This will include practices that have retained their independent status, as well as practices that are fully integrated within a larger organisation. Our new KLOEs will enable us to assess how well these services are integrating with other parts of the health and social care system.

The pace and scale of change is different around the country, so we need a flexible and responsive approach. We will inspect some practices as part of a coordinated complex provider or area inspection and, in time, we may move towards also inspecting at the highest level of accountability for quality, in line with our proposals set out in Part 1 of this consultation. If and when we introduce a provider-level assessment, we may consider using our CQC Insight model to select a sample of locations for practice-level inspection and rating.

During 2017/18, we will work with a number of areas to pilot our approach to how we regulate evolving models of primary care.

Consultation questions

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).

Timetable for implementation

April 2017 to March 2018:

- consult on proposed changes to primary medical services
- refine and test our new methodology, including for rating population groups
- CQC Insight published for general practice providers (June)
- introduce provider information collection (non-digital collection up to April 2018) and implement regulatory review process (November)
- start inspections using the new approach (November)
- remove the six-month limit on focused inspections changing overall ratings.

April 2018 to March 2019:

- introduce provider information collection for GP federations and super practices
- develop and test provider-level assessment alongside live-testing of registration changes.

April 2019 to March 2021:

- phased implementation of provider-level assessments, subject to registration changes for some providers.

2.2 Adult social care services

Introduction

In this section, we describe how we propose to develop our approach to regulating adult social care providers, in line with the direction set out in our new five-year strategy. We describe our approach to monitoring, inspecting and rating and using our enforcement powers to require providers to take action when they need to improve.

Since October 2014, we have found the quality of care in adult social services to be variable. At the beginning of May 2017, 77% of services were rated as good and just 2% rated as outstanding. We have also found that our ability to influence improvement has been mixed. Over three-quarters of services rated inadequate improved on re-inspection, but for services that require improvement the picture is less encouraging, with 38% remaining unchanged on re-inspection and 5% getting worse.

Summary of proposals

We will strengthen our use of information and relationship management to support a more responsive and targeted approach to inspection. We will focus more on providers that are unable to sustain improvement, and on recognising providers that have improved but have not yet managed to achieve a better rating.

We propose to:

- implement a more consistent approach to working with providers and other stakeholders to understand the quality of care and encourage improvement
- introduce an online provider information collection and share information with key stakeholders
- develop a new CQC Insight model that brings together information about all the locations of a provider to help inspectors see the broader context for performance
- increase the period between comprehensive inspections for services rated as good and outstanding, as our monitoring improves
- make more use of focused inspections, which will always include an assessment of the well-led key question
- remove the 'six month limit', which only allows us to change an overall rating if a focused inspection is carried out within six months of the last comprehensive inspection
- extend the time in which to gather views about the quality of services that provide care to people in their own homes
- increase our focus on services rated as requires improvement to drive improvement.

The changes we propose for adult social care

Monitor

Our monitoring function will play a greater role in how we regulate. Our new Insight model and online provider information collection will enable us to monitor potential changes in the quality of care, and we will monitor more closely services that repeatedly fail to achieve a good standard of care. This will help us to target our responses to these services to encourage them to improve.

Provider information collection

We will introduce a new approach to collecting information from providers. This will be a live online process, rather than a form to collect information in the run-up to an inspection. We will ask providers to provide a statement of quality in relation to the five key questions and to describe what they are doing to support continuous improvement. The process will facilitate regular, ongoing engagement with providers.

Providers will need to complete the information collection once a year as a minimum. However, by keeping the information up-to-date, a provider can demonstrate an open culture and show that they are committed to continual learning. We will continue to work with health and local authority commissioners, providers and other stakeholders, to explore how we might develop and share the information as the basis of a single core dataset – information that is collected once and shared many times.

CQC Insight

CQC Insight is a tool that presents information about services and, where possible, compares performance over time or in relation to other providers. We hope that the new provider information collection will help to provide a dataset that we can use across the adult social care sector to monitor quality and compare performance between services and over time.

CQC Insight can also help inspectors to understand the broader context, by setting out how a provider is performing across all of its services. Changing the level of registration – as recommended in Part 1 – would make it much easier to bring together information about services run by corporate provider groups.

Strengthened relationship management

We will be clearer and more consistent about how we engage with the leaders of provider organisations and other stakeholders, such as local authority commissioners and clinical commissioning groups (CCGs) – for example:

- when we find recurring themes across a provider's services
- where services fail to sustain a good standard of care
- where ratings of inadequate and requires improvement are predominant across a provider.

Current approach to monitoring	New approach to monitoring
• Intelligent Monitoring • Provider information return issued before an inspection • Engagement with providers and partners variable • Data collected by many different organisations	• Clearer and more consistent engagement with leaders in organisations and other stakeholders, such as local authority commissioners and CCGs • Provider information collection will be an online process, containing a 'statement of quality' in relation to the five key questions and activities supporting continuous improvement • Provider information shared with key stakeholders as a single shared view of quality

Planning our regulatory response

We will continuously monitor all available information to inform when we will inspect and the issues we may look at. For example, where information does not flag up risks or concerns, we may maintain our comprehensive inspection schedule. We may bring forward comprehensive inspections in response to a wide range of concerns, or conduct a focused inspection where concerns are more limited. We will have the flexibility to expand the scope of focused inspections where additional or different concerns are identified before the inspection or during the site visit.

Where an adult social care service is provided alongside hospital or primary care services within a complex provider, we will monitor quality and plan a coordinated inspection schedule as set out in Part 1. Where we identify a pattern of concerns across services within a larger provider, we may also plan a coordinated approach to inspection, and in future may decide to undertake a provider-level assessment, subject to the proposed registration changes.

Consultation questions

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]

11b Please give reasons for your response.

Inspection

Scope of inspections

We want to introduce a more proportionate, targeted and responsive approach to inspection, with a better balance between monitoring, comprehensive inspections and focused inspections. Every service will have a comprehensive inspection, which will address all five key questions. Focused inspections are more targeted. They focus on specific risks or concerns identified through monitoring activity or from a comprehensive inspection. They may not address all five key questions but will always address the well-led question. We may also use focused inspections to inform reports that examine particular themes or aspects of care, such as pathways of care or how people with specific conditions are cared for.

Inspection scheduling

As our monitoring improves, we believe it would be more proportionate to increase the maximum timescales between planned comprehensive inspections:

- from two to two and a half years for services rated as good
- from two to three years for services rated as outstanding.

We will continue to monitor quality in these services and will respond to risks by bringing forward a comprehensive inspection or carrying out a focused inspection. We may also bring forward an inspection where we have information that indicates that a provider has improved or deteriorated.

We will continue to re-inspect services that are rated as requires improvement overall every year. However, we will address inconsistencies in our approach to regulating services that are consistently rated as requires improvement. Our proposed approach is described on page 52.

We have found that on re-inspection, over three-quarters of services rated as inadequate have improved, so we will continue to re-inspect these services every six months until they are able to achieve a better rating.

Wherever possible we will inspect adult social care services delivered by a complex provider as part of a coordinated scheduled of inspections, as set out in Part 1.

We may inspect any service at any time, irrespective of rating, where this is appropriate.

Inspecting services providing care to people in their own homes

It can be harder to assess the quality of care when people are cared for in their own homes by domiciliary care, supported living and extra care housing services. Unannounced and short notice inspections can make it difficult to discuss experiences with people who need time and support to participate and share their experiences, such as those with cognitive impairment.

We are therefore developing a more extensive 'toolkit' for inspectors that will include new methods for gathering additional information from providers, people using services and their families, and other stakeholders:

1. An announced inspection: we may not specify the actual day and time of an inspection, but we could point to a period when it will happen, retaining an unannounced element in certain circumstances.
2. Extended time for additional fieldwork: this could involve activity after an unannounced or short notice first visit.

Rating

Ratings are an important indicator of quality. They help people using services, their families and carers to make choices about the services they use. They increase accountability and transparency and incentivise improvement. They also help providers and others to compare performance over time and between organisations, and to identify good practice.

We will continue to rate services against each of the five key questions. Ratings will be changed on the basis of evidence from data and inspections and we will be able to change an overall rating on the basis of a comprehensive or focused inspection. We also propose removing the current 'six month limit', which only allows us to change an overall rating if a focused inspection is carried out within six months of the last comprehensive inspection.

Current approach to inspection and rating	New approach to inspection and rating
• All key questions inspected and rated as part of comprehensive inspection programme • Comprehensive inspection carried out within two years for good and outstanding services • No requirement to inspect any area or key question as a minimum when carrying out a focused inspection • Inspection only at location level • Focused inspection can only change overall rating if within six months of a comprehensive inspection • 'One size fits all' for inspecting the quality of care delivered to people in their own homes	• Using registration, risk and rating information to target when, what and how we inspect • Comprehensive inspection carried out within 2.5 years for good services and within three years for outstanding services • Focused inspections will always include an assessment of the well-led key question • Will be able to change an overall rating on the basis of a focused inspection, removing the 'six-month limit' that we currently apply • More flexible approach for inspecting care delivered to people in their own homes, supported by a 'toolkit' of methods to support evidence gathering

Reporting

Our inspection reports will be shorter, clearer and more informative. We will include the inspection history of the individual service and will explore how we can also include a picture of quality of all the services operated by the provider. As we develop our use of data over time, we will consider introducing an evidence table, setting out the facts and figures that support our judgements, in line with our proposals for other sectors.

Consultation questions

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]

12b Please give reasons for your response.

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]

13b Please give reasons for your response.

Taking action to improve care

Services that repeatedly require improvement

When a service is rated as requires improvement, our regulatory response will take into account whether it has breached any regulations, its track record on quality and plans for improvement.

We will engage with partners to highlight good practice, examples of improvement, and available sources of support. We will also monitor services more closely to identify any changes or deterioration in quality, so that we can respond more quickly if necessary.

In some circumstances, for example where services are unable to demonstrate that they have the leadership or governance processes in place to assure and improve quality, this may represent a breach of Regulation 17 (good governance). We will always consider this when a provider has received an overall rating of requires improvement more than once, and we may ask them for a written report that sets out how they will assess, monitor and improve the quality and safety of their services. This action plan will need to be agreed with the provider's commissioners. If they are rated as requires improvement for a third time, we will hold a formal management review meeting (MRM) to consider the next steps and the potential use of our enforcement powers.

We will also monitor quality across all of a provider's services and, where more than half are rated as requires improvement or inadequate, we will hold an MRM to decide the best course of action. We will engage directly with the provider's leadership and, in future, may consider enforcement action against the provider, subject to the changes in the level of registration proposed in Part 1.

More effective and consistent enforcement

Our proposed change to the level of registration for corporate provider groups will mean that we can hold the corporate-level leadership to account when we have concerns about poor care. We want to explore the use of provider-level conditions, which would include setting out the actions that the provider must take to deal with systemic failings across its services. This will support a more consistent approach and will encourage providers to monitor the quality of care across all their services and to respond when it falls below acceptable standards.

We cannot currently publish information about enforcement activity in inspection reports until the period in which providers may submit representations and appeals has closed and the outcome of these have been decided. In future, we want to be more transparent with the public when we are taking enforcement action by publishing the details sooner. We are working with the Department of Health to take this forward.

Current approach to enforcement	New approach to enforcement
• Enforcement action taken in response to issues at individual services • Potential for repeated requires improvement ratings with no enforcement	• More action taken at provider level (including corporate head office level) where issues affect more than one service • More consistent approach to repeated ratings of requires improvement, including potential breach of Regulation 17

Consultation questions

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]

14b Please give reasons for your response.

Timetable for implementation

April 2017 to March 2018:

- refine and test new methodology
- implement online provider information collection and new inspection methodology
- start using the revised assessment framework (inspections in the first six weeks will use the existing PIR)
- start using the revised methodology for services providing care to people in their own homes
- removal of six-month limit on focused inspections changing overall ratings.

April 2018 to March 2019:

- pilot provider-level assessments alongside live testing of registration changes.

April 2019 to March 2021:

- phased implementation of provider-level assessments, subject to registration changes for some providers.

PART 3: FIT AND PROPER PERSONS REQUIREMENT

This section sets out our proposed changes to the way CQC will carry out our role in relation to the fit and proper persons requirement (Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014), including the way we will share information with providers when we receive information of concern from a third party. We also provide additional guidance for providers on interpreting "serious misconduct and serious mismanagement".

The fit and proper persons requirement

The fit and proper persons requirement (FPPR) was introduced in November 2014 for NHS hospitals and in April 2015 for providers in all other sectors. This was in response to concerns raised following investigations into Mid Staffordshire NHS Foundation Trust and Winterbourne View Hospital. It requires all providers registered with CQC to assure themselves that all directors (or those in equivalent roles) are fit to carry out their responsibility for the quality and safety of care.

CQC's role is to make sure that providers have appropriate recruitment and performance management processes in place, and to take action against a provider if we believe they are failing to meet the requirement. It is not our role to regulate individuals or to assure that any individual is fit or proper. We will continue to check this when a provider applies to register, or to vary its registration, and when we carry out inspections using the well-led key question.

Following up concerns

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.

In future, we propose to continue to notify providers of all concerns relating to their directors, but will ask them to assess all the information we receive. We will ask the person providing the information for their consent to do this, and will seek to protect their anonymity if necessary. In some exceptional cases, we will need to progress without consent when we are concerned about the potential risk to people using services. We will also inform the director to whom the case refers, but we will not ask for their consent and will not disclose the identity of the person who provided the information to us.

When we share information of concern with a provider, we will ask them to detail the steps they have taken to assure themselves of the fitness of the director. We will also indicate what type of response we will expect from them after we notify them about the concern. This response will need to include assurance from a provider that:

- they have used a fair and proportionate process to establish the primary facts of any matter giving rise to a concern about the director (the investigation stage)
- having ascertained the primary facts, they have assessed whether the facts establish that the director falls within any of the categories in Regulation 5(3) (the assessment stage)

If the response does not satisfy CQC that the provider has followed a robust process and reached a reasonable decision, we will either ask the provider for further information, carry out a follow-up inspection, or potentially take regulatory action.

If a provider has demonstrated that they applied the appropriate checks but CQC has concerns that the decision it has made about the fitness of a director is a decision that no reasonable person would have made, we will apply our enforcement policy to decide if there has been a breach of the regulations.

Current approach to FPPR	New approach to FPPR
• We review information of concern and send a selection to the provider for comment	• We will send all information we receive to the provider and ask them to detail their current processes. We will assess the information and, where necessary, carry out an investigation and assessment

Consultation questions

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

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

Interpretation of 'serious misconduct and serious mismanagement'

Regulation 5(3)(d) states that "the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England would be a regulated activity".

Providers have asked CQC to clarify what is meant by "serious mismanagement" and "serious misconduct". Our new guidance (set out in Annex A) is intended to help providers interpret and implement the regulation.

Consultation question

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

How to respond

You can respond through our online form at: **www.cqc.org.uk/nextphase**

You can write to us at:
Freepost RTTE-JTBT-ZTHH
Next Phase Consultation
Care Quality Commission
151 Buckingham Palace Road
LONDON
SW1W 9SZ

If you have any questions about this consultation, please email: **nextphase@cqc.org.uk**. You can also tweet us your thoughts at: **#CQCNextPhase**

Please reply by **Tuesday 8 August 2017**.

Thank you for taking the time to contribute to the development of our future work. Your feedback and comments are important in helping us get it right.

Summary of consultation questions

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?

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

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?

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

3b Please explain the reasons for your response.

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

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

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

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

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

6b Please give reasons for your response.

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.

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.

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.

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).

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

11b Please give reasons for your response.

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]

12b Please give reasons for your response.

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]

13b Please give reasons for your response.

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]

14b Please give reasons for your response.

PART 3: FIT AND PROPER PERSONS REQUIREMENT

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

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

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

Annex A: Guidance for the implementation of the fit and proper persons requirement

Fit and proper person requirement: Serious misconduct and serious mismanagement and good character

Contents

A. Introduction

1.1 All registered providers subject to Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (the 2014 Regulations) are required to satisfy themselves as to the fitness of their directors. This requires diligent enquiries at the appointment stage, and effective performance management for the duration of the appointment. It is for providers to ensure they comply with this Regulation when recruiting directors by complying with all relevant guidance.

1.2 In this document the use of the word 'director' encompasses shadow directors, by which we mean individuals who are not directors but their roles and responsibilities are the same as or equivalent or similar to directors of the service.

The criteria that must be satisfied:

1.3 Registered providers must satisfy themselves that all of their all of their directors meet all the requirements relating to fitness in Regulation 5(3) of the 2014 Regulations.

1.4 The requirements that each registered provider must satisfy in respect of each director are:

(a) the individual is of good character,

(b) the individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed,

(c) the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed,

(d) the individual has not been responsible for, been privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity, and

(e) none of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

When can concerns arise?

1.5 The fitness of a director or proposed director may be called into question at any time. This may be during a recruitment process or may be in the course of the director's employment or when he or she is acting as a self-employed director.

1.6 If a director comes within any of the categories in Part 1 of Schedule 4 to the 2014 Regulations they must be removed from their position as a director.

1.7 In all other cases, the registered provider is required to make an assessment of the individual's fitness If the registered provider decides that a director does not meet any of the requirements set out in paragraphs 1.4 (a) – (e) above, it must relieve that director of their responsibilities as a director. This does not necessarily mean that the director should be dismissed from his or her employment.

B. Serious mismanagement or misconduct

What is misconduct?

2.1 "Misconduct" means conduct which breaches a legal or contractual obligation imposed on the director. It could mean acting in breach of an employment contract, breaching relevant regulatory requirements (such as mandatory health and safety rules), breaching the criminal law or engaging in activities which are morally reprehensible or likely to undermine public trust and confidence.

What is mismanagement?

2.2 "Mismanagement" means being involved in the management of an organisation or part of an organisation in such a way that the quality of decision making and actions of the managers falls below any reasonable standard of competent management.

2.3 The following gives examples of behaviour that may amount to mismanagement:

- Transmitting to a public authority or any other person inaccurate information without taking reasonably competent steps to ensure it was correct.
- Failing to interpret data in an appropriate fashion.
- The suppression of reports where the findings may be compromising for the organisation.
- Failure to have an effective system in place to protect staff who have raised concerns.
- Failure to learn from incidents, complaints and when things go wrong.
- Failure to model and promote standards of behaviour expected of those in public life, including protecting personal reputation, or the interests of another individual, over the interests of service users, staff or the public.
- Failure to implement quality, safety and or process improvements in a timely manner, where there are recommendations or the need is otherwise manifest.

When should proven misconduct or mismanagement be assessed to be "serious misconduct or mismanagement"?

2.4 Providers will have to reach their own decision as to whether any facts which are alleged reach the threshold of being "serious misconduct or mismanagement". The Shorter Oxford English Dictionary defines serious as:

> "Important, grave, having (potentially) important especially undesired consequences, giving cause for concern of significant, degree, amount, worthy of consideration"

2.5 Misconduct differs from mismanagement, in that a single incident of misconduct may be so serious as to amount to serious misconduct, whether the provider also concludes that this was incompatible with continued employment or not. However, any serious misconduct renders a director unfit within the terms of the fit and proper person requirement.

2.6 However, an isolated incident is unlikely to constitute serious mismanagement unless it is so serious as to call into question the confidence the organisation and the public can have in the individual concerned.

2.7 Serious mismanagement is likely to consist of a course of conduct over time. Any assessment of its seriousness needs to consider the impact of the mismanagement on the quality and safety of care for service users, the safety and well-being of staff, and the effect on the viability of the provider.

2.8 Not all misconduct or mismanagement in which a director has had some involvement will reach the threshold of "serious". Where there is evidence of misconduct or mismanagement that is not judged to be "serious", the provisions of Regulation 5(3)(d) do not apply. However, it will be for the provider (as the employer) to determine the most appropriate response, so as to ensure that performance is managed and the quality and safety of services is assured.

2.9 Isolated incidences of the following types of behaviour could be considered by a provider to amount to misconduct or mismanagement which does not reach the required threshold of seriousness:

- Intermittent poor attendance;
- Minor breaches of security;
- Minor misuse of an employer's assets;
- 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.

2.10 The following are examples of misconduct and mismanagement which providers would be expected to conclude amounted to serious misconduct or mismanagement, unless there are exceptional circumstances which makes it unreasonable to determine that there is serious misconduct or mismanagement:

- Fraud or theft;
- Any criminal offence other than minor motoring offences;
- Assault;
- Sexual harassment of staff;
- Bullying;
- Victimisation of staff who raise legitimate concerns;
- Any conduct which can be characterised as dishonesty, including:
    - Deliberately transmitting information to a public authority or to any other person which is known to be false;
    - Submitting or providing false references or inaccurate or misleading information on a CV;
- Disregard for appropriate standards of governance, including resistance to accountability and the undermining of due process;
- Failure to make full and timely reports to the Board of significant issues or incidents, including clinical or financial issues;
- Repeated or ongoing tolerance of poor practice, or failure to promote good practice, leading to departure from recognised standards, policies, or accepted practices;
- Continued failure to develop and manage business, financial, or clinical plans.

2.11 As part of reaching an assessment as to whether any actions of omissions of the director amount to "serious misconduct or mismanagement", providers should consider whether an individual director played a central or peripheral role in any wider misconduct or mismanagement. The more central the role of the director, the more likely it is that the conduct of the director should be assessed to be serious misconduct or mismanagement. The provider should also consider whether there are any mitigating factors which could be relied upon to downgrade conduct that should otherwise be assessed to be serious misconduct or mismanagement so that the conduct did not meet that threshold of seriousness.

What key factors should be considered when concerns arise regarding serious misconduct or mismanagement?

2.12 Providers are invited to note the following points:

- The relevant matters can arise in the director's current role, in a former role within the provider's organisation, when the director carried out any role where he or she was concerned with a service which is regulated by CQC or which, if provided outside the UK, would be a regulated activity if the activity was carried out within the UK;

- Allegations about a director's conduct whilst engaged in any other type of business or non-business activity is not relevant for Regulation 5(3)(d), but it is likely to be relevant to the director's good character (Regulation 5(3)(a)) and/or his or her competence, skills and experience (Regulation 5(3)(b));

- A director's conduct comes within Regulation 5(3)(d) if he or she has been "responsible for" serious misconduct or mismanagement, namely that he or she was one of the decision makers that led to the serious misconduct or mismanagement;

- A director's conduct comes within Regulation 5(3)(d) if he or she has "contributed to" serious misconduct or mismanagement, namely where the director was not one of the lead decision makers that led to the serious misconduct or mismanagement but where, by action or omission, the director took some significant step or steps to assist the lead decision makers who were responsible for that misconduct or mismanagement;

- A director's conduct comes within Regulation 5(3)(d) if he or she has "facilitated" any serious misconduct or mismanagement, namely that he or she took steps or failed to take steps which he or she ought to have taken which enabled those primarily responsible for the misconduct or mismanagement to carry out the acts or omissions which constituted the serious misconduct or mismanagement;

- A director's conduct also comes within Regulation 5(3)(d) if he or she has been "privy to" serious misconduct or mismanagement, in that the director was aware that misconduct or mismanagement was happening in an organisation and failed to respond to that knowledge by acting in an appropriate manner. An appropriate response to serious misconduct or mismanagement will depend on the circumstances and the internal governance arrangements of the organisation in which the director worked, but it could include:

- drawing the serious misconduct or mismanagement to the attention of an appropriate senior member of staff;
- making a formal complaint;
- drawing the serious misconduct or mismanagement to the attention of a suitable person outside the provider's organisation;

- Providers would be entitled to conclude a director had been "privy to" serious misconduct or mismanagement if the director knew sufficient details of that misconduct or mismanagement (or the circumstances was such that it is reasonable to conclude that the director ought to have known of that mismanagement or misconduct) to require appropriate action by the individual and failed to take any appropriate action in a timely manner.

2.13 Providers will be expected to follow the procedure set out in below paragraphs [4.1 to 4.8] in section D when assessing whether the behaviour of the director in question amounts to serious mismanagement or misconduct.

C. Good character

What is good character?

3.1 There is no statutory guidance as to how 'good character' in regulation 5(3)(a) of the 2014 Regulations should be interpreted.

3.2 However, the following are some of the features that are normally associated with 'good character':

- Honesty;
- Trustworthiness;
- Integrity;
- Openness (also referred to as transparency);
- Ability to comply with the law.

3.3 To consider that a director is of 'good character' the registered provider should be able to regard the director as a person in whom the provider, CQC, people using services and the wider public can have confidence, and who will comply with the law.

What must a provider take into account when assessing 'good character'?

3.4 Providers must have regard to the following matters specified in part 2 of schedule 4 to the 2014 Regulations when assessing whether a director is of good character:

- Convictions of any offence in the UK;

- Convictions of any offence abroad that constitutes an offence in the UK; and
- Whether any regulator or professional body has made the decision to erase, remove or strike-off the director from their register.

What other things should a provider look for in assessing good character?

3.5 When making decisions about character, providers would also be expected to consider:

- The prior employment history of the director, including the reasons for leaving;
- Whether the director has ever been the subject to any investigations or proceedings by a professional or regulatory body;
- Whether the director has ever breached any of the Nolan Principles of Public Life;
- Whether the director has ever breached any of the duties imposed on directors under the Companies Act;
- The extent to which the director has been open and honest with the provider;
- Any other information which may be relevant, such as disciplinary action taken by an employer.

3.6 Providers will be expected to follow the procedure set out in below paragraphs [4.1 to 4.8] in section D when they receive information or an allegation that a director is not of good character.

D. Procedure for assessing compliance with the regulation

How does the registered provider carry out an assessment?

4.1 Where a provider receives information or an allegation that a director is or may be unfit, the regulated provider will need to carry out a 2 stage process, namely:

1. Establish the primary facts of any matter giving rise to a concern about the director by a fair and proportionate process ("the Investigation Stage").
2. Having established the primary facts, make an assessment as to whether the facts establish that the director comes within any of the categories in Regulation 5(3) ("the Assessment Stage").

The Investigation Stage

4.2 There may be occasions where there is a dispute about the relevant facts, with different accounts given by different individuals. The provider needs to conduct a sufficiently thorough investigation before reaching a decision as to whether any relevant facts can be established or not. The provider should consider facts proved if, after a reasonable investigation, the

provider considers that it can decide that it is more likely than not that the fact is proved. When undertaking this investigatory process, providers should ensure that they follow their own HR policies (including those governing disciplinary proceedings).

4.3 In some cases, the role performed by a director within the organisation may mean that an external decision maker is appropriate either to undertake an impartial investigation to establish the primary facts or to carry out an impartial assessment as to whether the director comes within one of the categories in Regulation 5(3). The identity of the external decision maker should be carefully considered and their independence should be specifically assured.

4.4 If the concerns are about the director's conduct with another employer, the provider will need to make sufficient attempts to obtain the relevant information from the previous employer(s) and others to establish the primary facts as clearly as is reasonably possible. Furthermore, unless there are very special circumstances, all information gained regarding the director should be shared with the director concerned so they have an opportunity to comment on it before a decision is made about the primary facts of the incident(s).

4.5 However, documentary evidence is not necessary before a "fact" can be established. If the provider receives evidence from someone who saw or heard relevant matters, that can be evidence to support a factual conclusion even if no contemporaneous record was made of the incident. Hearsay evidence can be relevant but providers should exercise caution before making decisions solely based on hearsay evidence and should consider carefully what weight to give to such evidence where there is a conflict of evidence.

The Assessment Stage

4.6 Once a provider has established the primary facts, it will need to decide whether those facts bring the director within any of the categories set out in Regulation 5(3) of the 2014 Regulations.

4.7 If the provider concludes that the primary facts do bring the director within Regulation 5(3), the director must be relieved of his or her directorial responsibilities. If the primary facts do not bring the director within Regulation 5(3), the provider is not required to relieve the director of their directorial responsibilities (although the facts as found by the investigation may still lead the provider to take any other form of disciplinary action or recommend further training or support for the director).

E. Enforcing the regulation

How will CQC enforce the regulation?

5.1 When there is information of concern regarding the fitness of a director CQC will share this information with the provider. The response from the provider will need to satisfy CQC that a robust process has been followed to ensure the fitness of the director or will lead to a request for further dialogue with the provider, a follow-up inspection, or regulatory action.

5.1 When a provider is unable to demonstrate that it has undertaken the appropriate checks when appointing directors, be that externally or through internal promotion, this may potentially be a breach of regulation. We will use our Enforcement Policy to decide whether there is a breach of the regulation and, if so, what regulatory action to take.

5.2 In the case of a new aspirant registrant we will refuse the registration if the provider is unable to satisfy us that appropriate checks have been undertaken in line with best practice.

Further details on how CQC will enforce the regulation are available on the website at:

http://www.cqc.org.uk/content/regulation-5-fit-and-proper-persons-directors

How to respond to this consultation

Online

Use our online form at:
www.cqc.org.uk/nextphase

By post

Send your response to:
Freepost RTTE-JTBT-ZTHH
Next Phase Consultation
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151 Buckingham Palace Road
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SW1W 9SZ

For enquiries about this consultation, please email:
nextphase@cqc.org.uk

If you would like a summary of this document in another language or format, or you have general queries about CQC, you can:

Phone us on: 03000 616161

Email us at: enquiries@cqc.org.uk

Write to us at:
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Newcastle upon Tyne
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www.cqc.org.uk

CQC-375

ADULT SERVICES COMMITTEE

27 July 2017

Report of: **Director of Child and Adult Services**

Subject: **TRANSPORT FOR PEOPLE WITH A DISABILITY – ACTION PLAN UPDATE**

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1. PURPOSE OF REPORT

1.1 To provide an update on the Action Plan that was developed in response to the recommendations of the Audit and Governance Committee investigation into Access to Transport for People with a Disability.

2. BACKGROUND

2.1 As a result of the investigation into Access to Transport for People with a Disability, a series of recommendations were made which were approved by Adult Services Committee on 3 November 2016. An Action Plan was subsequently developed and provided to the Committee in January 2017.

3. PROPOSALS

3.1 The Action Plan is attached as **Appendix 1**. Additional information provided by Hartlepool & Stockton on Tees Clinical Commissioning Group (HaST CCG) regarding Patient Transport Services is attached as **Appendix 2**.

4. RISK IMPLICATIONS

4.1 Details of risk implications are included in the Action Plan.

5. FINANCIAL CONSIDERATIONS

5.1 Details of financial considerations are included in the Action Plan.

6. LEGAL CONSIDERATIONS

6.1 There are no legal considerations identified.

7. CHILD AND FAMILY POVERTY CONSIDERATIONS

7.1 There are no identified child and family poverty considerations.

8. EQUALITY AND DIVERSITY CONSIDERATIONS

8.1 The recommendations and associated Action Plan aim to improve equity of access to transport by improving access for people with disabilities.

9. STAFF CONSIDERATIONS

9.1 There are no staff considerations identified.

10. ASSET MANAGEMENT CONSIDERATIONS

10.1 There are no asset management considerations identified.

11. RECOMMENDATION

11.1 It is recommended that the Adult Services Committee reviews the updated Action Plan and notes progress over the last six months.

12. REASONS FOR RECOMMENDATIONS

12.1 To progress implementation of the recommendations following the investigation into Access to Transport for People with a Disability.

13. BACKGROUND PAPERS

Final Report of the Audit and Governance Committee into Access to Transport for People with a Disability – September 2016

14. CONTACT OFFICER

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AUDIT AND GOVERNANCE SCRUTINY ENQUIRY ACTION PLAN

NAME OF COMMITTEE: Audit and Governance Committee

NAME OF SCRUTINY ENQUIRY: Access to Transport for People with a Disability

RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION[+]	FINANCIAL / OTHER IMPLICATIONS	UPDATE – JUNE 2017
(a) That a mapping exercise be undertaken to explore the viability of a travel membership club for people with disabilities to access, as and when required, with a detailed exploration of the following areas:-	(a) A number of discussions have been held with local providers who expressed an interest. • A consortium of local businesses were considering the option of developing and investing in a scheme to support local citizens, however following due diligence concluded that there was little evidence to suggest it would be successful or cost neutral. • A private provider with experience of providing transport for adults with disabilities has expressed interest in purchasing a vehicle to set up an alternative travel service. • Community Travel Clubs - Clubs can be established in geographical areas by a number of community groups, Transport Champions, Parish Councils etc to consider the travel needs of individuals within their community. The travel club determines the needs of its members and the Local Authority can provide the service required The Council's Passenger Transport Service has a variety of vehicles available to support a Community Travel Club scheme, ranging from 67	Previous 'Dial a Ride' running costs in excess of £250,000 per annum to operate. Cost to run service is unknown, a provider is willing to contribute towards set up costs. Costs of journeys will vary depending on the needs of each group; the charge is made up of proportional costs of the vehicle, driver and fuel. Several community travel clubs are operating via Passenger transport none of which are subsidised routes. No cost to the Council	A private provider (Paul's Travel) has established a Dial a Ride Service having purchased a wheelchair accessible vehicle. The service is available to people of all ages and provides door to door transport for people with a disability or health problem. The service can be used for short journeys such as shopping, visiting friends, attending health appointments and social occasions.

RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION[+]	FINANCIAL / OTHER IMPLICATIONS	UPDATE – JUNE 2017
	seat coaches, 33 seat buses and 17 seat minibuses, including vehicles suitable for those using mobility aids. These vehicles would potentially be available to travel clubs outside of school travel times, evenings and weekends. Transport provision would be flexible and delivered on a demand lead basis across a varied geographical area. The cost of each journey will be predetermined and shared between the patrons using the service. There is interest from a provider operating a patient transport service in Durham (NHS - transport) which has a number of vehicles and volunteer drivers. The provider is interested in exploring options to extend into Hartlepool.	Service is funded through a contract with Durham CCG an Durham CC (public health grant)	
(i) Identification of the actual number of people affected;	(i) Information provided from a number of sources, no definitive list of the number of people reliant on a wheelchair. • Office for National Statistics (2011 census) - 1.9% of the UK population uses a wheelchair (Hartlepool = 1,757). • Number of people claiming Severe Disablement Allowance (SDA) in Hartlepool = 480. • North Tees and Hartlepool NHS Trust has 3,709 adults and 452 children registered with wheelchair services (Hartlepool = 1,387). • Adult receiving Council provided day opportunities that are reliant on accessing a	A definitive number of people cannot be predicted.	(i) Conservative estimates suggest that over 1,000 people in Hartlepool may experience difficulties accessing transport.

RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION[+]	FINANCIAL / OTHER IMPLICATIONS	UPDATE – JUNE 2017
	wheelchair accessible vehicle (WAV) 14 per day.		
(ii) Membership fees for those wishing to access the service (exploring whether it could be funded from direct payments, independent living / mobility payments);	(ii) An adult meets the eligibility criteria if their needs arise from or are related to a physical or mental impairment or illness; as a result of those needs the adult is unable to achieve two or more of the outcomes specified below and as a consequence there is, or is likely to be, a significant impact on the adult's well-being. The specified outcomes are— • managing and maintaining nutrition; • maintaining personal hygiene; • managing toilet needs; • being appropriately clothed; • being able to make use of the adult's home safely; • maintaining a habitable home environment; • developing and maintaining family or other personal relationships; • accessing and engaging in work, training, education or volunteering; • making use of necessary facilities or services in the local community including public transport, and recreational facilities or services; and • carrying out any caring responsibilities the adult has for a child.	(ii) Adult services currently have a service level agreement with HBC passenger transport to provide wheelchair accessible vehicles to people using its day services. The cost to support on average 61 people with a learning / physical disability is circa £270,000 per annum. The service has access to 5 vehicles and on average 14 spaces are allocated to people who are reliant on a wheelchair. If the buses were only utilised for wheelchair users this would equate to a daily cost of £40.18, however the bus is also used by people who do not require a wheelchair and has been set at £10 per day, or £18 per day for those who require a passenger assistant.	(ii) The SLA is still in place supporting people with a learning / physical disability. The journey and route times have improved following the consolidation of day services in the new Centre for Independent Living.
(iii) Funding from Ward Member Budgets, the CCG and NTHFT to help towards the running of the service; and	(iii) Head of Service to work in partnership with prospective organisations to pull together a lottery bid to pump prime the running of a service.	(iii) Potential to pump prime a new service, cannot guarantee bid would be successful and would not create sustainability in the long term	(iii) The bid submitted was unsuccessful.

RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION[+]	FINANCIAL / OTHER IMPLICATIONS	UPDATE – JUNE 2017
(iv) The use of volunteer drivers	(iv)Meeting held with 'We are Supportive', which has 150 volunteer drivers in Durham. Subsidised service funded by public health and Durham CCG, provider is keen to expand into Hartlepool.		(iv) 'Supportive' continue to show an interest in further developing their volunteer driving scheme. At present they have 7 drivers from the Hartlepool area. The service currently provides support to Durham CC and provides support to Child & Adult Services for example transport to respite and supporting family contact.
(b) That the potential of accessing / expanding existing Charity run schemes in the region be explored	RSVP (Retired and Senior Volunteer Programme) runs many driving schemes across the UK which provide free or low-cost door-to-door service for older or more vulnerable people NEAS - Ambulance Car Service Drivers (ACS) are volunteers who use their own vehicles to help with the transportation of patients to and from hospitals and clinics, thereby leaving ambulances free for emergencies and for patients too ill to travel by car. Over 150 volunteers helping out throughout the North East. Volunteers are not paid for their time, however they do receive out of pocket expenses for their mileage.	Cost is subject to individual requirements. Currently looking for any Ambulance Car Service volunteers in the Teesside, Darlington, Middlesbrough and Stockton-on-Tees areas and Hartlepool	

RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION[+]	FINANCIAL / OTHER IMPLICATIONS	UPDATE – JUNE 2017
(c) As part of the review of transport services at NTHFT:-	(c) Contact made with Brian Christleow, facilities manager at NT&HFT.		
(i) A request is made to provide a hospital shuttle bus that is wheelchair accessible and can be used at all times including peak periods; and	(i) Highlighted the recommendations in the report and proposal that a WAV be considered when procuring hospital transport		Note attached re eligibility criteria - see **Appendix 2.**
(ii) Explore whether this service could be included in a wider partnership scheme, such as the travel club	(ii) Scheme already runs alongside the NEAS passenger transport service and volunteer ACS driver's scheme.		
(d) Examine whether a pre-bookable service could be put in place to provide transport to GP / hospital /	(d) Meeting held with Tracie Jacobs (H&ST CCG) and John Davison (CEO) of 'Supportive' who operate a Health Appointment Car Scheme (HACS) across Durham funded by Public Health and CCG. The provider is keen to expand into Stockton and Hartlepool.	Service is reliant on funding, and is subsidised by grants from Durham CCG and Durham CC.	There was previously a pre-bookable transport service available to support access to GP appointments but this

RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION[+]	FINANCIAL / OTHER IMPLICATIONS	UPDATE – JUNE 2017
dental appointments which is co-ordinated and booked by the health service, when appointments are made;			ceased as it was deemed to be too time consuming. Hospital Trusts are now able to make bookings with NEAS online, for follow up outpatients' appointments and planned admissions. There are no investment opportunities at this time from the CCG, above and beyond the existing Patient Transport Service service that is commissioned.
(e) In relation to the Patient Transport Service, ensure that the assessment criteria includes arrangements for carers to travel with patients and that this is implemented on all journeys when needed;	(e) Discussed and shared the report with CCG and NT&HFT	Awaiting feedback re future plans linked to conveyance.	There is a process to assess the requirement of an escort to accompany the patient on the journey. If a patient has a requirement for a carer, then this is considered and authorised where appropriate. See **Appendix 2.**

RECOMMENDATION	EXECUTIVE RESPONSE / PROPOSED ACTION[+]	FINANCIAL / OTHER IMPLICATIONS	UPDATE – JUNE 2017
(f) Explore the potential of any financially viable options for drivers and taxi companies to provide wheelchair accessible transport along with the potential of any available funding streams	(f) Discussion with local Transport Provider willing to provide a WAV vehicle. Provider has produced estimated costs of running a service. Provider agreed to await the outcome of further work to ascertain future demand.	(f) Initial discussions suggest an incentive of £2-£3 per journey may be sufficient to encourage Taxi Companies to provide WAV. Using the Severe Disablement Allowance SDA figure of 480 people. with an average of 6 journeys per week at £3, it would equate to around £449,000 in subsidies.	In terms of any future changes or assessment of impact for wheelchair users – the CCG will continue to look at and review the criteria for PTS in place. The CCG aims to understand and address where specific cohorts of patients fall between the gaps of the criteria and try to amend as required to remove any inequality. If there are any examples of where the criteria could be improved, feedback would be welcomed.

Introduction to Patient Transport Services

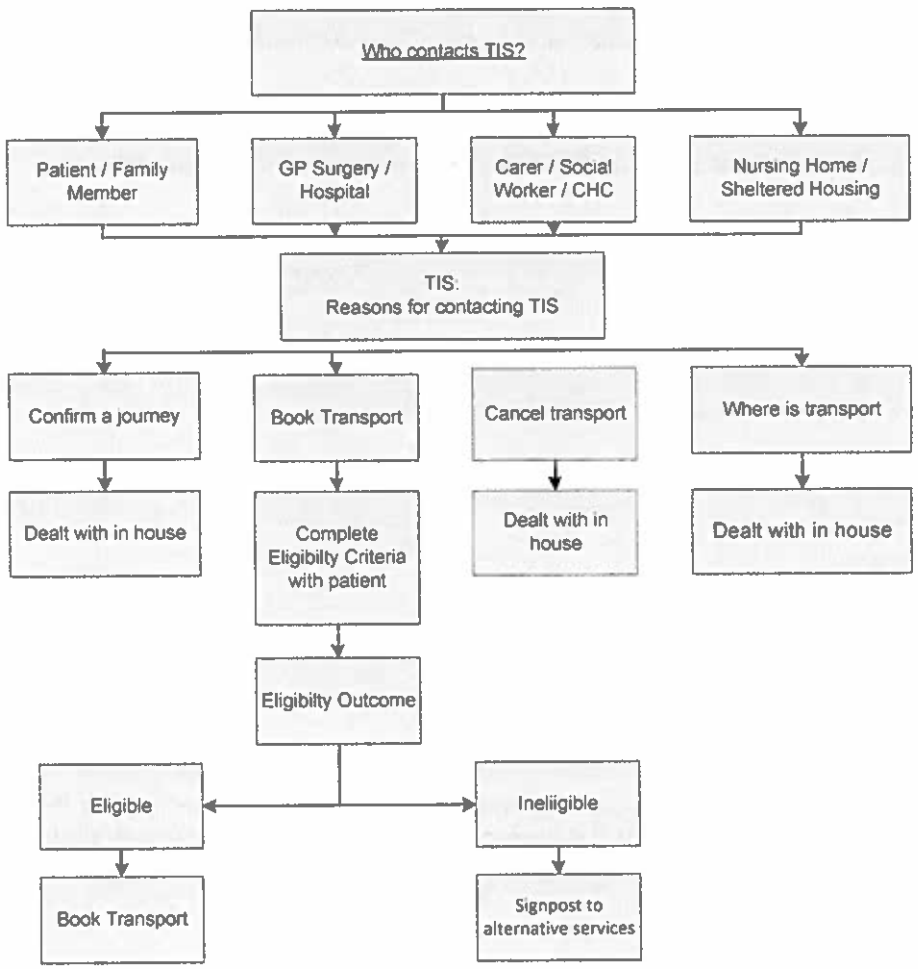
Patient Transport Services (PTS) provide pre-planned, non-emergency transport for patients travelling to a hospital or treatment centre. Transport is provided for patients who have a medical condition that would prevent them from travelling to their appointment by any other means, or who require the skills of an ambulance crew assistant during the journey.

In 2007 the Department of Health published guidance around appropriate use of NHS funded PTS. The purpose of this document was to provide criteria for establishing which patients were eligible for non-emergency patient transport services. The Teesside area was one of the first to implement the criteria. This was not consistent across the North East, which produced something of a post code lottery when it came to receiving PTS. Due to this and what was acknowledged to be an unsustainable increase in demand on local PTS provision, the north east Clinical Commissioning Groups (CCGs) collectively agreed in 2014 that it was time to implement a consistent, region wide criteria for determining patient eligibility.

The new criteria were implemented on the 20th October 2014 and since this date, the criteria have been asked for every booking.

Transport Information Service (TIS) deliver a Teeswide booking service for patients requesting NHS Patient Transport Services, and assess all patients contacting the service. A series of eligibility criterion is applied on each occasion a transport request is made to determine the suitability of patients requiring transport. Answers provided by the patient to the eligibility questions, establish their medical and mobility needs for the service. Transport is booked according to the outcome of the assessment.

Process Map



PTS Criteria

The following eligibility criteria are applied on each occasion a patient requests Patient Transport Services. A patient is required to score 31 points or over to become eligible for patient transport:

Eligibility Criteria for transport:

Is the patient's appointment for radiotherapy, chemotherapy or renal dialysis?

Yes	[50]
No	[0]

Is the patient registered blind?

Yes	[50]
No	[0]

Is the patient's journey for an inter-hospital transfer or hospital discharge?

Yes	[50]
No	[0]

Does treatment prevent the patient from making their own way home safely?

Yes	[50]
No	[0]

Is the patient able to use their own transport?

Yes	[0]
No	[0]

Can the patient drive comfortably to the hospital/clinic?

Yes	[Ineligible]
No	[0]

Is the patient able to use public transport to attend the hospital/clinic?

Yes	[Ineligible]
No	[0]

Does the patient have friends or family who could take them to the hospital/clinic?

Yes	[Ineligible]
No	[0]

At this time how does the patient normally travel to do their shopping and other general outings?

Done by someone else	[10]
Walk	[7]
Mobility Scooter	[7]
Community Transport	[2]
Other- Car, Taxi, Private Hire	[Ineligible]

At this time how does the patient move around their own home?

Confined to a bed	[31]
Only with a carer/parent	[18]
In a wheelchair	[7]
Using a Zimmer frame	[6]
Using a walking stick or crutches	[5]
Walking	[4]

At this time how far can the patient move outside of their home?

Nowhere	[31]
Into the street	[8]
Around the local area	[5]
To a main town	[0]

Given what you have told us about how the patient moves in and around their home, does the patient need support with getting from the hospital entrance to the relevant department/clinic?

Yes [10]
No [0]

Does the patient have any sight or hearing impairment which prevents them finding their own way?
Yes [31]
No [0]

Is the patient in regular contact with any mental health services?
Yes [31]
No [0]

Does the patient require Oxygen from our staff en route to hospital /clinic?
Yes [31]
No [0]

Eligibility for Escort: Score required 10

Is the patient 16 years or under?
Yes [10]
No [0]

At this time do any of the following apply when requesting escorts to travel with the patient?
Has a severe communication/learning difficulty? [10]
Requires an escort from a nursing or residential home? [10]
First referral cancer appointment? [10]
[None of the above] [0]

Patients who receive an ineligible decision, are provided with information for alternative means to get to their appointment. Contact numbers and information for voluntary services, shuttle buses, help with their travel costs and wheelchair accessible taxis, are provided to the patient.

NHS organisations work to ensure that users can get into hospital sights safely and conveniently. Consideration is given to the needs of people with disabilities, and Blue Badge holders, and disabled parking spaces are provided at the hospital sights.

Patients who are deemed ineligible for patient transport may also appeal against the decision. Appeals are actioned by the Patient Transport Appeals Team (PTAT) an independent service to maintain neutrality. During an appeal further information is gathered from the patient, and consideration is given to other contributing factors such as, the distance a patient is required to travel to their appointment, assistance requirements from the ambulance crew and how their medical condition prevents them from using other forms of transport to take them to their appointment. A patients GP practice may also be contacted with the patients' permission.

Below are the number of appeals and complaints

Hartlepool & Stockton CCG Appeals - 1 April 2015 to 31 March 2016	
Total number of Stockton patients requesting PTAT to appeal an ineligible decision	87
Total number of Hartlepool patients requesting PTAT to appeal an ineligible decision	98
Total number of appeals	185

Stockton Patient Appeals - 1 April 2015 to 31 March 2016			
Number of appeals decision overturned	Reason for overturning decision	Number of appeals decision upheld	Reason for upholding decision
61	Distance 43	26	Can Use Taxi 21
	Escorts 4		Escort 1
	Other 14		Cost Issue 2
			Other 2

Hartlepool Patient Appeals - 1 April 2015 to 31 March 2016			
Number of appeals decision overturned	Reason for overturning decision	Number of appeals decision upheld	Reason for upholding decision
66	Distance 36	32	Can Use Taxi 20
	Other 29		Escort 5
	Treatment 1		Cost Issue 1
			Other 6

TIS have not received any complaints regarding transport bookings for patients who have a disability during the period 1 April 2015 to 31 March 2016.

ADULT SERVICES COMMITTEE

27 July 2017

Report of: Director of Child and Adult Services

Subject: COMMISSIONING AWARD FOR INTEGRATED APPROACH TO HOSPITAL DISCHARGE

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1. TYPE OF DECISION/APPLICABLE CATEGORY

No decision required, for information.

2. PURPOSE OF REPORT

2.1 To notify the Adult Services Committee that the work that has been done locally to improve the hospital discharge process has been recognised in the North East, Cumbria, Yorkshire and Humber Commissioning Awards, winning the award for the Best Innovation Project.

3. BACKGROUND

3.1 As reported to Adult Services Committee in June 2017, a significant amount of work has been undertaken locally to improve the experiences of people who are being discharged from hospital.

3.2 Factors that contributed to this improvement in performance include:

- Daily Discharge Planning Meetings;
- Weekend working arrangements within adult social care;
- Weekend working arrangements within the FT's Discharge Liaison Team;
- Implementation of the Patient Choice Policy which has ensured that patients and their families receive consistent messages and appropriate support to consider alternatives;
- Development of Integrated Discharge Pathways;
- Support for people to access suitable out of area placements; and
- Support for existing care homes to maintain current capacity.

4. UPDATE ON CURRENT POSITION

4.1 The work to that has been undertaken across Hartlepool and Stockton to Develop an Integrated Approach to Discharge from Hospital was nominated for the North East, Cumbria, Yorkshire and Humber Commissioning Awards by Hartlepool and Stockton on Tees Clinical Commissioning Group (HAST CCG) on behalf of the key partners involved in this work:

- NHS Hartlepool and Stockton-on-Tees CCG
- North of England Commissioning Support
- North Tees and Hartlepool NHS Foundation Trust
- Hartlepool Borough Council
- Stockton-on-Tees Borough Council
- Voluntary and Social Enterprise Sector

4.2 The nomination highlighted that 'Reducing unnecessary delays in discharging older patients from hospital is a key priority for NHS Hartlepool and Stockton CCG, the Local Authorities and other partner organisations not only from a system perspective but more importantly because we know that longer stays can lead to worse health outcomes and can increase long-term care needs'.

4.3 It is noted that the Better Care Fund (BCF) provided a mechanism to progress integrated working in this area and all partners have shown huge commitment and have made significant progress. The first priority was to develop an Integrated Discharge Team (IDT) which is an enabler to address a number of the other key principles and this model is now established and working well.

4.4 As well as excellent feedback from people accessing the service and staff, recent data indicates that the number of delayed days has reduced by 41% between Q3 (2016/17) to Q4 (2016/17).

4.5 Partners will continue to build upon the principles, learn from the work to date and develop integrated approaches to further impact on delays and improve the patient experience.

4.6 Staff representing the partner organisations attended an award ceremony in Newcastle on the evening Friday 30 June and were delighted to accept the award on behalf of all involved in the development of this approach.

5. RISK IMPLICATIONS

5.1 There are no risk implications associated with this issue.

6. FINANCIAL CONSIDERATIONS

6.1 There are no financial considerations associated with this issue.

7. LEGAL CONSIDERATIONS

7.1 There are no legal considerations identified.

8. CHILD AND FAMILY POVERTY CONSIDERATIONS

8.1 There are no identified child and family poverty considerations.

9. EQUALITY AND DIVERSITY CONSIDERATIONS

9.1 There are no equality and diversity considerations identified.

10. STAFF CONSIDERATIONS

10.1 There are no staff considerations identified. All staff involved in the work have been congratulated and thanks for for their contribution.

11. ASSET MANAGEMENT CONSIDERATIONS

11.1 There are no asset management considerations identified.

12. RECOMMENDATION

12.1 It is recommended that the Adult Services Committee notes that the work to improve hospital discharge has been recognised through this award, and continues to support initiatives that reduce delayed transfers of care and improve outcomes for people using services.

13. REASONS FOR RECOMMENDATIONS

13.1 Improvements to the hospital discharge process that reduce delayed transfers of care result in better outcomes for local people, including a reduction in readmissions following a hospital stay, reduced duplication through integrated working and a better experience for people using services and their families / carers.

14. CONTACT OFFICER

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ADULT SERVICES COMMITTEE

27 July 2017

Report of: Director of Child and Adult Services

Subject: CARE QUALITY COMMISSION: APPRECIATIVE REVIEW PROGRAMME

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1. TYPE OF DECISION/APPLICABLE CATEGORY

No decision required, for information.

2. PURPOSE OF REPORT

2.1 To provide the Adult Services Committee with information regarding the Care Quality Commission's programme of appreciative reviews in 2017/18, and Hartlepool Borough Council's involvement in the programme

3. BACKGROUND

3.1 Following the announcement of additional funding for social care in the Spring budget, work has been undertaken nationally to develop performance measures associated with this allocation, which will form part of the Improved Better Care Fund.

3.2 The measures, which include Delayed Transfers of Care, aim to assess patient flow and how the interface between health and social care services is managed.

3.3 Based on an assessment of these indicators, the Department of Health has identified areas that they perceive to be experiencing particular challenges, where there has not been any other form of intensive support initiated, and have asked the Care Quality Commission to undertake appreciative reviews in those areas. It is intended that twenty areas are reviewed, with the first twelve reviews to be undertaken by November 2017.

3.4 A notification was received on 4 July 2017 advising that Hartlepool Borough Council has been identified as one of the first twelve Councils to be reviewed.

3.5 The complete list of Councils that will be part of the first phase of reviews is as follows:

- Birmingham
- Bracknell Forest
- Coventry
- East Sussex
- Halton
- Hartlepool
- Manchester
- Oxfordshire
- Plymouth
- Stoke
- Trafford
- York

3.6 The review is intended to consider the health and social care system within a local area, rather than being focused only on the Local Authority's role, and it is expected that health partners will also receive formal notification of the planned review in Hartlepool.

4. PROPOSALS

4.1 At the time of writing this report, limited information is available regarding the review process, methodology or timescales, with further detail expected to follow.

4.2 It is anticipated that the twelve reviews will take place between August and November 2017 with a six week preparation phase where documents and information are shared with the CQC, prior to a one week site visit which will involve partners across health and social care. Formal confirmation of local arrangements will be sent to the Chair of the Health & Wellbeing Board.

4.3 During the site visit inspectors will meet with a range of people including commissioners, providers of services, frontline staff, people who use services and carers, local Healthwatch organisations and third sector organisations. They will also review some cases and meet with senior leaders from across health and social care organisations within the locality.

4.4 It is expected that, following completion of the on site visit, feedback will be provided regarding the outcome of the review. This will be focused on identifying areas where improvements can be made and will be confirmed in a letter to the Chair of the Health & Wellbeing Board.

4.5 Following the completion of all twenty reviews, it is expected that a report will be published nationally that summarises the issues identified and shares the learning regarding improvements that can be made in local areas.

5. RISK IMPLICATIONS

5.1 There are no risk implications identified at this stage.

6. FINANCIAL CONSIDERATIONS

6.1 There are no financial considerations associated with this issue.

7. LEGAL CONSIDERATIONS

7.1 There are no legal considerations identified.

8. CHILD AND FAMILY POVERTY CONSIDERATIONS

8.1 There are no identified child and family poverty considerations.

9. EQUALITY AND DIVERSITY CONSIDERATIONS

9.1 There are no equality and diversity considerations identified.

10. STAFF CONSIDERATIONS

10.1 There are no staff considerations identified.

11. ASSET MANAGEMENT CONSIDERATIONS

11.1 There are no asset management considerations identified.

12. RECOMMENDATION

12.1 It is recommended that the Adult Services Committee notes that the CQC will be undertaking a programme of appreciative reviews in 2017/18 and that Hartlepool Borough Council has been identified as one of the first twelve

Councils to be reviewed. The outcome will be reported to the Adult Services Committee at the earliest opportunity following completion of the review.

13. REASONS FOR RECOMMENDATIONS

13.1 The Adult Services Committee has oversight of adult social care services that will be the subject of the review by the CQC.

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ADULT SERVICES COMMITTEE

27 July 2017

Report of: Director of Child and Adult Services

Subject: FIRE SAFETY IN RESIDENTIAL CARE HOMES

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1. PURPOSE OF REPORT

1.1 To provide the Adult Services Committee with information regarding fire safety regulation within care homes in Hartlepool following the Grenfell Tower disaster in London.

2. BACKGROUND

2.1 Following the Grenfell Tower disaster members of the Adult Services Committee requested an update on fire regulations and fire safety in care homes within Hartlepool, to provide assurance that the most vulnerable people within local communities are appropriately protected.

2.2 This report provides a summary of current legislation relating to care home establishments and an update on the current position within Hartlepool. It should be noted that the there are no examples locally of residential care provision in tower block type settings - the highest care home building is Sheraton Court which has three floors.

3. CURRENT LEGISLATION

3.1 The Council's Health & Safety Team has provided the following summary of the fire safety requirements within residential care homes:

3.1.1 There is a legal requirement for a suitable and sufficient fire risk assessment to be undertaken and in these types of property this should be undertaken by a competent person.

3.1.2 In existing properties Her Majesties Guide to Fire Safety in Residential Care Premises should be used by the fire risk assessor as the Approved Code of Practice. In new or refurbished properties this would fall under the Duty to Consult process and the requirements of Approved Document B to Building

Regulations. On completion Building Control Officer(s) issue the appropriate structural compliance certification and the agreed fire strategy then needs to be made available to the Fire Risk Assessor to ensure successful completion of the Fire Risk Assessment for the premise.

3.1.3 Owing to these type of properties being anywhere from ground floor bungalow type properties with 3 or 4 residences, to multi floor complex structures there is no standard model. In existing properties the Fire Risk Assessor identifies the required level of fire safety systems based on the activities and processes identified. Generally sprinkler systems are only required to offset significant fire safety shortfalls that are identified (e.g. poor storage facilities or excessive travel distances when evacuating) or to alleviate the requirement for certain fire safety requirements, (e.g. if the end user wanted to remove self closing devices from bedroom fire doors the installation of sprinklers may facilitate this).

3.1.4 The most crucial element to fire safety is that the Fire Risk Assessment is suitable and sufficient and that all recommendations are implemented, reviewed at least annually by the Responsible Person and reviewed when anything changes (such as structural alterations, change in procedures, occupancy levels etc). The Fire Risk Assessor takes account of the building's structure, fire prevention and fire precaution measures (including the home's evacuation procedure) when completing the Fire Risk Assessment.

4. MONITORING OF FIRE SAFETY

4.1 There are a range of ways that statutory bodies gain assurance that regulations are being adhered to. The Care Quality Commission (CQC) is the regulator of care homes, and regularly reviews Health & Safety procedures, which encompass fire safety, as part of the routine inspection regime. The CQC will identify any risks to residents and take appropriate action which may be in the form of advice and guidance or enforcement action if there is potential immediate danger to residents of a home.

4.2 The Council's Quality Standards Framework (QSF) includes an assessment of Health and Safety, which again encompasses fire safety. Information regarding Health & Safety compliance is provided by the provider for each care home and this element of the QSF is checked by the internal Health & Safety Team and the level of compliance assessed. The questions that are asked of each provider are attached as **Appendix 1**. The legal responsibility for all Health & Safety measures rests with the provider of care under the CQC regulatory framework. The role of the Council is to ensure contract compliance and to provider support and guidance.

4.3 Cleveland Fire Brigade will undertake regular checks at each establishment but do not provide Fire Risk Assessments; this is for the provider to obtain independently.

4.4 The Health & Safety Stage 1 Assessment that forms part of the QSF is a desk top exercise and the Health & Safety Team look for evidence of a Fire Risk Assessment having been undertaken and evidence that any actions identified within the assessment are being addressed. If the Fire Risk Assessment for the home identifies the need for sprinklers to be fitted, compliance with this would then be reviewed in the QSF Stage 1 Health & Safety Assessment.

4.5 The recent Health & Safety desktop exercise identified some actions for a number of homes linked to fire safety, none of which were deemed high risk. All actions have since been completed and are monitored through ongoing QSF monitoring.

4.6 In addition to fire safety checks carried out by the regulator, the Fire Service and the Council each home also operates a system of 'Personal Evacuation Plans' (PEEPS) which are individual to each resident and will identify how each resident is supported in the event of a fire. Plans may include people walking to the nearest fire exit, if they are physically and cognitively able or waiting until they are supported by staff. When residents require additional support, this is identified and appropriate equipment provided in order to facilitate safe evacuation. Each individual is risk rated to ensure that the evacuation of residents is completed swiftly and effectively. Some residents would be at greater risk if they tried to leave a building unaided rather than waiting for support, and this may also put others at greater risk.

5. RISK IMPLICATIONS

5.1 There are risk implications in relation to fire safety which are managed through compliance with current regulations. There are no actions identified locally which have been assessed as high risk, and all identified actions have been completed.

6. FINANCIAL CONSIDERATIONS

6.1 There are no financial considerations associated with this issue.

7. LEGAL CONSIDERATIONS

7.1 There are no legal considerations identified.

8. CHILD AND FAMILY POVERTY CONSIDERATIONS

8.1 There are no identified child and family poverty considerations identified.

9. EQUALITY AND DIVERSITY CONSIDERATIONS

9.1 There are no equality and diversity considerations identified.

10. STAFF CONSIDERATIONS

10.1 There are no staff considerations identified.

11. ASSET MANAGEMENT CONSIDERATIONS

11.1 There are no asset management considerations identified.

12. RECOMMENDATION

12.1 It is recommended that the Adult Services Committee notes the report which provides assurance regarding fire safety within residential care settings in Hartlepool.

13. REASONS FOR RECOMMENDATIONS

13.1 There is a robust regulatory framework both nationally and locally to ensure the safety of residents in residential care.

14. CONTACT OFFICER

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Day Care, Domiciliary, Residential and Independent Living Providers

Health and Safety Assessment Assessor's Record of Findings

This Pro-forma is used to provide a record of findings arising from a desktop audit.

This assessment report should be completed by the assessor and sent to the Commissioning Team.

The report should reflect the assessor's findings and be more than just a list of ticks. The record should include notes of conversations that may have taken place between parties. If there are areas of improvement required a note should be made in the relevant comments section and summarised in the letter to the service provider. This too should be sent to the Commissioning Team.

Assessors Name:

Email address:

Phone number:

12. FIRE PRECAUTIONS AND EVACUATION

Are satisfactory actions for employees described should there be a fire or emergency?	Y	This may be the arrangement described in the policy or providing notices in the workplace.	The expectations here are the same as for any provider with a recorded fire risk assessment. It is not the aim a fire risk assessment should be a bureaucratic exercise. The website at http://www.communities.gov.uk/fire/firesafety/firesafetylaw/aboutguides/ says this clearly. It provides guidance notes for residential care premises at (http://www.communities.gov.uk/publications/fire/firesafetyrisk5 It is designed to tell the provider what they have to do to comply with fire safety law. It helps them to carry out the fire risk assessment and identify the general fire precautions they need to have in place. The guides give a responsible person, who has limited formal training or experience, what they need to be able to carry out a fire risk assessment. If they read the guide and decide they are unable to apply the guidance then they should seek expert advice. More complex premises will probably need to be assessed by a person who has comprehensive training or experience in fire risk assessment.
Do the arrangements cover all the areas of work?	Y	This should include offices and workshops.	
Is a person named as responsible for ensuring the evacuation arrangements are in place and tested?	Y	Self-evident	
Is the fire risk assessment "suitable and sufficient"?		There should be a completed fire risk assessment. It should adopt the hierarchy of control and show how the risk of fire is reduced or removed.	
Is there evidence of satisfactory instructions for employees including training, evacuation procedures or fire prevention advice for example?	Y	Self-evident	
Is it clear there is a person competent in fire issues?	Y	Self-evident	
The assessment should identify all sources of ignition related to the work and how hierarchy of control controls the risk.		Self-evident	

Notes from the assessment:
EXAMPLE
Evidence of fire drills being undertaken and clear fire evacuation arrangements supplied.
The fire risk assessment supplied is dated April 201* with a recommendation of an annual review. It is recommended that you instigate an annual review of fire risk assessment within the home.