



HM Government



# Cutting Red Tape

Review of adult social care - residential and nursing home sector

March 2016

# Contents

<b>Ministerial foreword</b> .....	<b>3</b>
<b>Introduction</b> .....	<b>4</b>
<b>Executive summary of findings</b> .....	<b>6</b>
<b>Background</b> .....	<b>10</b>
Regulatory Landscape.....	12
The role of local authorities.....	14
Clinical Commissioning Groups (CCGs) .....	16
CCGs and the Adult Care Home Sector .....	16
The role of NHS England.....	17
<b>Findings - what we heard</b> .....	<b>18</b>
Headline findings .....	18
Detail of the findings .....	19
<b>Potential savings to business</b> .....	<b>28</b>
Sources, caveats and assumptions .....	28
<b>Issues raised out of scope of the Review</b> .....	<b>30</b>
Deprivation of Liberty Safeguards (DoLS) .....	30
National Living Wage.....	30
Recruitment and training.....	31
<b>Going forward</b> .....	<b>32</b>
<b>Annex 1: Detail of responses</b> .....	<b>33</b>
<b>Annex 2: Summary of other evidence gathering</b> .....	<b>60</b>
<b>Annex 3: Review scope</b> .....	<b>62</b>

# Ministerial foreword

This Parliament we have committed to cut £10bn of red tape as part of our plan to support business and drive productivity by axing unnecessary regulation and ineffective enforcement, while ensuring the protections we want in place are delivered consistently and efficiently.

The Cutting Red Tape Review of the adult social care residential and nursing home sector was launched on the 16th July 2015 and gathered evidence until 18th September 2015. The Review enabled us to hear from providers, users, regulators and commissioners of services about their experiences: how current regulation and its implementation is working for them – the good and bad and where Government action could support improvements and make life easier.

No one disputes the importance of a robust regulatory system in this sector. It's vital to ensure high standards of care and to protect people who are vulnerable and that message came through loud and clear from the Review. However, those of you who responded also told us that often there is still a level of duplicated activity between regulators and those commissioning services. You have told us that this extra process and paperwork leaves less time for dedicated staff to deliver care as well as adding to the financial burdens of a hard pressed sector. That is why we are determined to see any wasteful duplication of process and unnecessary paperwork removed, giving everyone more time to do their job and care for people.

We have listened to what you told us and taken on board all the findings of the review. I am grateful to my Ministerial colleagues The Rt Hon Alistair Burt MP and Marcus Jones MP in the Departments of Health and Communities and Local Government for their commitment to working with their Executive Agencies, local authorities, Clinical Commissioning Groups and most importantly, care providers. Together we will develop an ambitious plan of action to tackle the issues you have identified. I am determined that through this work we will develop a more proportionate and coordinated approach to the regulation and commissioning of adult social care which will benefit providers, regulators, and care recipients and help drive up the quality of care.

**Anna Soubry**  
**Minister for Small Business, Industry and Enterprise**

# Introduction

1. This report summarises the findings of the Cutting Red Tape review on progress of regulatory reform in the Adult Social Care Residential and Nursing Home Sector<sup>1</sup> in England. The review is one of a series<sup>2</sup> of reviews that examine whether legislation and its implementation can be simplified or improved to aid compliance and reduce unnecessary burdens on business. Each review is a short, sharp investigation of stakeholder experiences and evidence carried out by a small review team typically involving a six to eight week fieldwork phase.
2. Our evidence gathering included a website comments box, a dedicated mailbox for more detailed submissions, of which 8 were received, and 38 in depth, qualitative interviews with individual care home providers, ex-providers, regulators and local authorities (primarily through ADASS<sup>3</sup> and the LGA<sup>4</sup>) conducted face to face or via telephone. We also heard from individual local authorities who shared examples of what they had done to work collaboratively with the Care Quality Commission and/or different Clinical Commissioning Groups (CCGs), to coordinate their approach to inspections and data requests from providers. Additionally we spoke to national and regional care home representative organisations.
3. Details of all responses, including a thematic breakdown of comments from the website can be seen at Annex 1.
4. The aim of the review is to address issues such as overlap and duplication between regulators, and to identify instances where legislation, guidance or the approach to implementing regulations is unclear, confusing or unnecessarily burdensome.
5. This review builds on the earlier Focus on Enforcement (FoE) review<sup>5</sup>, published in 2013, which looked at regulatory practice and enforcement burdens in the adult social care sector. Since then reforms have been made to the CQC's regulatory model and to the Department of Health's governing legislation to embed a new model across all the sectors it regulates, including adult social care. These planned reforms addressed a number of the findings of the Focus on Enforcement Review.
6. The Cutting Red Tape Review has looked at how the CQC's reformed model is being received by providers and the progress that has been made since the

---

<sup>1</sup> Like the earlier Focus on Enforcement Review this review looked specifically at the Adult Care Home sector, not domiciliary care.

<sup>2</sup> Other sectors in the first wave of CTRs are: minerals extraction, waste, energy, farming and anti - money laundering.

<sup>3</sup> Association of Directors of Adult Social Care

<sup>4</sup> Local Government Association

<sup>5</sup> [www.gov.uk/government/publications/adult-care-homes-sector-focus-on-enforcement-review](http://www.gov.uk/government/publications/adult-care-homes-sector-focus-on-enforcement-review)

FoE Review was published, particularly through hearing directly from small and medium sized providers. It has particularly sought evidence from the sector on the issues of duplication and overlap between regulatory inspections and monitoring activities by different local authorities and CCGs and on how these impact on providers both financially and in terms of the service and care they provide.

7. It is important to make clear at the outset that none of the respondents to the review disputed the importance of having a robust regulatory framework that places the individual at the centre. This review has not been about removing or stripping back existing regulatory protections. It is about driving up quality by removing unnecessary burdens on business, whilst maintaining all the necessary protections – and where possible, allowing care home providers to devote more time to caring for their residents, than on unnecessary burdens such as duplicating paperwork.
8. Underpinning this work is the Government's commitment to ensuring that all health and social care services are delivered in a safe, effective and compassionate way with good and proportionate regulation playing an important role in achieving this.

# Executive summary of findings

## **The role of different public agencies is unclear to many providers and appears to them to involve a significant amount of overlap:**

9. The overarching message from the review's respondents was that many providers were unclear about the respective roles and responsibilities of the different public agencies they interacted with and that this lack of a common understanding of "who does what" was compounded by the often inconsistent approaches by those public agencies in different areas. Numerous different agencies visit care homes for a variety of reasons and at different frequencies. Providers feel the cumulative burden is significant, that there is duplication in visits and in information requests, and that there often appears to be little joining up between the agencies, or clarity as to how each one relates to the others.
10. Underpinning this message the headline findings of the review can be grouped under six key themes:

## **The overall burden of monitoring activities is having a negative impact on care and the time staff can spend with residents:**

11. The review team heard that an important concern for providers is what they report as the disproportionate time spent on form filling and pre-inspection work and how this significantly impacts on the time staff can spend with residents. Although none of the respondents disputed the importance of good regulation, to protect some of the most vulnerable people in society, many felt there was scope to streamline the amount of paperwork required by the CQC, local authorities and CCGs which would increase the time spent on providing quality care. Typical comments included:

*"An absolutely excessive amount of documentation required in care homes which inevitably takes time away from caring".*

*"Recently completed a very successful CQC inspection which was time consuming, took staff away from operational tasks. We accept this. However, now our local commissioning body will be doing their own day long Inspection visit!! Takes time away from front line care, trying to operate on minimal staffing levels".*

## **The overall burden of monitoring activities also risks having a negative impact on the market:**

12. Providers have told us both directly and through their associations that the increasing administrative burden associated with fulfilling necessary regulatory checks was so resource intensive that it was becoming unsustainable and causing them to consider leaving the market.

13. The sector has indicated through its responses to the review that it is concerned about the sustainability of the adult social care residential and nursing home sector. Providers said:

*“Anything that can be done to ease this situation will help providers to work more effectively and lessen the risk that providers will go out of business- a very real risk to many smaller businesses”.*

*“Staff complain and constantly struggle with time management, paperwork often taking a priority over the hands on quality care, I deal daily with a frustrated team trying to keep up morale and ensure paperwork is being completed as required by our inspection authorities”.*

**There is duplication of local authority contract monitoring requirements with CQC inspection requirements which results in overlap in inspection visits and information requests:**

14. A recent FoE review identified the duplication of activities by local authorities and the CQC as one of the most significant issues for providers. The evidence provided by the sector through the course of this review suggests that the situation has not improved and that this, in their view, is continuing to impose significant unnecessary administrative burdens and additional costs.
15. As commissioners and funders of care places, local authorities have a duty to check the quality and appropriateness of the care that an individual receives – ensuring the person’s needs are being met and their overall wellbeing is central to the services delivered. However, some providers told us of instances where the contract management checks by local authorities were extending to the broader care home environment in a way that directly duplicated the assessments carried out by the CQC, but not always to the same benchmark. This means providers have to report on the same topics often through multiple and varying inspections, visits and information requests:

*“Had a Quality Assurance for our residents, then 1 month after a Quality Assurance for paper work, then a business meeting review with the council. Council booking another Quality Assurance for November, CQC haven’t even inspected yet”.*

**There is inconsistency of approach between local authorities, which can lead to a lack of clarity about requirements and lead to similar data being collected in multiple formats:**

16. Where a home has residents funded by more than one local authority there is additional scope for duplication as without a standardised approach to contract management across local authorities many use their own reporting systems and checks. We also heard of cases where some local authorities refused to accept data that had already been provided to other agencies or local authorities unless it was transposed into their own preferred format.

17. Multiple providers highlighted considerable overlap resulting from this lack of a coordinated approach in terms of inspections, with the CQC inspecting every 2-3 years on average and local authority monitoring checks taking place annually.

*“Paperwork is unbelievable and over whelming to frontline staff and managers. The other frustration is inconsistency across different boroughs – who have different systems and expectations. This creates another problem of not only duplication but using different formats and requirements”.*

*“If paperwork was streamlined and governing bodies worked together this would free up managers/nurses on the floor to observe that the care provided was always to a very high standard”.*

*“Whilst commissioning of nursing and residential care remains separate each commissioning organisation insist on their own set of paper work and audits which often collect the same information from the same provider. Government need to use levels to bring together commissioning and quality assurance of the sector into one place”.*

**There is a lack of clarity around the role and responsibilities of CCGs, and an apparent lack of coordination with local authorities and CQC leading to additional uncertainty and duplication of activities:**

18. CCGs are a relatively new part of the adult social care landscape replacing Primary Care Trusts (PCTs). Because of their independent statutory status they maintain autonomy over how they carry out their statutory assurance functions. The review team were told that CCG processes and guidance for providers could vary significantly from area to area. As such these different approaches can result in providers across England being asked for different information, different levels of detail and at different times.
19. Providers who had dealt with multiple CCGs commented on their frustration at the lack of a standard approach across CCGs, which use varying approaches to commissioning and monitoring and which issue different guidance from each other.
20. The review also found that many providers were still unclear on the precise statutory role of CCGs and often felt that their inspections and information requests – duplicate what is asked of providers by local authorities. Providers told us that there was a need for better coordination between CCGs, local authorities and the CQC to improve clarity of understanding and reduce duplication. Comments from providers included:

*“System should be streamlined. Overlap from contractors such as CCG and LA. There is confusion that CCG and LA are undertaking inspections when in fact they are looking at whether their contract obligations are being met and the service is “Value for Money”. And:*

*(Providers have to) “Meet the criteria of one body, then asked to repeat a similar action to meet another body’s preference. Without it we will be in breach of a*



*contract. Operate in a number of areas across the country, demanded by different commissioners to change our policies so they fit in with theirs.*

*Pressure to change minor items to fit with contracts officer's opinion or meet a local initiative rather than any quantities or qualitative improvement. The CCG dictates we use theirs. Requested to keep out own - told we must continue to do theirs but also to keep ours too- double work!"*

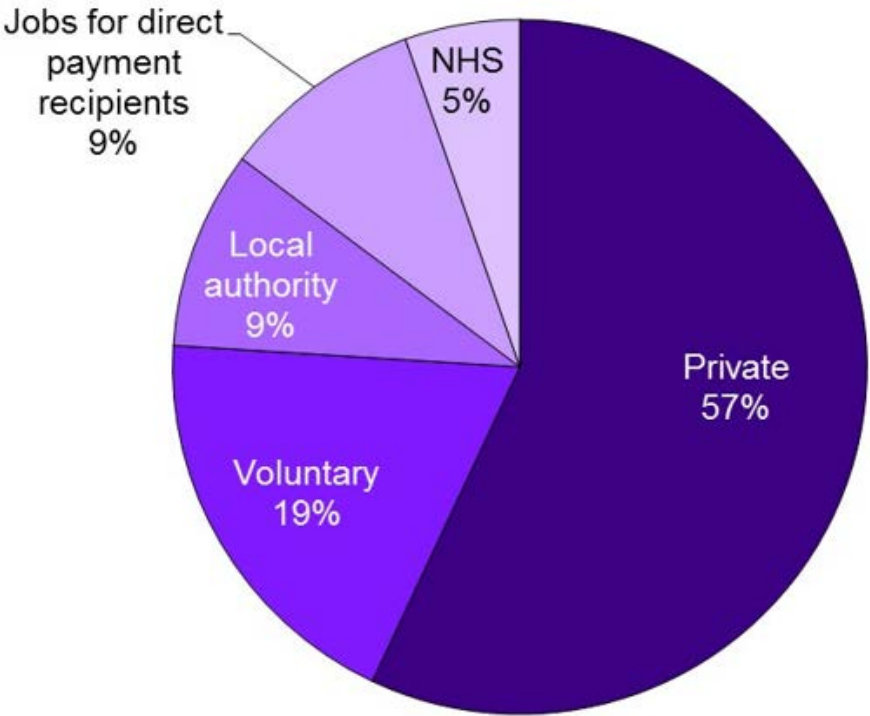
**A number of different agencies are exploring improved approaches, but often these actions do not seem to be coordinated, suggesting a need to join up fragmented initiatives:**

21. The review has identified a number of pieces of work that appear to be aimed at facilitating a more strategic and standardised approach to the commissioning and monitoring of care homes, and at data and information management. However, many of the different initiatives were much localised and the review team was unable to find much evidence of the impact that they had had, of how agencies had joined up to deliver these, or on strategies for rolling these out more widely. Examples included:
  - Commissioning for Better Care outcomes – led by ADASS;
  - A national procurement strategy – led by LGA;
  - A secure email project – led by NHS England;
  - An information sharing pilot – led by CQC.
22. The purpose of this review is not to reduce inspections or the effectiveness of monitoring, but to ensure that the inspection and monitoring of care homes carried out by different public bodies, works effectively and is coordinated to ensure proper use of public funds and to reduce unnecessary burdens on providers. The Government is clear that robust and effective regulation of this sector is vital to protect and safeguard vulnerable people in our community from abuse. But believes that by removing unnecessary red tape we can help to drive up the quality care of and help deliver a sustainable care market.
23. Likewise the purpose of this review is not to make recommendations on ways in which public agencies such as the CQC and local authorities should coordinate their activity and work together to raise standards. The report sets out the issues and challenges as described by those affected by the regulations in order to identify the scope for improvement.
24. Alongside this report, Government has published an action plan on what steps it will take to address the findings of the review. In taking this work forward we will look to secure the commitment of the CQC, local government, CCGs and other lead agencies to work in partnership with Government and with the sector to tackling these issues wherever possible.

# Background

25. The adult social care landscape is coming under increasing pressure driven by the changing demographic of more older people with complex care needs and the growing financial demands in the sector. Government policy is to support the sustainability of the overall market so that commissioners and recipients of care have a choice of providers. Therefore, a proportionate and well enforced regulatory framework that minimises unnecessary burdens on providers, whilst simultaneously safeguarding standards of care and protection for users is key to achieving this.
26. Genuinely unnecessary burdens on care providers represent a cost to the industry that may be passed on to the public purse in fees paid by local authorities and the NHS, and higher than needed fees to the significant numbers of self-funding people, representing diminished value for money. They may also represent an opportunity cost of time that could otherwise be spent with residents.
27. The adult care sector in England comprises of a wide range of provision responding to the differing needs of the adult and elderly population. Care provision ranges from domiciliary or home care to supported living; and to residential care in nursing or care homes. The sector also includes specialist provision for patients who have specific care requirements, such as mental health needs, dementia or requiring physical health care.
28. Over 90% of adult care services are provided through an active and competitive market of independent providers. The remainder of care is provided “in-house” by local authorities and this can be segmented into two; residential care and domiciliary (“home”) care. In respect of residential care, there are approximately 8,000 providers with the largest 159 organisations holding approximately 40% of the market share.
29. Together with domiciliary care this constitutes a market of services worth around £22bn per annum. The vast majority of both residential and domiciliary care is provided by the private sector (78% and 91% respectively), with the remainder being a mixture of public and voluntary provision. The market is split between state and self-funded care: 49% of residential care is funded by local authorities, with a relatively small amount of funding coming from the NHS.
30. Like the previous FoE review, this progress review focused specifically on registered adult care providers who operate adult social care homes and nursing homes, respite care facilities and supported living accommodation. It covers those businesses that are required to register with the CQC because they carry out regulated activity in the form of the provision of accommodation for persons who require nursing or personal care.

- 31. There are estimated to be over 300,000 people in England who live in residential care homes, with the market employing high numbers of part time, and fulltime staff. The National Audit Office<sup>6</sup> estimate that local authorities manage £19bn of spending on adult social care with a further £10bn spent on care and support by self-funders. The Department of Health last year provided estimates of 17,000 providers in the adult social care sector, of which nearly 90% are thought to be small or micro businesses, and nearly half micro businesses (meaning that they have less than 10 employees).
- 32. The 2014 Skills For Care report provides an overview of the size and structure of the adult social care sector as at 2013 (see Fig 1).<sup>7</sup>



**Figure 1: The Size and Structure of the adult social care sector and workforce in England, Skills for Care 2014**

---

<sup>6</sup> Adult social care in England: overview [www.nao.org.uk/wp-content/uploads/2015/03/Adult-social-care-in-England-overview.pdf](http://www.nao.org.uk/wp-content/uploads/2015/03/Adult-social-care-in-England-overview.pdf)

<sup>7</sup> [www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/NMDS-SC/State-of-2014-ENGLAND-WEB-FINAL.pdf](http://www.skillsforcare.org.uk/Document-library/NMDS-SC,-workforce-intelligence-and-innovation/NMDS-SC/State-of-2014-ENGLAND-WEB-FINAL.pdf)

**Table 1: Percentage of adult social care jobs in England by employer type**

Sector	Number of jobs	Percentage of jobs
Independent	1,160,000	76%
Local authority	141,000	9%
Jobs for direct payment recipients	145,000	9%
NHS	80,000	5%
Total	1,520,000	

## Regulatory Landscape

33. The Health and Social Care Act 2008 (amended in 2012)<sup>8</sup> sets out the system for registering and regulating adult care provision in England.
34. Adult care providers are primarily regulated through the CQC.<sup>9</sup> The CQC was established by the Act as the independent regulator of all health and adult social care services in England. In addition to adult social care, it also regulates hospitals; and GP and dental surgeries. Its role is to monitor, inspect and regulate services to make sure they meet the fundamental standards of quality and safety and publish what it finds. Before a care provider can operate legally they must register with the CQC and satisfy them, that they meet a number of requirements. In addition to ensuring the fundamental standards are met, the CQC ask five questions of all the services it inspects:
- Are they safe?
  - Are they effective?
  - Are they caring?
  - Are they responsive to people's needs?
  - Are they well-led?
35. A rating is given for each of their five key questions along with an overall rating. The ratings help people compare services and make choices about their care.
36. To maintain valid registration a provider must ensure the information provided to the CQC remains up to date and then be subject to regular inspections. The CQC also monitors performance between inspections by collecting information from a variety of sources. This may include:

---

<sup>8</sup> [www.legislation.gov.uk/ukpga/2008/14/part/1](http://www.legislation.gov.uk/ukpga/2008/14/part/1)

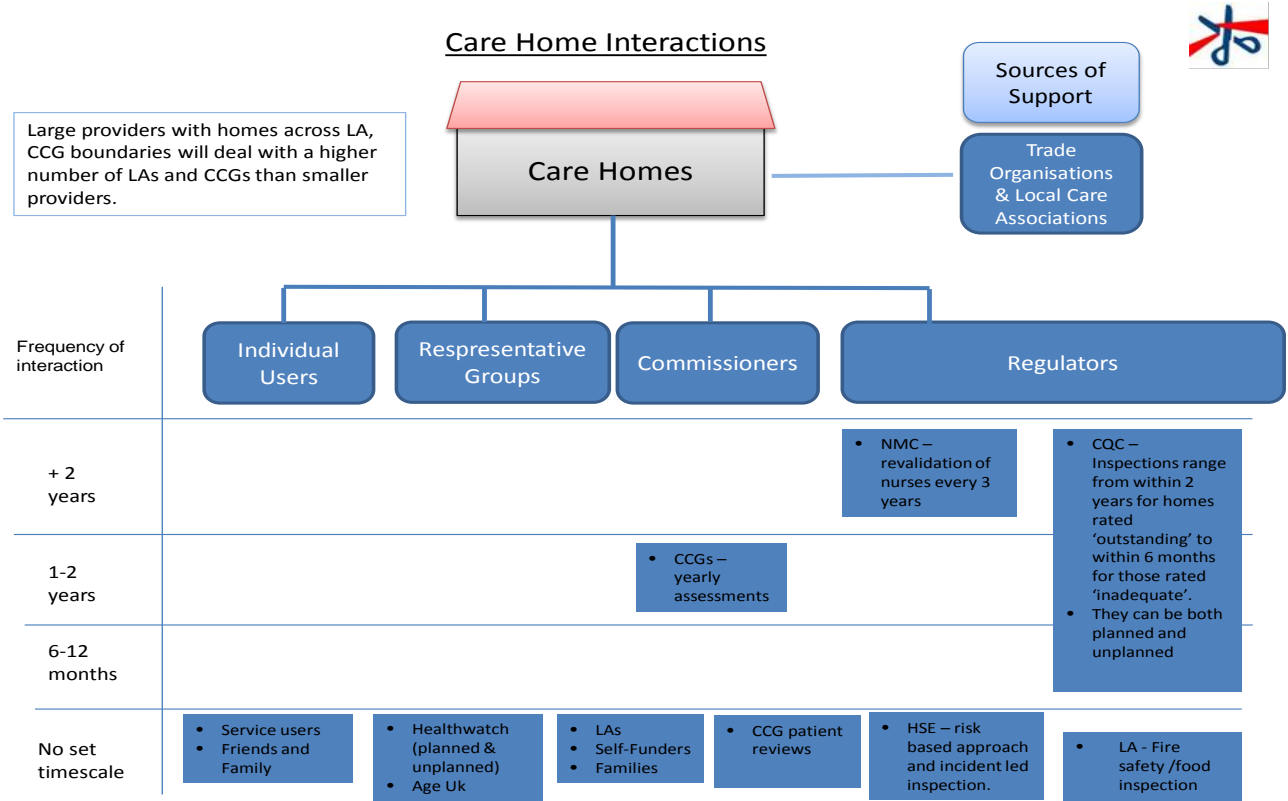
<sup>9</sup> [www.cqc.org.uk/content/registering-and-monitoring-services](http://www.cqc.org.uk/content/registering-and-monitoring-services)

- Information about people's experiences of care and the views of their families and carers.
  - Information collected directly from care providers.
37. From April 2015, the Care Act 2014<sup>10</sup> introduced a new “market oversight” responsibility for the CQC to assess the financial sustainability of certain “hard-to-replace” care providers. These are providers who, because of their size, concentration or specialism, would be difficult to replace if they were to fail commercially, and so where the risks posed by this failure would be highest for individual local authorities and their communities. In tandem, the Care Act imposes clear legal responsibilities on local authorities where a provider fails. In these circumstances the local authorities must take steps to ensure that a person affected does not experience a gap in the care they need as a result of the provider failing.
38. It is worth noting that the CQC inspections run on completely different cycles to local authority inspections. For example, CQC may only inspect a well-run, home which has been judged low-risk from the previous visit every 3 years. Whereas local authority care commissioners need to monitor the agreed contractual arrangements, to check or review an individual’s care and support needs at least annually, and could have a direct involvement in any individual safeguarding issue.
39. Local authorities have duties that were clarified and amplified by the Care Act 2014. They play a crucial role in administering the state funded social care system, in particular for meeting the needs of people who are eligible for funded care as they meet the financial means test criteria.

---

<sup>10</sup> [www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga\\_20140023\\_en.pdf](http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf)

The diagram at Figure 2 is not definitive but gives an indication of the different agencies a care home will interact with:



**Figure 2: Care home map of interactions with agencies**

### The role of local authorities

40. Local authorities are responsible for assessing an individual’s need for care and support and eligibility for local authority funded care provision. They are responsible for commissioning care places for those in their communities who are eligible for public funding support, and they provide advice on available places both for those going into local authority funded places, and for those who are self-funding. The Care Act places duties on local authorities to facilitate and shape their market for adult care and support as a whole, so that it meets the needs of all people in their area requiring care and support, whether arranged or funded by the state, the individual themselves, or their families or representatives. The ambition is for local authorities to influence and drive the pace of change for their whole market, leading to a sustainable and diverse range of care and support providers, continuously improving quality and choice, and delivering better, innovative and cost-effective outcomes that promote the wellbeing of people in need of care and support.

41. Local authorities do not have a formal regulatory role but as commissioners and funders of 49% of adult social care places,<sup>11</sup> they have significant contact with care homes through ensuring access to an adequate supply of suitable places and their need to procure and manage the contracts for these places. They must also ensure value for money and account for the use of public funds. This means that as part of the contract management processes, local authorities will visit and inspect homes on a regular basis to ensure that the needs of care recipients are still being met; and that the care packages being provided are of the necessary quality and value for money.
42. For those who receive care and support funded or partly-funded by the local authority, or in the case of someone requesting a needs assessment, the local authority is required to assess an individual's needs, provide for care and support planning and undertake a review of the needs at least every year. All this needs to be done with the 'involvement' of the individual and will often be undertaken in the person's own home. This will require local authority staff to visit a significant number of people living in care homes.
43. The local authority also has statutory duties with regards to the safeguarding of adults where it has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):
  - (a) has needs for care and support (whether or not the authority is meeting any of those needs);
  - (b) is experiencing, or is at risk of, abuse or neglect; and
  - (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.
44. As local authorities are responsible for public health, they work closely with CCGs through Health and Wellbeing Boards<sup>12</sup> to achieve the best possible outcome for the local community, by developing a joint needs assessment and strategy for improving public health. Health and Wellbeing Boards provide a forum for leaders from the health and care system to work together to improve the wellbeing of their local population and to reduce health inequalities.

---

<sup>11</sup> 43% of adult scale care is self-funded, 8% is funded by the NHS ( source Laing and Buisson 2012/2013.

<sup>12</sup> Health and Wellbeing Boards are statutory bodies introduced in England, following the Health and Social Care Act 2012.



## Clinical Commissioning Groups (CCGs)

45. The one significant part of the regulatory and commissioning landscape that has changed since the original FoE review is the replacement of Primary Care Trusts with CCGs. Like PCTs before them, CCGs play an important role in commissioning adult social care places for individuals' also needing healthcare.
46. CCGs are statutory organisations set up under the Health and Social Care Act 2012 to organise the delivery of certain NHS services. They are independent and accountable to the Secretary of State for Health through NHS England. They are responsible for healthcare commissioning such as mental health services, urgent and emergency care, elective hospital services, and community care. They oversee the health of community populations ranging from under 100,000 to 900,000,<sup>13</sup> although the average population covered by a CCG is about a quarter of a million people. They are collectively responsible for approximately 60% of the NHS budget; or £60 billion per year.

## CCGs and the Adult Care Home Sector

47. For the purposes of this review, adult care homes can be split broadly into two categories: residential - for individuals no longer able to live independently but not requiring nursing or significant continuing medical care; and nursing homes in which residents need nursing or medical care. Many larger care homes provide both, but they would usually separate residents onto different floors or buildings, as the equipment needed and staff profiles are different. The CCG's role is to commission NHS continuing healthcare from nursing homes. There are two ways NHS fund care home places through CCGs:
  - NHS Continuing Healthcare (CHC) – a package of care that is arranged and funded solely by the NHS for individuals who are not in hospital and have been assessed as having a "primary health need". To be eligible for NHS continuing healthcare individuals must have been assessed as having a "primary health need", meaning that the main or primary need for care must relate to a person's health. The CCG is responsible for all aspects of commissioning for those eligible for CHC, including securing ongoing case management for those in receipt of CHC. The CCG is responsible for monitoring quality, access, the patient experience and provider performance in relation to those individuals whose places they are funding.
  - Funded Nursing Care - care provided by a registered nurse for people who live in a care home. The NHS will pay a flat rate non-means tested contribution of £112 a week directly to the care home. This is a free, non-means tested package of care for people who have been assessed as having significant and complex ongoing healthcare needs.

---

<sup>13</sup> [www.ons.gov.uk/ons/rel/sape/health-geography-population-estimates/mid-2012/stb----health-geography---mid-2012.html](http://www.ons.gov.uk/ons/rel/sape/health-geography-population-estimates/mid-2012/stb----health-geography---mid-2012.html)



48. Under NHS England's assurance framework (see paragraph 51) CCGs are required to demonstrate that the individuals they commission care for are receiving high quality health services. They have a duty to ensure good quality through an initial assessment visit and subsequent quality assurance visits to the relevant nursing care homes; this may be alongside the local authority monitoring teams or on separate visits. They measure quality standards against the nursing contract with the homes and nursing care of individuals and may work in partnership with homes where additional support is needed to meet those standards. The CCG will monitor the quality and whether the care package being delivered continues to meet the individual's needs. CCGs also review care plans annually to ensure health needs are continuing to be met, and assess whether care needs have changed.
49. Each CCG has autonomy over how it carries out its statutory assurance functions. This means there is no standardised approach across the 209 CCGs on carrying out inspections. These different approaches mean that if more than one CCG is funding different individuals in a particular care home, all admitted at different times, which several of the respondents indicated is not uncommon, this will result in multiple visits at different time with the accompanying multiple information requests.
50. CCGs are also represented by NHS Clinical Commissioners (NHSCC),<sup>14</sup> which is the CCG membership body representing 86% of CCGs. The NHSCC does not have a governing power over CCGs on how they commission locally. However, they do support the dissemination of best practice.

## The role of NHS England

51. Under the Health and Social Care Act, NHS England has a responsibility to ensure good quality commissioning by CCGs, Its responsibilities are:
  - Assurance: assuring itself that CCGs are fit for purpose, and are improving health outcomes.
  - Development: helping support the development of CCGs.
52. NHS England is also a direct commissioner of care, responsible for highly specialised services and primary care. As co-commissioners, CCGs work with NHS England's Local Area Teams to ensure joined-up care.
53. CCGs play a major role in achieving good health outcomes for the local population that they serve. Jeremy Hunt, Secretary of State for the Department of Health has initiated a project for NHS England to develop a scorecard for CCGs which will be a way for the public to see performance metrics for their local CCGs.

---

<sup>14</sup> [www.nhscc.org](http://www.nhscc.org)

# Findings - what we heard

## Headline findings

- **The overall burden of monitoring activities is having a negative impact on care and the time staff can spend with residents:** Providers told us they are spending a disproportionate time on form filling and other administrative requirements and this is taking them away from caring for their residents.
- **The overall burden of monitoring activities also risks having a negative impact on Market:** Providers told us that the increasing administrative burden associated with fulfilling necessary regulatory checks was becoming so resource intensive that it is causing some to consider leaving the market.
- **There is duplication of local authority contract monitoring requirements with CQC inspection requirements which results in overlap in inspection visits and information requests:** Providers reported unnecessary duplication of local authority contract monitoring requirements with CQC inspection requirements.
- **There is inconsistency of approach between local authorities, which can lead to a lack of clarity about requirements and lead to similar data being collected in multiple formats:** Providers flagged the lack of a standardised approach across all local authorities as a particular problem where a home has residents funded by more than one local authority each one using their own system and checks.
- **There is a lack of clarity around the roles and responsibilities of CCGs, and an apparent lack of coordination with local authorities and the CQC leading to additional uncertainty and duplication of activities:** Providers and some local authorities suggested that the varying approaches of CCGs to commissioning, monitoring and issuing of guidance created confusion and often generated unnecessary extra paperwork - diverting resource away from care. Several respondents stressed the need for better coordination between CCGs, local authorities and the CQC to improve clarity of understanding and reduce duplication.
- **A number of different agencies are exploring improved approaches, but often these actions did not seem to be coordinated, suggesting a need to join up fragmented initiatives:** Our fieldwork identified a number of localised examples of good practice and several existing initiatives to develop a more strategic and standardised approach to the commissioning and monitoring of care home places and to information management. However, these are fragmented and we were unable to find much evidence of their impact or of how agencies had joined up to deliver these.

## Detail of the findings

### **The overall burden of monitoring activities is having a negative impact on care and the time staff can spend with residents:**

54. Providers reported a disproportionate time spent on form filling and pre-inspection work and how this significantly impacts on the time staff can spend with residents. For example, one care home referred to the *“absolutely excessive amount of documentation required in care homes which inevitably takes time away from caring”*. Another manager of a nursing home talked about *“being chained to my computer and desk on a daily basis and finding no time to spend with my service users, their relatives or staff”*. She voiced her exasperation at being *“overwhelmed at the amount of documentation and records expected from local authorities, CQC, CCGs etc.”* resulting in *“paperwork often taking a priority over the hands (sic) on quality care provided to our service users”*. Another respondent representing a care home with 30 beds and 3 full-time staff estimated spending 7 hours a week on form-filling. Yet another care home manager commented about the disproportionate time spent *“in dealing with people, coordinate people, prepare information and complete paperwork. This has a massive impact on managers, taking them away from the daily management of the home.”* We also heard from a large charitable provider dealing with over 60 local authorities which commented:

*“Whilst we recognise the importance of inspection, these visits must be undertaken in a balanced way so that there is no detriment to the delivery of care under inspection. Inspections take up time and that time taken is less time delivering care or managing the delivery of care”.*

55. On a visit to a care home, the review team were told that the introduction of a new electronic management system for care plans had greatly streamlined the time spent for internal recording and resulted in clearer and more accurate record keeping within the home but that the local authority would not accept printouts of the data and insisted that the home submit the same data but in the authority’s required format. The provider felt this highlighted evidence of a need to adopt a more sensible approach to information collection. To quote another respondent whose experiences were not dissimilar to those of the care home visited: *“We support and believe in regulation and subsequent inspection but think that there needs to be more “intelligent regulation” not just tick box exercises”*.

### **The overall burden of monitoring activities also risks having a negative impact on the market:**

56. The Government policy is to support people to live independently at home with the care support that they need for as long as possible. The demand for adult social care is continuing to increase as people are living longer often with more complex medical and care needs. Therefore this changing demographic will have an impact on the demand for available care home places in the longer term

57. The CQC's "The State of Health Care and Social Care in England 2014/15"<sup>15</sup> describes the adult social care sector as being under pressure. The increasing complexity of people's care needs, cuts to local authority budgets, increasing costs and pressures from local commissioners to keep fees as low as possible have, they say, resulted in a fragile market. We were told by some providers that in some areas local authorities' rates for care places would not cover the level and quality of care that the provider was then measured against by that same local authority.
58. The cost of complying with a range of regulatory requirements from local authorities, CQC and CCGs needs to be seen in this context of the other financial pressures on providers. All of which hit small and medium providers particularly hard.
59. Care England and the National Care Forum were just two of the representative bodies for the independent care sector who told us that many of their members had considered, or were considering leaving the market, partly because of the increasing administrative burden associated with fulfilling regulatory checks.
60. Some respondents described the amount of work involved as being so resource intensive it meant that running a care home was becoming unsustainable.
61. One of our respondents also cited recent Forum of Private Business research.<sup>16</sup>
- "The Forum of Private Business reports that regulatory reform costs about 22% more to administer in the care sector than any other. This comes at a time of reducing income and rising demand."*
62. The review team also spoke to an ex-care home manager who had left the sector because of the costs of complying with a local authority's inspection and information requests. The provider felt strongly that their local authority was carrying out the same inspections as the CQC because the authority didn't feel CQC's standards were rigorous enough. The same provider also felt that the local authority created duplication and overly onerous burdens by 'gold plating' information requests and inspection criteria. In the provider's view this meant that they were having to comply with requirements well in excess of what was legally required and the associated costs of this had caused them to sell their care home and scale down their business to the provision of home care instead of residential care.
63. Several comments received from providers via the website demonstrated the strength of feeling about this issue; and illustrate how in the view of particularly smaller providers, the increasing burden of compliance is directly threatening the sustainability of the market:

---

<sup>15</sup> [www.cqc.org.uk/sites/default/files/20151103\\_state\\_of\\_care\\_web\\_accessible\\_4.pdf](http://www.cqc.org.uk/sites/default/files/20151103_state_of_care_web_accessible_4.pdf)

<sup>16</sup> Forum of Private Business 212 Referendum, The Cost of Compliance , July 2015.

*“Adult social care providers are taking hits from local authorities, CQC, various government departments and legislation. Anything that can be done to ease this situation will help providers to work more effectively and lessen the risk that providers will go out of business- a very real risk to many smaller businesses.”*

Another respondent said *“small homes are being forced to close because of all this increasing regulation. The big public companies have whole departments to do this, but the small provider does not “*

**There is duplication of local authority contract monitoring requirements with CQC inspection requirements which results in overlap in inspection visits and information requests:**

64. The original FoE review identified the duplication of activities by local authorities and the CQC as one of the most significant issues for providers. Evidence from this review suggests that this continues to be the case and that there has been little improvement in relation to this specific issue.
65. Providers told us that local authority contract management processes often require care homes to provide local authorities with the same information already provided to the CQC. This unnecessary duplication diverts staff away from care giving. Providers told us how in their experience, some local authorities (as commissioners of care), overlay their own quality and contract monitoring requirements into local contracts as they don't regard the CQC's standards as sufficient.

*“Although the CQC is the national regulator, its national standards are not always seen as sufficient by local commissioners and additional quality and contract monitoring requirements are often overlaid onto national standards into local contracts.”*

*“Historically, because of the poor reputation of the National Regulator, many commissioners of care, for example local authorities, felt the need to carry out their own inspections and due diligence. To a great extent, there has been considerable duplication between work done by local authorities and the national regulator.”*

66. Contract monitoring requirements vary from local authority to local authority and the review learnt from the evidence that this was a major concern for providers as highlighted in the quotes below. In homes where residents are funded by more than one local authority, they are required to provide the same or slight variants of information multiple times to 4 or 5 local authorities, as well as other agencies. Instances of care homes with residents funded by more than one local authority are not uncommon, particularly in London and other large conurbations. The review findings suggest that this can be a particular issue for faith or philosophical based charities running care homes that may draw in residents from a wide range of areas under different local authority control.

**There is inconsistency of approach between local authorities, which can lead to a lack of clarity about requirements and lead to similar data being collected in multiple formats.**

67. Providers told us that they found it inexplicable that there was no standard approach by local authorities when monitoring contracts, as they should be inspecting and assuring the same standards of care quality.

*“It is hard to understand why different authorities cannot use a standard model where they are in essence providing the same service”.*

*“..Up and down the country different local authorities are doing different things to monitor and check quality. A number of these systems are nonsense and provide very little evidence about the standard of care and support, they are mainly focused on box ticking. This kind of process sucks time from the organisation which costs money”*

68. Poor co-ordination by the agencies involved may also mean multiple inspections and visits over short periods, requiring further staff support:

*“.....in April we had a quality assurance visit from the local authority for our residents, then another one for paper work a week later , then another a week later followed by the CQC inspection. I absolutely understand and agree that inspections need to be done by why so many so often?”*

69. Many people commented that a better coordinated approach between agencies both in inspection timetabling and information requests would do much to reduce the burden and enable providers to focus more on care:

*“Why not have joined up thinking across local authorities so that the “quality processes they are using are the same across the board, wouldn’t this help to look at areas across England and how they compare from the local authorities; or CQC’s perspective, would it provide more robust information to identify where the challenges are and maybe where central Government needs to have more focus?”*

*“Why can’t we have an agreed “fit for purpose” national documentation set so that it can be used universally?”*

*“I would greatly welcome if the industry had a common set of documentation that was transferrable with service users like NHS patient records, these could be developed to cover standards and criteria that all inspection authorities could use to complete their inspections. They could be developed to be a common document, user friendly to staff and minimise record keeping overkill. Surely a common set of standards and documentation would make the inspection process clearer and easier to perform too”*

**There is a lack of clarity around the roles and responsibilities of CCGs, and an apparent lack of coordination with local authorities and the CQC leading to additional uncertainty and duplication of activities.**



70. We have noted that CCGs are independent statutory organisations and therefore have great flexibility and autonomy over how they carry out their statutory assurance functions. Evidence submitted to the review cited additional burdens from the lack of a standardised approach across all CCGs. Providers told us that this has led to them experiencing confusion, complexity and duplication.
71. The review evidence from the sector also suggests that there is still a lack of clarity around the role and responsibilities of CCGs, and how they interact with local authorities and CQC. This seems to be compounded by the fact that individual CCGs adopt different approaches to commissioning and monitoring and the issuing of guidance. This is despite the work of NHSCC, the body representing 86% of CCGs, to support and encourage the dissemination of best practice across CCGs and its role to ensure national principles of best practice are followed locally.
72. The review team met representatives from the NHSCC. Although it has no directive powers over how CCGs commission locally, it does disseminate best practice and has developed national principles for producing guidance that attempts to foster a consistent standardised approach, whilst recognising the need to consider the local context. But despite this the team discovered many different types and formats of guidance for providers which varied considerably, not only in the level of detail asked for, but often in the quality criteria being measured. We found examples of CCG guidance which rather than focusing on assessing the individual's quality of care, also covered areas which were the remit of CQC and local authorities when inspecting the home itself.
73. Approximately 25% of the comments we received from providers on the Cutting Red Tape website cited an overlap between what CCGs ask homes for when reviewing individuals' care and the requests made by local authorities as part of their contract management processes; and with CQC pre-inspection and inspection requirements.
74. Comments on the website and the broader fieldwork undertaken by the team with providers, their representative bodies and local authorities also confirmed that the role of CCGs and their interactions with other bodies across the piece was perceived as complicated. According to one charity, *"Many local authorities and CCGs have made the Commissioning process extremely complex"*.
75. CCG's role is to carry out quality checking visits to care homes to monitor the care of those whose care it is funding against the nursing contract with the homes. This could include looking at some wider aspects of the home itself in terms of being suitable for the patient's needs. However, responses to the review suggested, that in many instances, providers were unclear on what the CCG should be assessing and if or how those assessments should overlap with checks made by other agencies: Comments we received included:

*"System should be streamlined. Overlap from contractors such as CCG and local authority. There is confusion that CCG and local authority are undertaking*

*inspections when in fact they are looking at whether their contract obligations are being met and the service is “Value for Money”.*

**A number of different agencies are exploring improved approaches, but often these actions did not seem to be coordinated, suggesting a need to join up fragmented initiatives.**

76. The fieldwork revealed various pieces of work across England that appear to be aimed at facilitating a more strategic and standardised approach to the commissioning and monitoring of adult social care and health care and to data and information management.
77. However, many of these are localised or have either stalled in their implementation or are not being promoted or publicised efficiently to encourage wider take up. Some of these initiatives may be as fragmented and disjointed as some of the issues they are trying to address. We were unable to find any reliable evidence about the impact of some of these initiatives in tackling some of the issues around poorly regulated activity, or of how agencies were continuing to work together. But that said, the team were convinced that some of these initiatives had the potential to achieve a more joined up approach between agencies.
78. Some respondents provided examples of local good practice and ways in which duplication could be reduced. For example one local authority detailed how its multi-disciplinary Care Quality Assurance team had achieved effective interagency working through monthly information sharing meetings with summaries of these meetings then being circulated more widely to CQC, and safeguarding and operational teams. This joined up, information sharing approach has reduced the number of direct requests for information from different bodies to providers in the area. The same local authority team discussed how it had also developed an open access “quality helpline” through which professionals could contact the team directly for updates on work being carried out by a provider or to raise any other concern for the team to respond to.
79. Another local authority referenced developing a shared framework to enable benchmarking across localities and reduce duplication by requiring providers to complete a minimum data set of information on a quarterly basis. This framework was developed by quality management experts and commissioners of care who represent CCGs and several local authorities so therefore possess a good understanding of how local authorities can operate differently. When designing the framework they took into account that local authorities operate using an existing methodology for overseeing care quality in residential settings but that none of the quality assurance information could easily be shared across local authorities. Therefore this new shared framework now enables benchmarking across different local authorities thereby reducing duplication where several commissioners make requests for different data sets from care homes.
80. This framework has subsequently been modified and rolled out by a small number of local authorities, with the general principle being that only information



which care homes can reasonably provide without causing additional administrative burdens should be requested. The returns also enable risk monitoring and potentially reduces the number of visits that are required to a provider by the council if the information provided does not suggest an elevated risk. This has the potential to reduce on-site monitoring which acts as disruption to residents.

81. However, our evidence indicated that these approaches were not being used or applied consistently. A response that typified the frustration providers felt about the different agencies all doing their own thing was *“It is hard to understand why different local authorities cannot use a standard model where they are in essence providing the same service”*.
82. Another respondent summed up the complexity and lack of coordination between agencies as *“dysfunctional”*. Much of what we learnt from our discussions with stakeholders mirrored what people told us from the website. Our stakeholder engagement ranged from meetings with the CQC which was able to update us on how its new inspection model was being received by the sector to conversations with CCGs and local authorities. We also held a number of meetings and telephone conversations with individual providers who were able to flesh out the real world impact on their business and services of disjointed frameworks of regulatory enforcement and monitoring and compliance on care home staff and importantly, on its residents:
83. One provider described the range of inspections and visits they experienced as follows:

*“We have recently been subject to several inspections, sometimes on one site. It could be said that a care home now gets inspected by:*

*2x Healthwatch enter and watch (what is this a zoo?)(sic)*

*2X LA-contract monitoring (despite only having 5 residents on LA contract out of 72)*

*1X CCG- NHS contract monitoring*

*1x infection control nurse*

*2X CQC inspectors*

*1x expert by experience*

*Some between a week of each other*

*That’s a lot of public money and time. And from a resident’s perspective it’s a lot of intrusion into their private lives.”*

Examples that the team believe are worthy of further investigation include:

**Commissioning for Better Care outcomes –A route map;**

84. Commissioning for Better Outcomes published November 2014<sup>17</sup> is a Department of Health/ADASS/LGA initiative and is designed to support local authorities improve their commissioning practice in line with new duties under the Care Act. It provides a framework for councils to self-assess their progress and identify areas for further improvement, and is relevant to all aspects of commissioning, service design and decommissioning.
85. The framework is made up of 12 standards which were co-produced by local authorities, service providers, people who use services and a steering group overseen by Think Local Act Personal.<sup>18</sup>

The standards are grouped into four main domains. The domains are:

- Person-centered and outcomes-focused
- Inclusive
- Well led
- Promotes a sustainable and diverse market place.

86. The prototype document was piloted by 3 local authorities and revised. A further 10 peer challenges are being planned by the LGA and funded by the Department of Health to be completed by April 2016. Additionally a number of local authority commissioning regions have used the guidance themselves as part of continuous improvement. The Department of Health's intention is that it will subsequently inform a new offer within the LGA peer challenge programme from April 2016. However, the review team were unable to find evidence that the standards were now being rolled out to local authorities and impacting on commissioning practices, which is perhaps not surprising at this stage of the roll-outs.

**A national procurement strategy – led by LGA;**

87. The LGA's National Procurement Strategy published in 2014 contains general principles on management of good procurement outcomes for local authorities. As part of this broader outcomes focused work, the LGA has also recently consulted on a "National Social Care Category Strategy- calling for an integrated approach to procurement. A more joined up approach to the principles of good procurement which focuses on quality outcomes for the resident could be instrumental in obtaining a more standardised approach to contract management.

---

<sup>17</sup> [www.local.gov.uk/documents/10180/5756320/Commissioning+for+Better+Outcomes+A+route+map/8f18c36f-805c-4d5e-b1f5-d3755394cfab](http://www.local.gov.uk/documents/10180/5756320/Commissioning+for+Better+Outcomes+A+route+map/8f18c36f-805c-4d5e-b1f5-d3755394cfab)

<sup>18</sup> [www.thinklocalactpersonal.org.uk](http://www.thinklocalactpersonal.org.uk)

### **A secure email project – led by the Health and Social Care Information Centre (HSCIC) and ADASS**

88. The ultimate aim of this project is to implement a culture change in the way individuals' confidential health/social care is processed and recorded. The project team has been working to educate and encourage admin and health care professionals to send transfer/discharge forms using a standardised secure email system. Currently lots of important and confidential patient information still gets faxed between hospitals/GPs/local authorities (social care providers) with all the resultant missing documents, delay, confusion and lack of clarity that can ensue when handwritten documents are being transferred in this way. As a useful and very relevant by-product, the roll out of the project in London has also resulted in some significant standardisation and reduction of form filling [e.g. London Health Needs Assessment document was reduced from 80 plus pages to 18 pages].
89. The main focus of the work so far has been standardising the information transfer between hospitals and local authorities but the review team has learnt that it is now being piloted for transfer of docs to care homes and providers in Shropshire.
90. At time of publication this work is very much ongoing and the team's fieldwork revealed a recognition that a secure and efficient way of electronically sending sensitive information would benefit both providers and care recipients.

### **An information sharing pilot – led by CQC and ADASS**

91. The review team spoke to both CQC and ADASS about the joint pilot to explore information sharing between local authorities and the CQC, commonly referred to as the "ADASS portal". The pilot was used to capture the specific requirements of both parties and to test the technological solution (the portal) used for the pilot. CQC's evaluation of the pilot found that CQC were able to supply data in a form that added value to local authorities but that currently this would not be scalable to all local authorities across England because of the variance between local authorities in how they collect, categorise and organise their information.
92. However, using the lessons of the pilot CQC and ADASS are taking forward an initiative in the Eastern region to build a consistent approach to monitoring quality and risk in a way that is compatible with CQC's framework as well as that of the region's CCGs. The project involves working across all 11 regional local authorities, developing toolkits for a standardised approach to working with providers. This includes a single set of Terms & Conditions, a regional standard for care and a range of regional monitoring toolkits to deliver effective provider relationship management as well as a proportionate response to risk management of 'hard to replace' providers.

## Potential savings to business

93. The fieldwork for this review has enabled the gathering of more evidence on the specific nature of some of the duplicatory activities suggested by stakeholders. In tandem, the review team sought to quantify the potential monetary impact of necessary regulatory and other monitoring activity on providers.
94. Through an online survey targeting small and medium sized care homes – either directly or through representative bodies we have been able to get an indication of the real world impact of regulation and its enforcement on providers. The aim of this survey was to provide depth to the qualitative findings. Due to the short time frame of the reviews, we developed a relatively simple survey. Potential savings presented are likely to be upper bound estimates, as some of the duplication indicated by business may be unavoidable.
95. The review team analysts used the Interdepartmental Business Register 2013 (IDBR) to obtain the number of businesses in the sector and were able to scale up the results to give an indicative representation of the issues with the assumption that micro businesses exhibit the same behaviour as small businesses.

## Sources, caveats and assumptions

96. Results are based on an industry survey questionnaire sent out to businesses and representative bodies in the residential care home sector in September 2015. The questionnaire had a total of 28 respondents. The headline figures illustrate 87% of respondents identifying duplication of inspection as a concern and 96% of respondents citing duplication of information requests as a major barrier. Numbers presented are based on the assumption that questionnaire results can be extrapolated to the sector as a whole, i.e. that the proportion of respondents experiencing a problem is similar to the proportion of businesses in the sector experiencing the problem, and that average costs experienced by respondents is similar to average costs experienced by businesses in the industry as a whole.
97. Due to the low number of respondents, and due to potential self-selection, the results should not be seen as fully representative of the sector population and they are not statistically robust. We have used IDBR 2013 to obtain the number of businesses in the sector (IDBR 203, Class 87: Residential Care Activities; 10,810 businesses). Based on the IDBR we have scaled up the underlying distribution of company size. Since there were no Micro businesses responding to the survey, we have assumed that micro businesses exhibit the same behaviour as small businesses.

## **Inspections**

98. The survey results suggest that businesses in the residential care sector on average spend around 16 days (117 hours), per business and year, on dealing with inspections (e.g. preparing for, or assisting inspectors on the day). 87% of businesses feel that there is duplication in inspections, for example where more than one authority visit a business to inspect similar or the same activities, and/or where one authority overlooks evidence produced by other authorities. The survey results suggest that, on average, businesses in the industry could save 11 days per business and year if there was no duplication. If this would apply to the sector as a whole, this could represent a potential saving of £19m a year, with the largest saving falling on smaller businesses (<50 employees).

## **Information requests**

99. The survey results suggest that residential care homes on average spend around 25 days (188 hours) per annum and business on handling information requests and data reporting. According to our survey, 96% of care homes feel that information requests are duplicated, i.e. where the same or similar information is requested to be provided to different or the same authority. According to our survey, businesses in the industry could save 19 days per business per annum if there was no duplication, with the largest saving falling on smaller businesses. If this would apply to the sector as a whole, there could be a potential saving of £40m per annum.

# Issues raised out of scope of the Review

100. A number of respondents raised issues which were not directly related to regulatory enforcement so were outside of the scope of this review.

## Deprivation of Liberty Safeguards (DoLS)

101. There were 4 comments on the Cutting Red Tape website relating to changes to the application of DOLS and the additional burden this was creating for care homes. A Supreme Court judgement widening the scope of deprivation of liberty has led to, many more requests for authorisations under the deprivation of liberty safeguards to be made for people in hospitals or care homes.

102. The Department of Health has undertaken a review of the non-statutory bureaucracy associated with DoLS. This review resulted in the number of process forms associated with the DoLS process being reduced from 32 to 13. Feedback from social care providers has been positive about the reduced bureaucracy and health and care professionals are reporting that the forms lead to a higher quality assessment of vulnerable individuals' needs.

103. A key focus for the Department (DH) is the Deprivation of Liberty Safeguards (DoLS) – a system for ensuring that vulnerable individuals subject to a level of restrictive care that amounts to a “deprivation of liberty” have their situation independently assessed to ensure restrictions are proportionate and in their best interests. Following a request from Oliver Letwin and as part of the Red Tape Challenge, in 2014/15, DH set about reviewing the non-statutory bureaucracy associated with DoLS. This review resulted in the number of process forms associated with the DoLS process being reduced from 32 to 13. Feedback from social care providers has been positive about the reduced bureaucracy and health and care professionals are reporting the forms lead to a higher quality assessment of vulnerable individual's needs.

104. Having largely exhausted red tape reduction options in non-statutory areas the DH's focus in 2015/16 is on the statutory framework for DoLS. As such, the Department is funding the Law Commission (as the experts in law reform) to perform a fundamental review of DoLS with a view to minimising pressures on care providers. The Law Commission have recently finished their public consultation and will publish provisional proposals to government in spring 2016. Should the Department decide upon legislative change, their ability to make these cuts to red tape will be determined by decisions on the priority and the identification of the necessary parliamentary time in 2017-18.

## National Living Wage

105. The introduction of the National Living Wage in 2016 has also raised concern in the sector, with many worried about the impact when margins are very tight and a number of providers reported that they use privately funded places to cross-

subsidise beds for local authority funded residents. The Joseph Rowntree Foundation has recently published a report which examines in detail the implications of the new National Living Wage for care providers, their staff and by extension recipients of care.<sup>19</sup>

## Recruitment and training

106. Evidence received from website comments, and discussions with several small and medium sized providers highlighted a number of concerns relating to recruitment and training requirements and the associated costs that were incurred to comply with regulatory standards. The review heard in some cases that this was compounded by local authorities imposing higher requirements than the regulatory minimum.

107. For example, evidence was given by a small provider who said they employ a trainer who is qualified to doctorate level but is still required to put their staff through in house local authority training to meet the local authority's minimum standards as it will not accept the trainer's qualification as sufficient. Another provider commented:

*“Training demands by the LA far exceed what is required by government legislation, adding significant costs to providers, often because the assumption is that providers won't do it otherwise. We all want our staff to be trained and developed to a high standard but LA requirements make demands way in excess of what is reasonable, even detailing the exact content of any courses”.*

---

<sup>19</sup> [www.jrf.org.uk/report/costs-and-benefits-paying-all-lowest-paid-care-home-workers-uk-living-wage](http://www.jrf.org.uk/report/costs-and-benefits-paying-all-lowest-paid-care-home-workers-uk-living-wage)

## Going forward

108. The Government has carefully considered all the evidence submitted to this review and accepts the findings. We have already committed to work with all the key agencies involved in the regulation and commissioning of care; and with providers to tackle the issues the review has highlighted. The Government's initial formal response, which will be led by the Department of Health, sets out its commitment to this agenda including a number of immediate steps it will take. It is being published alongside this report and is available on the Cutting Red Tape website.<sup>20</sup> This response will be underpinned by a detailed and ambitious programme of work which we will develop in partnership with the sector and on which we will report progress at six monthly intervals.

---

<sup>20</sup> <https://cutting-red-tape.cabinetoffice.gov.uk>



# Annex 1: Detail of responses

As at time of publication the Cutting Red Tape Call for Evidence website has received 1837 hits and 49 substantive comments posted by individual providers, ex-providers, their representative trade bodies, charities, individuals working in the sector, local authorities and other interested parties.

The breakdown of comments on the website is set out in the table below: 40% came from care home providers working in the industry. 40% from members of the public some of whom described themselves as working in the sector but used their personal email addresses and approximately 20% comments came from other bodies including the charity sector.

**Table 2: Break down of website comments**

Website comments by	Number of comments
Care home providers	20
Trade body	1
Local authority	2
NHS staff	2
Public	20
Charity	4
Total	49

The tables below categorise the website comments and summary of written evidence findings.

**Table 3: website comments (49 responses)**

Common findings from website comments	Number of respondent raising this as an issue	% of respondents
Duplication of local authority contract monitoring requirements with CQC inspection requirements	25	51%
Paperwork take staff away from care	25	51%
Delay in re inspection by CQC	3	6%
LA inspection overly burdensome because they don't rate the CQC inspection	13	27%
LA inspection by unqualified staff	5	10%
Domiciliary (Comments relating to home care provision (Out of review scope)	2	4%
CQC complaints /varying standards of inspection	6	12%
Deprivation of Liberty Orders. (Out of scope of review)	5	10%
Procurement	1	2%
Personal subject views (Out of Scope adding no value to findings)	8	16%
LAs to share info	3	6%
Single monitoring system (CQC, LA, CCG)	1	2%
Costs of compliance impact on market	7	14%
Clinical Commissioning Groups lack of clarify around their role & singular approaches	9	18%
Fragmented initiatives	2	4%
Burden on training staff and meeting costs/LA standards v CQC standard	4	8%

**Table 4: summary of written evidence findings (8 responses)**

<b>Common findings from email submissions</b>	<b>Number of respondent raising this as an issue</b>	<b>% of respondents</b>
Duplication of local authority contract monitoring requirements with CQC inspection requirements	5	100%
Paperwork take staff away from care	4	80%
LA inspection overly burdensome because they don't rate the CQC inspection	3	60%
Deprivation of Liberty Orders. ( Out of scope of review)	2	40%
LAs to share info	1	20%
Industry common set of paperwork	1	20%
CGC examples of best practice	2	40%
Costs of compliance impact on market	1	20%
e.g. of best practice by Local Authorities	2	40%

## Summary of written evidence

The review team received a number of formal written submissions, emails and reference documents in addition to the 49 postings received via the Cutting Red Tape Website.

Summary of website comments:

### Posting 1

- **Home Care Providers:** What about home care red tape, do not appear to be included? Many poor providers; often improvements have only been made because the local authorities take action under their contract when CQC take no action.

### Posting 2

- **Time consuming:** Domiciliary Carer respite Charity, fully regulated/Inspected by CQC, also audited by our own network partner body; all very time consuming, to a large degree necessary to maintain high quality standards in all regulated care services.
- **Unregulated services:** Though who checks the standards of the multitude of unregulated services? They seem to be able to operate under all radars!
- **Duplication:** Recently completed a very successful CQC inspection which was time consuming, took staff away from operational tasks. We accept this. However, now our local commissioning body will be doing their own day long Inspection visit!! Takes time away from front line care, trying to operate on minimal staffing levels.
- **Quality of inspection staff:** Local authority individuals carrying out the Inspection are not qualified in the expertise required.
- **Impact on front line care:** Do they not realise the impact they have on the daily operational requirements of the services they are supposedly 'inspecting'? Waste of both time and Money. Our charity has seen a reduction in funding which means less respite for local Carers. Local authority social workers continue to refer struggling carers to us! Purpose of the CQC is to inspect on behalf of the Government and the Local authority!

### Posting 3

- **Cost of reform:** The Forum of Private Business reports that regulatory reform costs about 22% more to administer in the care sector than any other.
- **Gap between self-funders and state funders:** Government have delayed the introduction of the Dilnot Care Cap. This is welcomed by giving temporary breathing space it will have the effect of placing pressure on self-funders to find the gap between state funded care and the actual cost of care.

- **Duplication:** Welcome the Red Tape impetus to help reduce costs by reducing duplication. Would be a help if some attention could be paid to disproportionate impact of the NHS Standard Care Homes contract on small and medium size care home businesses.
- **Smart reporting system:** Commend the work in some CCGs to reduce duplication by introducing a smart reporting system called Quest4Care. Replaces other reporting activities rather than adding to it!

#### Posting 4

- **Duplication:** Work for a Local Authority, strive to maintain good working relationships between CQC and other agencies to reduce duplication.
- **Collaboration:** Working closely with providers ensures a cohesive approach when dealing with any issues which may arise.
- **Staff responsibilities:** Training around documentation is provided to care homes to ensure staff recognises responsibility to record interventions. Good quality recording evidences that care is being provided - vital when dealing with safeguarding issues.

#### Posting 5

- **Duplication:** Had a Quality Assurance for our residents, then 1 month after a Quality Assurance for paper work, then a business meeting review with the council. Council booking another Quality Assurance for November, CQC haven't even inspected yet.
- **Conflicting advice:** CQC and the council inspected and both said totally different things.

#### Posting 6

- **Duplication:** Meet the criteria of one body, then asked to repeat a similar action to meet another body's preference. Without it we will be in breach of a contract. Operate in a number of areas across the country, demanded by different commissioners to change our policies so they fit in with theirs.
- Pressure to change minor items to fit with contracts officer's opinion or meet a local initiative rather than any quantities or qualitative improvement. The CCG dictates we use theirs. Requested to keep our own - told we must continue to do theirs but also to keep ours too- double work!
- **Impact on front line care:** Reduces the amount of time to spend with residents. Why can't we have an agreed "fit for purpose" National documentation set provided by government so that it can be used universally?

## Posting 7

- **Quantity of documentation:** The amount of documentation required in care homes is excessive and takes time away from caring. Should be able to report on exceptions and not endlessly writing every move a resident makes, how can that be home like?
- **Duty to investigate a death:** Additional work required to meet the deprivation of liberty standards has been the last straw for many home managers. See the value for those in custody, but not to anyone in a care home. Those who have a current DOLS have to be referred to the coroner and / or the police, again a complete waste of time and a very difficult thing to explain to families.

## Posting 8

- **Duty to investigate a death:** Under Section 1 of the Coroners and Justice Act 2009, a coroner has a duty to investigate a death if one or more of three conditions are met.

The deceased died a violent or unnatural death. The cause of death is unknown. The deceased died in custody or otherwise in state detention.

Majority of individual coroners interpret guidance produced by the Chief Coroner last year, *'On the law as it now stands, the death of a person subject to a DoL should be the subject of a coroner investigation because that person was in state detention within the meaning of the Coroners and Justice Act 2009'*.

As a consequence, many coroners investigating every death that occurs under DoLs as if the individual died under state detention.

This is a massive administrative burden for the coroners made even worse as a result of the increased numbers of people being placed under DoLs.

Current system is overly risk averse and completely unsustainable; we think the Chief Coroner should issue guidance revising his definition of what constitutes a state detention. Regulatory burden on coroners would be eased.

## Posting 9

- **Procurement law & process:** Context around procurement law and procurement processes needs to be included in the scope of this review.
- Rationalisation of procurement activity across a wider footprint might serve as a solution to cutting 'red tape' as long as governance, accountability and responsibility are resolved.
- **Contract monitoring:** Mixed picture of resource allocation across councils and CCGs to monitoring contracts, those with more resource generating more activity for providers. Commissioners who take a 'standards' or 'quality improvement' approach to monitoring and supporting the sector tend to overlap less with internal provider reporting, with CQC requirement and have better engagement.

- Procurement' and 'contract' functions = wider geographical footprint with 'standards' and 'quality improvement' = localised response.

## Posting 10

- **Effective monitoring not tick box:** The last (previous) care home my mother was in had completely done away with paperwork... The only thing that does sometimes save the people in 'care' homes is the red tape! Many residential homes don't document when medication is taken.
- **Transparency:** Services that are meant to be in place to ensure that such institutions run in accordance with some degree of humanity and law abidance in reality tend to do nothing of the sort.
- All residential care should a) document everything and b) should be OPEN and TRANSPARENT.

## Posting 11

- **Who is responsible for care regulation:** The business secretary says "I am determined to take the brakes off British businesses and set them free from heavy-handed regulators." How is it that a business secretary is making judgements about how care is regulated, not his responsibility, nor his remit? The criteria must be quality, and that's the responsibility of the Health Department. With private care services running home care – staff are treated like time and motion machines on low wage, and really exploited.

## Posting 12

- **Collaboration:** Good care comes from within care providers (homes and communities), from the collaboration and relationship of clients, teams and leaders. It does not come from outside – it cannot be prescribed, ordered or "inspected in".
- **Core role of care providers:** Not the job of care providers to supply information for outside bodies; it is the job of outsider bodies – including CQC and Local Authority commissioners – to contribute in every way they can to good care being provided. Providers should never be asked to provide additional information purely for inspection or commissioning purposes. To do so entails neglect of the provider's core task at the expense of the clients' health and wellbeing.
- **Transparency:** With these principles in mind, regulators will be able to concentrate on their core task checking that the care is good enough (it can never be perfect) and making that judgement public. Commissioners should be able to trust the judgement of the inspector.
- **Impact of front line care:** If we look at the perpetual churn, chopping and changing, of regulation and inspection we see social care losing its focus on the core task – good care. Care homes now have to work for the regulator and commissioners. The existential task now is to get a "good" or "outstanding" rating and that entails making sure all the red tape is complete, neat and tied up

correctly. This makes compliant administrators out of managers and liars out of honest people.

### Posting 13

- **Benefit of regulation:** I don't see regulating this sector as red tape. It's essential with scandal after scandal in this sector and the vulnerability of the clientele I think it's an inappropriate sector to look at reducing regulation I think more regs needed here.

### Posting 14

- **Support providers by aligning requirements:** Issue of burden is around approach and effectiveness of monitoring. Duty of care rests with Social Services - not unreasonable there should be a pro-active approach to monitoring / managing the services they buy. Crucial to gather and use information that already exists to inform the LA's approach, LA's that have rolled back their own engagement to simply rely on CQC.
- **Re-introduction of ratings:** Re-introduction of ratings will leave some services without a visit for a number of years. A lot can happen in this time. We have ensured that the monitoring we put in place supports providers by aligning our requirements with the existing regulatory framework. This ensures that we don't create conflicting expectations and instead build on the regulatory framework. The evidence we require supports CQC requirements and vice versa.
- **Working with providers:** The most important thing is how LA's approach and work with, not against, their providers. Good contract and relationship management should not be seen, or felt to be a burden, but instead a supportive framework that helps ensure good quality care and that public money is spent appropriately.

### Posting 15

- **Duplication:** Whilst commissioning of nursing and residential care remains separate each commissioning organisation insist on their own set of paper work and audits which often collect the same information from the same provider. Government need to use levels to bring together commissioning and quality assurance of the sector into one place.

### Posting 16

- **Time consuming:** Different local authorities are doing different things to monitor and check quality. Systems provide very little evidence about the standard of care and support they are focused on ticking boxes. This process sucks time from the organisation which costs money. With changes in legislation, keeping pace is challenging. Managers are busy, with case-loads that are unmanageable so research and reading the new information isn't high on their list of priorities, yet somehow that little bit more has to be squeezed out.



- **Cost of training:** We invest considerably in training our staff, we mustn't underestimate the cost of training, but the benefits are considerable. We train in the mandatory and NVQ type training, and spend time helping staff through a range of training that we are not 'required' to deliver but it helps our staff to be really good support workers. This is very costly we can't charge for this time, we have to absorb it and on top of this we also have management time allocated to this investment.
- **Duplication of information:** Must have robust regulation, we need to have local authorities checking we must keep and maintain good records; however in these challenging times need to have things kept simple. I use the data being gathered and share that.
- **Quality of care:** People using the service want good providers. Have joined up thinking across LAs so that the 'quality' processes they are using are the same across the board.
- **Realistic costings:** It's time that the investment that we are required to do and also need to do (staff training, support and supervision) is properly 'costed'; how can services be provided realistically for less than £15 per hour with everything that we need to provide?

### Posting 17

- **Duplication:** Doing a lot of duplicate work for LA and CQC. Notification of DOLS or safeguarding which are being processed by the LA so rigorously, have to be submitted to CQC as well. Should the LA not be forwarding them the statistics?
- **Impact on front line care:** Unannounced inspections from any authority can see you as you are and you are not spending hours filling in forms. I am not in the favour of sending evidence files for quality assurance visits. They are very time consuming and take you away from actual care.
- **Benefit of regulation:** I Agree we need to keep logs of everything because that is our evidence of what has been done provided they are actual records and not just for the purposes of pleasing the authorities. Quality should not be assessed by paper work only. If the CQC inspected they should just feed-back their comments to LA and vice versa. A lot of government time and money is being wasted by duplication and all LAs producing their own documents when standard national ones could be used.

### Posting 18

- **Duplication of regulation:** Abolish the PIR, a hugely time consuming document, and can be written to suit a purpose and not necessarily reflective of reality. The NMDS collects much data and could be an enforced replacement.

### Posting 19

- **Duplication and excessive documentation:** Exasperated and overwhelmed at the amount of documentation and records expected from LA, CQC, CCG etc., On

a daily basis chained to my computer and desk and finding no time to spend with my service users, their relatives and my staff.

- **Impact on front line care:** Staff complain and constantly struggle with time management, Paperwork often taking a priority over the hands on quality care, I deal daily with a frustrated team trying to keep up morale and ensure paperwork is being completed as required by our inspection authorities,
- **Tick box compliance:** A missing tick box, a missing signature, a missing entry in a report deems exercise v reality: a provider as inadequate and non-compliant regardless of the ACTUAL excellent quality of care we deliver, this completely frustrates me and my team.
- Benefit of regulation 100% agree that documentation and record keeping is essential and has a positive impact to a service user's quality of care, but as an industry we are being swamped and drowned by tick box evidencing.
- **Common set of documentation:** Would welcome a common set of documentation, transferrable with the service user - like NHS patient records, these could be developed to cover standards and criteria that all inspection authorities could use to complete their inspections, user friendly to staff and minimise record keeping overkill; would make the inspection process clearer and easier to perform too.

## Posting 20

- **Entrance assessment:** Appreciate the desire for inspectors to see where a client in a care home has come from (to see "progress" or "decline" one would expect); question whether keeping an "entrance assessment" on file and to hand for a client who has lived in the care home for 5, 10 even 15 years is actually necessary.
- We were "told off" by an inspector for not having an entrance assessment (paperwork used to assess needs on arrival) for a client who had been with us for over 10 years.
- **Quality of inspection staff:** Some inspectors ask us to devise care plans for "dementia" or "diabetes" or other conditions. We are then frustrated to talk to other inspectors about "person centred care"... A Care Plan is a plan of care for a client... not a condition! Our care plans state HOW the condition affects the client and how they deal with it... not how to care for a condition. Re-educate inspectors that person centred is not about conditions it about people.

## Posting 21

- **Duplication:** W Detailed person centred care plans take a considerable amount of time; they have to be documented in at least three times; due to the huge amount of paperwork for managers/nurses we are constantly on overload to meet and comply with regulations; standards and legislation.

- **Impact on front line care:** I am doing dressings; Care Plan reviews; dealing with a variety of health professionals throughout the day; medication rounds; doctor's visits; numerous phone calls; speaking to families; re-ordering medication; taking bloods; audits etc. etc. –we must get back to being proactive on the floor and caring for those in our care that is what we did the training for.
- **Excessive quantity of inspections:** Had inspections from CQC; CCG; HSE; Fire Service; Pharmacy Inspectors; Local Authorities and EHO – include the regular reviews from social services; RNCC assessors you can see the impact this has on us professional.
- **Common set of paper work:** If paperwork was streamlined and governing bodies worked together this would free up managers/nurses on the floor to observe that the care provided was always to a very high standard.

## Posting 22

- **Excessive quantity of inspections:** As a care and support provider we have:
  - Internal quality audits (including quality checkers)
  - Local authority validation visits annually
  - Quarterly contract monitoring
  - CQC inspection

And in addition we also undertake additional inspections from:

- External auditors
- ISO 9001
- OHAS
- Investors in People
- British safety council
- Autism accreditation

I could go on as we have many more.

- **Common set of paper work:** Paperwork is unbelievable and over whelming to frontline staff and managers. The other frustration is inconsistency across different boroughs – who have different systems and expectations. This creates another problem of not only duplication but using different formats and requirements.
- **Duplication:** Welcome a common sense joined up approach to avoid duplication. This is one area that could assist in a positive way.

## Posting 23

- **Duplication:** too much duplication with the LA and CQC - prefer the LA to demand less. Much of it is more to do with protecting the LA than the clients. This does not just apply to paper work but also demands for training.
- **Tick box inspection:** The PIR does not really provide CQC with what it needs and takes a lot of time to complete.

- CQC is more independent than the LA. The LA always looks at its own inspections and paper work with a bias to drive up service levels (but not paid for at a realistic level), cut costs and protect itself. LA monitoring could be cut back much more, saving public money, provider's time and with no significant detriment to our clients.
- **Experience of inspectors:** Frequently LA inspection officers have no experience of the care industry other than from a desk view. This can make their demands totally unreasonable.
- **Gold plating:** Training demands by the LA far exceed what is required by government legislation, adding significant costs to providers, often because the assumption is that providers won't do it otherwise. We all want trained and developed to a high standard but LA requirements make demands way in excess of what is reasonable.
- **Excessive quantity of inspections:** Adult social care providers are taking hits from LA, CQC, various government departments and legislation.
- **Cost to business:** Anything that can be done to ease this situation will help providers to work more effectively and lessen the risk that providers will go out of business- a very real risk to many smaller businesses.

## Posting 24

- **Duplication:** I work within the NHS supporting our community staff and care homes, - amount of duplication. A person or their family can be asked the same question by NSH staff, Social Care, CQC, Care Home staff, GP, DN, Out of hours, emergency staff etc. etc. the list can go on and on.
- **Common set of documentation:** When are we truly going to start working together and to share documentation would be a start.

## Posting 25

- **Experience of inspectors:** LA staff are trying to inspect against CQC regs and LA contracts but have absolutely no understanding of either. No direct experience of providing care, do not have the experience to understand that person centred care means you can't always do things the same way.
- **Impact on front line care:** We run a single 36 bedded care home, 3 working full time, we estimate that there are 7 hours a day of care staff time spent on writing records, reports etc., and it still isn't enough for the powers that be.
- **Duty to report a death:** Changes to DoLS have also had a huge impact. It is not just submitting the applications, dealing with the various assessors and independent reps etc., but then meeting the additional demands of the "conditions" that are being introduced. Completely subjective.
- **Benefit of regulation:** Do not need more regulation. Need the current regulations to be clearer and applied robustly!

- **Duplication:** Need to get rid of all the other layers – mainly local authority / CHC contracts that are so onerous and meaningless.
- **Alternative idea:** Implement direct payments so that service users and / or relatives have the power and control to choose the services that they use and provide some good quality advocacy to help them if they are unhappy with something.

## Posting 26

- **Length of placement reviews:** I manage a 51 bedded nursing home; Placement reviews are carried out by social workers and consist of a full audit of the care plan and drug record, and possibly home policies and procedures and maybe an inspection of the premises. Can take 3 hours plus the time of a member of staff. If the resident is very lucky the social worker will ask them if they are OK, but often they are not involved at all- in their own placement review!!
- **Local Quality Improvement team:** LA have a Quality Improvement team who are excellent, they offer support and advice generally but particularly if there are difficulties, safeguarding etc. They ensure we meet the standard required by the Council. Used to carry out formal 'inspections' or quality visits but they were stopped as it duplicated what CQC were doing- very sensible. Now, a few years later they are going to start them again even though they are overstretched already.
- **Impact of front line care:** It would be good to get back the 'person' in person-centred.
- **Excessive quantity of inspections:** Placement Reviews; - every new resident has one, and then every year it's repeated. Factor in that some residents are poorly and live days or weeks, then a new admission comes and so it goes on. Every week we have more than 1 assessment, there's funding reviews, SOVAs, MDTs for continuing health assessments and it goes on and on.
- **Duty to report a death:** Now we have to provide care records for people who've died.

## Posting 27

- **Impact on front line services:** Run a home for 25 elderly people. much harder for front line staff to deliver care residents need when so much time on shift is used to catch up with documentation.
- **Duplication:** I also think the NMDS is a waste of time and takes up so much time to update and input data. It is repetitive and not user friendly.

## Posting 28

- **Benefit of regulation:** Must have robust regulation, any reputable provider of care would agree but it needs to be measured and reasonable.

- **Public perception of the care sector:** it's understandable that CQC as the regulator now needs to be seen to be effective in the public arena. There seems to be an agenda that care providers even the good providers are subject to ratings that are harshly applied. CQC are nervous to praise care homes?
- **Disparity and duplication between CQC and Local Authorities:** Disparity between CQC and Local Authorities in their inspection processes and there so much duplication? Local Authorities have every right to check that the services they are commissioning give quality in all aspects of care but the monitoring processes are onerous.
- **Common set of documentation:** Why can't they be a joined up. Homes are constantly having to amend policy and work practices to be compliant, not to improve the service user's experience but to achieve band one ratings in that particular location.
- **Cost of inspections:** In a time of austerity it is outrageous how much of the social care budget is being wasted on bureaucracy and ineffective inspection protocols.
- **Impact on front line services:** More and more demands are made on the care sector; we are drowning in documentation so much so that it detracts from the time staff can actually spend with service users. Recruitment is difficult particularly into senior roles.

## Posting 29

- **Overly bureaucratic:** Alternative property for our students to reside in during term time. The process is lengthy and overly bureaucratic as the organisation and the registered manager have to complete 2 forms each – to “remove a location” and “add a location”. 4 forms in all. The process has little flexibility to recognise different needs and priorities. We needed to do this swiftly to fit in with term dates, we are told it has to take the 10 weeks.

## Posting 30

- **Duplication:** Too much duplication in the monitoring and inspection and many days are spent on continually updating paperwork, re writing policies and filling in forms.
- **Impact on front line care:** Managers of care services are now administrators; they have no time for care. Staff spend hours writing reports instead of spending time with service users. MCA/DoLs has made every decision a minefield and service users miss out on activities like holidays because the paperwork required is too onerous.
- **Common set of standards:** Stop changing the rules, have a basic set of standards and stick to them.
- **Sharing information:** If the local authority does a monitoring visit, then share that with CQC so they do not need to visit and vice-versa.

- **Small homes closing:** Small homes are being forced to close because of all this increasing regulation. The big public companies have whole departments to do this; the small local provider does not. Yet these small homes are among the best in the country for the standard of care they provide.
- **Gold plating:** Just been told my new staff have to do 12 courses and a 14unit portfolio before they are considered ready to work in care!!!!

### Posting 31

- **Public perception of the care sector:** Now have a national regulatory body who are desperately trying to recover their reputation by coming down hard on those they inspect. An inspectorate can never prevent incidents such as abuse. All it can do is encourage and help providers to be better.
- **Duplication:** Duplication of the work by local authorities is wasteful. The long term answer is to return the domiciliary and care home inspections to the LA's along with nursing homes. They are locally based and they place clients in care. They commission and review the care and will be best placed to judge if the care is good.

### Posting 32

- I am an auditor to charities, so this comment particularly relates to care organisations that are charities.
- **Duplication:** In England and Wales, the Charity Commission requires charities to report serious incidents promptly. A care charity is additionally regulated by the CQC and so will be reporting such incidents to them. It may have to report other incidents to the Health and Safety Council.
- **Experience of inspectors:** The Charity Commission is not well qualified to deal with care matters, health and safety, data protection
- **Alternative suggestion:** The Charity Commission should only deal with matters that are not the remit of another more specialised authority. The Charity Commission does have specialised knowledge of governance matters and so this should be their preserve.

### Posting 33

- **Experience of inspectors:** I and others are up against a very poor Council who employ people who have no clue how to run a business let alone look at care homes. They completely ignore the Care Act and do their own thing and disrespect care home owners.
- **Quality of inspection staff:** CQC make it difficult also by commenting on our residents as if they were objects.



## Posting 34

- **Benefit of regulation:** Your first point should be to assess the evidence. Instead, assess the evidence from the local media across the country. Then you will see stories of appalling care by private sector care homes, or private at-home care providers. Yet you assume that caring local authorities are the ones making things bad, and if only the private sector was left to its own profit-making devices all would be fine!!!

## Posting 35

- **Benefit of regulation:** As care providers we accept there has to be some monitoring to verify good/bad care within the care sector.

Excessive quantity of inspections: The intrusion we can experience as care providers overwhelming these include:

- 2 inspectors from CQC
  - 1 Lay inspector – expert by experience (at minimum)
  - 1 or 2 Local Authority contract monitoring officers
  - 1 or 2 CCG inspector
  - 1 NHS contract monitoring officer
  - 1 or two Healthwatch officer/s to observe and inspect files
  - 1 Infection control nurse
  - 1 Environmental Health officer (sometimes twice a year)
  - 2 Fire officers periodically
  - 1 or two placement reviewing officers annually for each resident
  - The above list is not exhaustive.
- **Duplication:** We have to complete documentation and/or questionnaires for the local authority, NHS, Skills for care, GP's, Opticians, Dentist, Chiropodist and others. Of course, that work and these professionals do are in addition to the other professionals that are required to come in and assist us with the good care that we provide such as District nurses, GP's, Psychiatrists, advocates and others. City Council's carry out regular contract monitoring and so does the NHS which also duplicates what CQC does.
- **Impact on front line services:** The intrusion on residents in a care home is burdening and largely detracts from the homely environment Inspector/officers expect or require managers and staff to give their time despite arriving unannounced most of the time. We believe there has to be some re-thinking and finding a balance to the unnecessary intrusion and the waste and abuse of public funds.

## Posting 36

- **Duplication:** Provider of residential care for clients with a mental illness. Regulated by the Care Quality Commission (CQC) and receive regular inspections that take between 1 – 2 days.



- Contracted with the Local Authority and I have to undergo a Compliance inspection each year, this also takes 1-2 days. CQC and the Local authority duplicate many areas of the inspection carried out. This is a waste of resources for everyone involved.

### Posting 37

- **Duplication:** System should be streamlined Overlap from contractors such as CCG and LA. There is confusion that CCG and LA are undertaking inspections when in fact they are looking at whether their contract obligations are being met and the service is “Value for Money”.
- **Alternative idea:** Stop contract visits and use the intelligence and reports from regulators to determine whether the service is worth contracting with or not.
- **Sharing information:** Lot of visits to care services that aren't thought about, Fire, Infection control, Healthwatch and CCG pharmacy as examples. All this information should be planned in line with the regulations and feedback to the CQC inspectors who are very skilled in understanding the economy in the area and liaison with others and invariably have a professional qualification and experience in the field. CQC has processes in place to make sure the information is valid.
- **Risk based inspections:** Reduce the amount of long formal inspections CQC does for service that aren't a risk and do short concentrated inspections on services that are clearly demonstrating some failings.

### Posting 38

- **Common set of paper work:** One of the biggest ‘red tape’ issues is that as a large provider we have numerous contract monitoring requirements to complete. These are onerous and repetitious. For example we are contracted with five different local authorities who all want similar information presented in a different way.
- **Common set of standards:** If Adult Social Care Commissioners could agree a standardised approach to contract performance monitoring across local authorities this would significantly reduce ‘red tape’ and improve the reliability and accuracy of information provided by us, we would be able align our internal reporting systems to reflect this.
- **Cost of inspections:** The Area Manager and the admin team have to spend a significant amount of time on a monthly basis gathering and presenting information. They then have to present this information for internal reporting and monitoring purposes too.

### Posting 39

- **Overly bureaucratic:** Current arrangements for changing the CQC registration of an office address are unnecessarily onerous and time consuming. Clearly, if a service is changing, then it is quite right and proper for CQC to focus on the

registration process. However, when we are simply moving an office address for the same registered service, there should be a streamlined process.

### Posting 40 [Spam]

- If old people weren't subject to the human rights act you could save a lot of money on care fees and all that red tape like having to feed them and stuff, yes, yes maximise profits, and get rid of the rules hahahahahaha

### Posting 41

- Cost of duplication Have more UNITARY AUTHORITIES so you are not having to go to one council for planning, environmental health etc. and another for education & care of the elderly, it streamlines the public sector but it also saves businesses money as less engagement and costs of contact and regulation.

### Posting 42

- **Benefit of regulation:** My mother gets appalling care, this industry needs a lot of reform.

### Posting 43

- **Duplication:** Duplication with what CQC check and ask for information on and the Local Authorities and the CCG. Now that LA's and the CCG carry out their own checks we have asked and suggested why they cannot liaise with each other.
- **Onerous documentation/inspections:** The ADASS workbook that some LA's use is onerous to use as it cannot be printed easily. Some LA's are in homes checking for several days and then we have to produce action plans and update these monthly. This is the same process for CQC but that is OK as they are our regulator.
- **Duplication:** Having to submit all these templates and quality monitoring forms to different commissioning bodies such as the CCG (sometimes three) if you have service users in your care from three different CCG's. Each CCG seems to expect a quality monitoring form submitted to them and there are also other forms we end up having to send to many different organisations.
- **Independence of inspection regimes:** Do not feel commissioners are sufficiently independent to be inspecting us as has been commented by others this is often a guise for trying to reduce fees or seek value for money as they put it!
- **Quantity of inspections:** Have asked our local CCG why they cannot share their report with other CCG's so we do not have to have three wanting to come in and inspect. Often however when a LA comes in they only want to see files of those they commission hence making other LAs feel they also should be inspecting.
- **Local agreement:** Locally it seems ADASS have come to some agreement to share inspections with other local authorities.

- **Conflict of opinion:** Having three bodies inspecting can also cause a difference of opinion between them and then you find even though the LA are happy they feel they cannot be seen to contradict CQC even though they know us better as they work more closely with us and we are then left in limbo.

## Posting 44

- **Remuneration:** The care is important and we need to remunerate properly to the people who delivers this care.
- **Impact of front line care:** There is also lot of red tape and administration which take away valuable time from the actual care.
- **Duplication:** There is also lot of duplicate administration rather than at one point.

## Posting 45

- **Duplication:** Overlap between CQC, Local Authority and CCG contract monitoring. Both agencies require Action Plans to rectify issues that were found but in different formats - within about 2 months the manager and her team had 8 full days of inspections/audits and at least 5 days of follow up with staff and writing action plans and responding to draft reports.
- **Common set of paperwork:** If CQC, CCGs and Local Authorities worked closer together, had common quality monitoring systems and agreed a time table for visits it would make life a lot easier for care homes.
- **Duty to Report a death:** The whole DoLS process is a bureaucratic nightmare and from what I have read the revisions proposed by the Law Commission will not improve matters and could make it worse.

## Posting 46

- **Benefit of regulation:** Whilst it is fine to cut red tape, the Government must bear in mind that the CQC has an essential role to play in the regulation of care providers and their authority should not be fettered.
- **Appeals mechanism:** The lack of appeal mechanisms for providers where the CQC has provided bad reviews or prosecuted them is potentially scandalous and must be reviewed as a matter of urgency.

## Posting 47

- **Remuneration:** Not all care providers are profit making. Some are also charities who work on no profits. However the large majority of all care providers are truly committed to compassionate person centred care and strive hard every day to achieve this aim. The few negligent care providers we sometimes hear about are a minority but they also attract a lot of media attention.

## Posting 48

- **Conflicting advice:** As a care home we are expected to conform to rules but no set of rules exists. Told by one inspector from CQC our recording of a certain procedure is correct, but another inspector says the same procedure is wrong. Two inspectors in the same team on the same visit can disagree.
- **Inconsistent advice:** Some inspectors make no comment about a procedure at one inspection and report to us it is wrong at the next inspection. Some inspectors give wrong information. Some inspectors argue with trained medical professionals when they are clearly wrong.
- **Quality of inspection staff:** Some inspections can be aggressive and unpleasant to the extent that after a CQC Inspection in February 2015 our longest serving employee, a wonderful trained nurse of 25 years' service, walked out of her job and would not return citing the conduct of CQC inspectors as the reason.
- **Business risk:** Current regulatory regime is an unacceptable and unmanageable business risk that will drive operators from the market and discourage new entrants. The conduct and tone of inspections will drive caring employees from the industry.
- **Result:** The result will be a shortage of beds.

## Posting 49

- **Benefit of regulation:** Recognise the importance of inspection, these visits must be undertaken in a balanced way so that there is no detriment to the delivery of care under inspection. Inspections take up time and that time taken is less time delivering care or managing the delivery of care.
- **Impact across whole of organisation;** Inspections do not just impact on the care homes, but impact on activity across our organisation. Also have our own internal visits on care quality and health and safety
- **Coordination within Local Authorities** Would be helpful. In one instance, one of our care homes in one week had unannounced visits from the LA's health and safety, scrutiny and monitoring teams. One of the LA teams consisted of five people.
- **Impact on front line care:** Took time in dealing with people. , prepare information and complete paperwork. Massive impact on managers, taking them away from the daily management of the home.
- **Duplication:** LA team's state they have seen the reports of CQC inspections but often go onto ask the same questions. The CQC are better at compiling information from a range of organisations.
- **Treating residents with respect:** There have been instances of LA inspectors entering resident's rooms without permission; it raises the question as to whether there should be standard guidelines for inspecting bodies on appropriate behaviour when visiting care homes?

- **Cost of inspections:** We are concerned that because all this duplication funds are being unnecessarily wasted. If paperwork and visits were streamlined and standardised this could have a beneficial impact of allowing staff to spend more time in their caring role and raise standards.
- **Centralised information:** A shared central database could reduce duplication and the need for visits, or could at least help to reduce the density of inspection visits.

## Overview of submission comments received by email

The review was sent a number of formal written submissions, emails and reference documents. The submissions received via the website provided some additional findings but also highlighted many of the issues raised through the website comments.

### Written submissions

#### *Submission 1*

- The review team received an email submission from a County Council via the Cutting Red Tape inbox illustrating good inter-agency work and co-operation. Key points made included:
- (It cited itself) as an example of good practice: The CC representative manages a Disability Quality Assurance Team. They describe themselves as a good example of effective inter-agency working reducing the burden of paperwork on homes.
- Burdensome contract monitoring: They agree that contract monitoring which is inconsistent or paper-work heavy is unnecessarily burdensome.
- They ensure feedback is helpful, rather than simply 'contract monitoring'.
- They are a joined-up team, operating on behalf of both the CCG and the council so do not duplicate.
- Hold monthly quality meetings, circulate fortnightly quality team summaries to colleagues in Safeguarding, Operational teams, Commissioners, the CQC and Healthwatch.
- This vehicle minimises duplication with the CQC. CQC are party to their soft intelligence, aware of action-plans a provider is already working to. Providers have commented on how helpful this is.
- Avoid form-filling. Providers direct them to evidence and might follow-up an action-plan by submitting evidence of things they have done, but they do not need to complete self-assessments.
- Developing a way of externalising their quality regime to make it available to people using personal budgets.
- Implementing a price/quality algorithm so that providers understand that the quality of their service has a bearing on their ability to successfully receive business.
- Quality helpline which is open-access to contact the team about a quality issue. This is another way of streamlining and avoiding duplication, as a professional can phone the helpline to request an update on work being carried out by a provider or to express a concern for the team to act upon, rather than acting of their own accord.

## **Submission 2**

The review team received a submission from a large provider, its main concern focused on the duplication of the national regulatory and local implementation processes. Key points to note:

- Keen to work with bodies to address duplication whilst maintaining high quality standards and safety required in the sector.
- Would like to see local authorities (both as commissioners and in their safeguarding role); NHS Clinical Commissioning Groups and the Care Quality Commission CQC align their work.
- CQC national standards are not always seen as sufficient by local commissioners (both local authority and NHS) and additional quality and contract monitoring requirements are often overlaid onto national standards in local contracts.
- Requirements set by different local commissioners vary for example on infection control and cleaning chemicals.
- Some local authorities criticise its national policies which are set to maintain consistency and high quality across a national organisation because they do not reference specific local rules and policies.
- Wide differences of interpretation of many regulatory requirements across local authorities. No single quality assessment process for commissioning residential beds.
- Little consistency between the different ways that local authorities run their safeguarding processes.
- (There should be) a memorandum of understanding between regulators; to share information better and a lead liaison between multi-disciplinary teams.

## **Submission 3**

The review team received a submission from a local authority which explained some of the reasons behind the duplication in inspections and why local authorities have to make certain requests that providers may perceive and cite as duplication. Key points to note:

- CQC operates to its own timetable of inspections and while it meets with local authorities on a bi-monthly basis to share intelligence, it does not share the dates of planned inspections. Local authorities therefore operate their own inspection or review methodology that enables their own assurance is achieved.
- (The local authority) referenced developing a shared framework to enable bench marking and reduce duplication.

- The framework has been enhanced by different localities since its development, so it is no longer uniform, but in line with guiding principles, it should only ask for information that all homes can reasonably be expected to have access to without additional administrative burden.
- Has over the last two years been completing multi-disciplinary team (MDT) reviews to care homes with colleagues from the CCG where there are multiple organisational concerns?

#### **Submission 4**

The review team received a submission from a research organisation highlighting a number of findings. Key points to note:

- Excessive 'paperwork' and 'red tape' are a real cause for concern in care homes.
- Adult social care is an essential part of the infrastructure of society and our economy. It is under more pressure than ever before in terms of funding, complex demand and regulation.
- Anything that can be done to maximise the time for hands-on care and relationship-building would be welcomed.
- A fundamental review, reassessment and redesign of the paperwork burden on care would be welcome and helpful in enabling care homes to concentrate on the quality of relationships.
- A completely fresh analysis of paperwork requirements, should be carried out. Experts in systems analysis and process management should undertake a comprehensive examination of what needs to be captured, examine and test the evidence as to why, and assess whether paper is the best method.
- Once completed, a clear, measurable, realistic, universal and evidence-based suite of paperwork could be designed, to be used across all care homes, which is acceptable to all regulators and commissioners.
- Balance between prevention of poor care and promotion of good care is out of kilter. Fuelled by fear and insecurity, care homes spend too much time attempting to cover themselves against blame or litigation.
- Staff can lose their sense of vocation if they feel like they are being judged more on how they produce paperwork than how they care for people.
- It is a misnomer to talk of a single 'set' of paperwork. The research identifies more than 100 separate items of paperwork that must be completed regularly in care homes, responding to a range of regulatory and commissioning requirements.
- Poor co-operation and co-ordination between agencies responsible for regulation, monitoring and purchasing care results in information being duplicated.



### **Submission 5**

- The review received a submission from an independent small provider who has now sold their business and moved into the home care sector because of the difficulties of complying with Red Tape. Key points to note.
- HMRC doesn't understand the way work patterns are in the sector and its interpretation of National Minimum Wage calculations is increasing costs and paperwork.
- CQC and councils do the same tasks because the council doesn't accept CQC standards. CQC trains its staff to a consistent standard. The problem CQC has is insufficient inspectors.
- Gold Plating: There is total duplication of work being done on inspections but also by the council, through its contracting arrangements, demands far more than is legally necessary thereby increasing costs.
- Duplication: bound by lots of legislation in one form or another and can lose our business/be fined/ if we do not.
- Size of contracts & appendices: The contracts and their appendices for both the council and the CCG/NHS are so long, unwieldy and prescriptive as to be unreadable.
- Cost: cannot pay more to attract staff as council rates do not allow more money to be paid.

### **Submission 6**

The review team received a submission from the national regulator CQC which welcomed the opportunity to provide an update on changes to the regulatory landscape since the first FoE review into the adult care homes sector. Key points to note:

- Continuing progress under the new inspection approach, which is now fully embedded across all the sectors that they regulate.
- Continuing co-production work with ASC providers, trade associations and other parties to ensure providers are involved and where possible reduce the regulatory burden and duplication on providers.
- (Submission) provides an update on working more closely with local authorities and its Memoranda of Understanding with key strategic partners.
- Currently in the process of developing a new five-year strategy for 2016-2021 focusing on three key areas: 1) Efficiency considering the balance between registration, inspection, monitoring and information from providers (or partners), 2) factors that affect quality beyond individual providers, 3) how providers use the resources available to deliver high-quality care.

- Recognises that the health and social care landscape is changing during a period of significant financial constraint.
- Through co-production work and participation in Focus on Enforcement, acknowledges concerns around duplication between local authorities and the CQC which creates an administrative burden on some providers.
- Has organised its adult social care directorate to reflect local authority boundaries which allows for the more effective alignment of staff with local authorities.
- Local authorities meet regularly with the regulator to share information of concern about locations.
- Encourage aligned regulator inspection and local authority visit schedules to lessen the amount of duplication on providers.
- Attends local safeguarding meetings and local safeguarding boards to provide an update on CQC's work annually.
- Referred to a case study which highlighted a number of ways they worked with a local authority to coordinate inspections and information requests on providers.
- Working closely with the National Information Board (NIB), seeking to identify improvements in future national information flows.
- Has run a six-month pilot to explore information sharing between local authorities and CQC, commonly referred to as the "ADASS portal".

### ***Submission 7***

The review team received a submission from a community organisation setting out their concerns on the issue of red tape in the adult care sector. Key points to note:

- The quality of regulation has improved considerably over the years. Previous regimes had been extremely fragmented. The current system is far more structured and consistent but the burden of bureaucracy is still considerable, and still very paper/desk based.
- Each local authority has developed its own form of contract and variation of contract. It's preferable for local authorities to adopt a uniform model particularly for providers of care for older people.
- To a great extent, there has been considerable duplication between work done by local authorities and work done by the national regulator. There is still much that could be done to deal with the duplication issue.
- Mental Capacity Act and Deprivation of Liberty Safeguards (DOLS) generates a considerable amount of additional documentation to provide what is effectively an audit trail.
- There have been numerous difficulties with the manner in which safeguarding enquiries have been carried out.

- Recruitment is one of the biggest challenges facing the care sector, both in terms of trained nurses and high quality carers due to changes to the immigration points system.
- Many local authorities and CCGs have made the Commissioning process extremely complex.

### **Submission 8**

The review team received an email submission from a provider. Key points to note:

- Changes to regulations require us to make internal changes to over 200 policies and procedures.
- Impact on front line care: Give us time to breath, constant changes of regulations and guidance does not give us enough time to implement.
- Business risk: Small organisation. Regulation is running businesses out of business.
- Duplication of paper work: “The paperwork is enormous. I have to pay two staff (admin and qualified nursing staff) to come in additionally to work to ensure paperwork is complete”.
- Local authorities pay us £3.50 an hour (half current min wage) and qualified nurses cost at least £16.00 per hour. 80% of all income is paid for wages.
- Quantity of inspections: We are inspected by CQC, also by local authorities, Food Safety standards, H & S Executive, Fire inspectors.
- Cost of training: Why is it that employers (also small employers) have to spend hundreds of pounds to send qualified nurses for specialised training, these should be a part of the basic nursing training for 3 years in nursing school.

# Annex 2: Summary of other evidence gathering

## Adult care review interviews with stakeholder highlights

- Apex care homes Bedfordshire
- Association of Directors of adult social services (ADASS)
- Care England
- Care Association Alliance
- Care Quality Commission (CQC)
- CQC – ADASS portal update
- Clinical Commissioning Groups Hardwick, Hastings & Rother
- Evesham and Worcestershire Home care provider
- Example from an NCF member
- Forum of Private Business
- Gloucestershire residential homes (Disability QA Team)
- HSE Social Care Partners Forum
- Health and Social care information centre (HSCIC)
- Hertfordshire County Council
- Home and Communities Agency
- Independent Care Group
- Jewish leadership Council (JLC)
- London Purchased Healthcare Team
- National Audits office
- National Care Forum
- National Care Association
- NHS Clinical Commissioners
- NHS England
- Professional Standards Authority
- Registered Nursing Home Association
- Social Care Institute For Excellence
- Voluntary Organisations Disability Group (VODG)
- Care Home visit Royal Masonic Benevolent Institution (RMBI)
- Prince Michael of Kent Court Stratford Road Watford Herts WD17 4DH

## Types of fieldwork undertaken for the evidence gathering 16th July to 14th September

The review gathered evidence through crowd sourcing comments via the website, written submissions and a survey monkey which was circulated to care providers via trade associations. The team also undertook a series of face to face meetings, teleconferences, and site visits with key stakeholders; this included individual companies (small and medium sized care providers) and trade associations. Several of the website comments were also followed up directly which provided some specific examples and case studies. All the meeting notes were written up and collated into a matrix of the key findings which are captured in the report.

The Review also spoke directly to a number of key delivery partners involved in the regulatory process including CQC, CCGs, LGA, and NHS England.

Trade associations were also invited to highlight to members the review via their newsletters and to complete the survey monkey as well as encouraging their members to feed their comments in to the website. This enabled us to reach over 200 care providers.

### Methodology

Introductory meetings with the care sector representative groups and key delivery partners focussed on broad themes in terms of what the review was aiming to achieve and the role that they could play in terms of facilitating views from their members. The discussions in these meetings also enabled us to gain an insight in to what had moved forward since the previous review and what were the general problems with regulations and enforcement that the sector felt they still faced.

The subsequent meetings with individual care homes and representative groups all followed a similar structure to ensure a consistent approach to the discussions. Whilst a series of prompts was used to ensure common emerging themes, the meetings were free-flowing, enabling participants to convey their experiences directly with little intervention from the team. The review team prompted contributors to provide specific examples and case studies. Many of the issues that were highlighted through website comments and the survey also came in our meeting discussions too.

## Annex 3: Review scope

### **Cutting Red Tape review of progress on regulatory reform in the Adult Social Care Homes sector – scope.**

This review will assess the progress being made in reforming regulatory practices in the Adult Social Care Residential and Nursing Home sector. The primary aim is to remove unnecessary duplication and overlap in inspections, visits, paperwork, data requests and in commissioning and contract management, whilst safeguarding standards of care and protection for residents.

The review will build on earlier analysis of the regulatory framework and regulators' practices in the adult care homes sector carried out under the Red Tape Challenge and Focus on Enforcement initiatives.

We are interested to hear your views and experiences specifically in relation to:

- examples of duplication and overlap;
- the impact of duplication and overlap on staff time, operating costs and time taken away from contact with residents;
- examples of good practice and suggestions for effective solutions to strip out unnecessary duplication and overlap.

### **In scope**

For the purposes of this review we are defining the adult care homes sector as including:

- adult residential social care
- adult residential nursing care
- adult respite care
- supported living

The focus of this work will be on reducing the duplication that is created by commissioning and contract management activities and regulatory enforcement in the sector. That will include the activities of local authorities, Clinical Commissioning Groups (CCGs) and the Care Quality Commission and others.

The review will assess the progress being made in addressing concerns raised by the findings from the original Focus on Enforcement Review into the adult care

homes sector which was published in October 2013.<sup>21</sup> The original review highlighted a number of consistent themes in providers' assessment of regulatory enforcement in the sector, including:

- significant duplication of visits and information requests by local authorities, Clinical Commissioning Groups (CCGs) and the CQC;
- an apparent lack of coordination between CQC and commissioners of places in homes in the work they carry out to monitor provision;
- a focus on paperwork by regulators and those commissioning places and not enough focus on assessing the actual standards of care.

This follow-up work will focus on tackling these issues, taking a cross-Government approach to driving improvement, and fully involving delivery partners and sector representatives in developing better approaches.

To add to our existing evidence base we would welcome examples of good practice and approaches that have helped providers meet their contractual and regulatory obligations whilst mitigating the problems listed above. We would also be interested in examples that illustrate and quantify the problems that have been identified.

## Out of scope

Related sectors and provision that are out of scope of this review include:

- general health care
- children's residential social care
- general areas of regulation that are not sector specific (such as employment law)

The Care Quality Commission has recently introduced a new inspection regime and regulatory model. Our intention is not to revisit those through this work.

The review will focus on the enforcement of regulations applicable in England, although we are interested in evidence from around the UK – in particular in examples of good practice.

## Background

This is one of a rolling programme of Cutting Red Tape reviews that are looking at the legal framework for regulations and the impact of compliance and enforcement of regulations for businesses imposed by Government Departments, national regulators and local authorities acting under their instruction, on different industries. The new Programme builds on the success of the previous Red Tape Challenge and Focus on

---

<sup>21</sup> [www.gov.uk/government/publications/adult-care-homes-sector-focus-on-enforcement-review](http://www.gov.uk/government/publications/adult-care-homes-sector-focus-on-enforcement-review)

Enforcement initiatives. These initiatives looked respectively at all aspects of the law as it impacted on business and at all aspects of how compliance with and enforcement of the law impacted on businesses in specific sectors.





© Crown copyright 2016

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk). Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

This publication available from [www.gov.uk/bis](http://www.gov.uk/bis)

Contact us if you have any enquiries about this publication, including requests for alternative formats, at:

Department for Business, Innovation and Skills  
1 Victoria Street  
London SW1H 0ET  
Tel: 020 7215 5000

Email: [enquiries@bis.gsi.gov.uk](mailto:enquiries@bis.gsi.gov.uk)

**BIS/16/150**