Consultation Response

Care Quality Commission: Our next phase of regulation – a more targeted, responsive and collaborative approach (cross-sector and NHS trusts)

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

About this consultation

This consultation, issued by the Care Quality Commission (CQC), asks for views on changes to the regulation of registered health and care services, to be implemented as part of CQC's five-year strategy between 2016 and 2021[i]. Some of the proposals apply to all regulated sectors, and include new approaches to complex or integrated services that might currently fall within several registration categories. The consultation also looks specifically at regulation of NHS trusts from April 2017. A further consultation in the spring will focus on adult social care and primary medical services.

Key points and recommendations

- We welcome CQC's renewed commitment to promoting, as well as protecting, the health and wellbeing of service users, and its overall intention to adopt a more integrated approach and to be responsive to changes in care provision.
- Innovation, and refocusing of services, can have an impact on risks to the wellbeing of service users regardless of whether they result in a change of registration. category. Providers should therefore be expected to inform CQC of such changes.
- Regulation should be proportionate to risks to the health and wellbeing of service users. This principle should not be diluted where poor providers are taken over by new management. Although it is legitimate for CQC to give new management time to implement a new longer term improvement strategy, consideration of immediate or short term risk should not change unless there is immediate action to mitigate these risks.
- Large organisations will often take different types of decision at different levels so it may be difficult to identify a single 'guiding mind' as the basis for registering a service at an appropriate subsidiary level of a large corporation.

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- Proposals for regulating new model of care focus on large organisations and say little about small single services that might cross the boundary between health and care regulatory frameworks, for example those for people living with frailty.
- We welcome the emphasis on shifting consideration of the service from the registration category to the service specific 'statement of purpose'. This should be accompanied by a similar shift in guidance for providers produced by CQC towards ensuring that the statement of purpose adequately describes the service, and that the provider can demonstrate their ability to meet regulatory requirement in relation to the specific service.
- It is difficult to comment on CQC's proposed methodology without knowing what the minimum frequency of inspections will be. Such minimum frequencies are referred to in the consultation for NHS trusts but not for other services. Smaller services may be more vulnerable to fluctuations in quality, so in Age UK's view the minimum frequencies set out for NHS trusts would not be appropriate for smaller services such as care homes.
- Assessment of aspects of sustainability and use of resources should form part of consideration of whether or not services are well led. This assessment should look at financial efficiency and controls but also at sustainability.
- However, CQC's assessment of the quality of a service should be based on objective standards – CQC should not modify its assessment of quality on the basis of the level of resources available.

Regulating new models of care and complex providers

Consultation question 1 – Do you think our set of principles will enable the development of new models of care and complex providers?

We strongly welcome CQC's commitment to promoting, as well as protecting, the health and wellbeing of patients and service users.

The consultation notes (page 6) that innovation can lead to periods of uncertainty. CQC accordingly commits to supporting providers through periods of transition and to ensuring that regulation is not a barrier to innovation. Providers will be expected to show how they will manage quality through a transition. However, in many cases providers seeking to refocus a service may also simply de-register and close the existing service.

The consultation states that CQC will 'encourage' providers to inform the regulator of innovations, even those that do not entail a change of registration category. This should also apply to changes in the service that are not innovative but may result in disruption for service users. In particular we have received enquiries from residents who are affected by care homes refurbishing in order to target self-funders rather than local authority clients. Though this might not entail a change in the type of needs that the home could meet, CQC should still be made aware of it as a factor that could affect the wellbeing of existing residents, and which might influence CQC assessments of risks to users.

CQC proposes replacing its existing 'six aims' with 'nine key principles'. We particularly welcome the fact that principle 1 commits CQC to taking action to promote, as well as protect, the health and wellbeing of people who use services.

Principle 3 states that regulation will be proportionate, but it is not very clear what it will be proportionate to, though previous track record is referred to. In our view the focus should be on risks to the wellbeing of service users. Wellbeing should not just be based on physical safety but on a wider concept of wellbeing such as that set out in the Care Act 2014. Age UK has developed a 'Wellbeing Index' based on the views of older people[ii]. The evidence gathered as part of this project shows that the outcomes that older people regard as most important are those that relate to their continued ability to function in society – so being able to participate in social and cultural activity and being able to remain physically active can be equally or sometimes even more important than material goods or existing social networks. In our view an emphasis on promoting individual functioning and capability should be an important part of CQC's methodology for assessing wellbeing.

Principle 6 states that CQC will not penalise providers that have taken over poor services because they want to improve them. However, if the basis for regulatory action is risk to service users it is difficult to see how it would be possible to take a different approach to providers under new management when considering current or imminent levels of risk. It might be appropriate to take a different approach to longer term risks. For example, where the reason for taking regulatory action is continual failure to improve, new management should be able to start with a clean sheet provided that their plan for future improvement is credible. However the assessment of current risk to service users should not change.

Providers of new models of integrated care may be large and complex. This section of the consultation raises the issue of the organisational level that should be regulated in order to

ensure that organisations are registered at the level of the 'guiding mind' that determines quality of services. The consultation notes that CQC is currently working with stakeholders to develop new proposals on this issue, which will be set out in more detail in the spring 2017 consultation referred to in the 'about this consultation' section above.

Our broad view on this issue is that the search for a 'guiding mind' might be misleading as it is in the nature of large and complex organisations that different decisions may be taken at different levels. For example, decisions about practice and service budgets, both of which will affect quality, might be made at different levels. Whilst many aspects of regulatory compliance will be decisions about practice, it may be that more senior management have made decisions about resources that make poor quality inevitable and they should be held accountable for this. The 'guiding mind' may therefore be different depending on the issue being considered so flexibility should be built in.

One approach might be to require large corporate providers to register at corporate level but to note that certain aspects of regulatory compliance are delegated to a lower level of management. Failures of compliance at the level of delegation might not be treated as a failure of the entire organisation to comply with regulatory conditions, but might be if senior corporate management could be held responsible; for example if failure to comply with regulations could be attributed to financial decisions at a senior level.

The consultation does not look at how CQC will deal with new models of care that might not fit existing registration categories because they deal with both health and care needs. Such providers might not be large or complex, but may provide a single cross-cutting service. An example might be support for older people living with severe frailty. In responding to CQC's consultation on the current five-year strategy we noted that 'for older people with frailty some of the best examples of proactive, positive care pathways are those that respond to goals set by the person and that react to the specific challenges they live with. These challenges are not isolated to health needs but the way in which services respond across all aspects of a person's life has a significant, if not critical, impact on the quality of their care'. Regulation of this type of service would require flexibility in applying both the care and health regulation frameworks.

The consultation notes that it will be important that providers keep their 'statement of purpose' up to date. This is described as a 'core document that enables CQC to offer a consistent and co-ordinated approach to regulation'. More to the point, the statement of purpose is also a valuable means of enabling flexibility in regulation. If the quality and risk

are defined in relation to the service as set out in the statement of purpose as well as in relation to the registration category, this enables the registration category to be broader and less specific.

If more emphasis is placed on compliance with the provider's statement of purpose, CQC should issue guidance on how the statement should be framed so that it accurately describes the service, and how CQC would evaluate whether providers were able to provide the service described in the statement to the standards required by regulation.

The updated assessment framework

Regulatory activity will be more targeted. Services will receive a comprehensive inspection at the time of registration but thereafter will only receive a comprehensive inspection if there are specific concerns about the service. We have a number of concerns about this approach, as is explained below.

The consultation sets out how quality ratings will be used as a guide to determining maximum intervals for re-inspecting core services in hospital trusts. For NHS trusts these intervals may be as much as five years for high performing trusts. The consultation does not state whether similar intervals will be used for other services. Without this information it is difficult to say whether CQC's overall proposals for more targeted regulation are workable or whether they pose unacceptable risks.

Risks to service users in smaller services are more likely to fluctuate than those in NHS trusts as factors such a change of manager or variations in the level of need of service users may have a greater impact. We would therefore have serious concerns if CQC intended to introduce similar frequencies in carrying out inspections of small services such as care homes.

The concept of 'effective' is particularly important in developing a more integrated assessment focus, as it is judged by whether treatment achieves good outcomes. Placing an emphasis on ability to meet the demands of the statement of purpose would also mean the registration category would not need to be so narrowly defined (as is CQC's intention), so would be less of a barrier to innovation.

Consultation question 2 - Do you agree with our proposal that we should have only two assessment frameworks: one for health care and one for adult social care (with sector specific material where necessary)?

Yes. As noted above we would like to see more emphasis on ability to comply with the statement of purpose, so it is less important that the registration category defines a particular type of service.

We welcome measures to promote greater alignment between health and social care assessment frameworks, including efforts to ensure that the key lines of enquiry (KLOEs) are similarly structured and where possible use common or similar wording. This approach might make it easier to appropriately regulate services such as those referred to above that cross the boundaries between health and care.

Changes to the well-led framework

The consultation highlights that CQC will continue to assess the quality of a service around five ‘key questions’, as outlined within CQC’s strategy for 2016 to 2021. The five ‘key questions’ refer to whether the service is ‘safe’, ‘effective’, ‘caring’, ‘responsive’ and ‘well-led’, each of which is underpinned by an assessment framework.

As part of this, the consultation proposes a new single ‘well-led framework’ for all healthcare providers, which will include a clearer emphasis on the sustainability of services, to reflect the approach set out by the National Quality Board in its *Shared Commitment to Quality*.

In our view the assessment of aspects of sustainability, including use of resources, should evaluate whether management systems are in place to ensure the most effective use of resources. We agree that this should be part of the assessment of whether services are ‘well-led’.

However, whether or not the service is sustainable is not the same as whether the provider has high-quality financial management systems. If a service is lavishly funded, it might not have good financial controls and might not be achieving good value for money, but it might

be sustainable. If the funding available to the service is insufficient to enable it to remain viable it may be unsustainable despite having excellent financial controls.

Although an organisation's management systems may contribute to sustainability, the actual sustainability of the service may be influenced by factors that are beyond the control of the service, for example if the service is underfunded or unable to recruit appropriately qualified staff. In this situation CQC should point out if poor quality is due to underfunding; however the inadequate funding should not itself influence the quality rating.

It is indeed important that the quality of all services is measured by the same yardstick, regardless of demand or financial pressures, otherwise it will become unclear what is meant by quality and CQC judgments about quality will not command public confidence. It will also be more difficult to link variations in quality to factors such as demand and financial resources.

A more complex approach might be that, instead of assessing the extent to which a service has the funds to sustain their current service, the assessment should look at the extent to which a service has the means to adapt to provide new models of health and care provision. This would be particularly important if local Sustainable Transformation Plans make clear that new models of care will be needed.

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

Alongside this question, CQC and NHS Improvement are consulting separately on 'use of resources and well-led assessments'[iii]. This consultation contains more detail on how providers' use of resources will be assessed through the introduction of a new use of resources assessment framework. The scope of that consultation is restricted to NHS trusts and NHS foundation trusts.

NHS trusts currently receive a CQC overall trust-level rating. The two consultations propose that this rating should include use of resources by the trust, and that this should be combined with CQC's quality rating into a single trust-level rating. The CQC and NHS Improvement consultation goes even further by suggesting that 'use of resources' could be added as a sixth 'key question' to the five existing questions that underpin CQC ratings. An alternative would be to aggregate the first four key questions under a single 'quality'

heading with separate sections on ‘leadership’ (reflecting the well-led key question) and ‘use of resources’. Both suggestions would initially be considered for acute trusts only and would lead to different weightings (as in the latter proposal ‘use of resources’ is one of three headings rather than one of six).

As highlighted in our separate response to the CQC and NHS Improvement consultation, and further to our response to question 2 above on financial aspects, we are concerned that the combination of use of resources and quality ratings within CQC overall trust-level ratings might be watering down the idea of what good quality care is. This risks undermining the public’s confidence in the judgements made by the regulator charged with assessing quality, as a result of elevating financial considerations to what we would view as an unreasonable degree.

Equally, at a time of mounting pressures on our health and social care system, in Age UK’s view it is vital that CQC retains its role of providing an independent and reliable assessment of quality that makes it clear, particularly to service users and their families, what the quality of a service actually is. For this reason we believe that NHS Improvement must distinguish between their own assessment that takes account of financial resources, and the overall quality rating which is awarded and legally owned by CQC.

In conclusion, we do not agree that use of resources should be combined with the CQC quality framework. If value for money and factors such as the unit cost of the service are to be taken into account, then they should form part of a wider performance rating of which quality is just one aspect. This should be clearly distinguishable from any CQC overall rating to reduce the risks of confusion on the part of the public.

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

[ii] Age UK, A summary of Age UK’s Index of Wellbeing in Later Life, February 2017. http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/AgeUK-Wellbeing-Index-Summary-web.pdf?dtrk=true

[iii] Care Quality Commission and NHS Improvement - Consultation on use of resources and well-led assessments - December 2016 - https://improvement.nhs.uk/uploads/documents/Consultation_on_use_of_resources_and_well-led_assessments.pdf