Adult Social Care Trade Associations Meeting

MINUTES

Date	**Wednesday 25 August 10:00 – 11:30**
Location	TEAMS online meeting
Attendees	**Care associations accepted so far:** Zoë Fry (ZF)- Outstanding Society James Nichols (JN)- National Association of Care & Support Workers Jasmine Peak (JP)– National Care Forum Amrit Sumal (AS)- National Care Association Anna Knight (AK)– Care Association Alliance Terry Donohoe (TD)- United Kingdom Home Care Association Clive Parry – Association for Real Change Gareth Lyon (GL)- Associated Retirement Community Operators Jan Burns (JB) – Dignity Councils Karolina Gerlich (KG) – Care Workers Charity Liz Jones (LJ) – National Care Forum Erika Murigi (EM) – Voluntary Organisations Disability Group Michael Voges (MV) – Associated Retirement Community Operators Louis Holmes (LH) – Care England **CQC:** Mary Cridge - Deputy Chief Inspector of Adult Social Care (**Chair**) Rob Assall - Deputy Chief Inspector of Adult Social Care Debbie Ivanova – Deputy Chief Inspector for People with a learning disability and autistic people Steve Holmes – Operations Assurance Manager, Adult Social Care Alison Murray – Head of Inspection, Adult Social Care Sam Wallace – Provider Engagement Lead Jennifer Charlton – Communications and Engagement Manager Louise Chapman – Provider Analytics Manager Latoya Tawodzera – Provider Engagement Officer (minute taking)
Apologies	Russell Leese (RL)– Horizon Healthcare Homes George Appleton (GA)- Care England Cathy McSweeney (CM) – Shared Lives Plus

Minutes	Lead
Welcome and Introductions	Mary Cridge
Provider Information Return • Louise Chapman (LC) advised that since the relaunch of the PIR in February CQC have reduced the number of questions so that it takes 11 hours to complete instead of 18.	Louise Chapman

• Louise's team continue to cross check with the capacity tracker to see which providers are facing challenges that mean they would struggle to complete a PIR. They're also listening to providers who feedback issues with completing the PIR and handling this on a case by case basis. • LC discussed data sharing, within CQC we're looking at data from the PIR on a location level, reviewing what's going well, and what's not going well. We're also looking at using data from the PIR in some of our publications. • There's work ongoing to look at reducing burden on providers to provide data, as well as duplication of information. We're working with Department of Health and Social Care (DHSC) and Skills for Care. • We've had questions in the PIR that go to DHSC and Skills for Care since before the relaunch, and this is clearly noted in the guidance on our website. (PIR guidance is available here) • We're working with the Office of National Statistics, on a piece they're doing on self-funding, using data from the PIR. Though this work won't show data from a location level. They're working to raise awareness of funding in the social care sector using aggregated data. • We've recently started working with Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS) on how information from the PIR can be used more widely. • LC asked the group what are the limitations of the PIR and what are their thoughts on opportunities for sharing data from it with LGA and ADASS? • Liz Jones (LJ) asked about data sharing and level of data that is being shared. Are CQC telling providers what level of data is being shared and who it is being shared with? From experience with the capacity tracker this level of communication is important. Is the data CQC is sharing being aggregated and anonymised when it's going to DHSC and LGA, or is it being sent by location? Concerned providers may not be aware of their responses being shared more widely than CQC. • LC advised guidance on what data goes to DHSC and Skills for Care is detailed in the PIR guidance on the CQC website. We share a small number of questions with them, the data is provided at location level strictly for their internal use. This has been in place since the previous PIR, and the purpose was to look at how we can share information. • In terms of sharing data with LGA we want to look at how we can share location level data, but first we need to understand from this group the limitations and opportunities in doing this. • LC advised she'd like to do a workshop with the group on how the PIR is going, any areas of interest providers want to discuss, and	

how to take sharing with LGA forward. Louise is looking to hold the session at the end of September. • Terry Donohoe (TD) asked if providers will be given information from the PIR to help self-monitor? • LC advised yes, we're happy to share information with providers where it will be useful. The workshops are flexible, we're looking for people with an interest in data, which can be this group or Registered Managers (RM).	
CQC Quality Assurance process • Rob Assall (RA) advised following a meeting with Kate Terroni, Prof. Martin Green, Ann McKay, and Jen Charlton where they discussed CQC's quality assurance process, it was decided that it would be helpful to also bring the conversation to this meeting. • Following an inspection, a peer inspector will review the report, this colleague would not have been involved in the inspection visit. They check the report is compliant with CQC guidance. • New inspectors go through a robust training process and must be signed off by an Inspection Manager (IM) to complete and inspection on their own, they will also have an experienced inspector as their buddy throughout their induction. • IMs selectively review Good and Requires Improvement reports. Where a provider is Outstanding, this is always reviewed by an IM and signed off by a Head of Inspection. • IMs have a daily rota where they review reports from a number of teams. They do not conduct factual accuracy checks on reports where they've been part of the inspection team and contributed to the findings. If a factual accuracy response is complex and independent IM may be asked to review it. • A ratings review looks at whether the inspector/inspection team have followed the correct methodology in our guidance to validate the findings in a report. We do not hold ratings reviews to solely change a rating. We use this process to check we've followed our inspection processes and methodologies. • Providers can submit a complaint about an inspector or any person at CQC. If providers have concerns, they can discuss with the local IM to try and resolve the issue. If the matter cannot be resolved the provider can make an formal complaint, by following our complaint process. • RA urged the group to advise their members in circumstances where they have a complaint about a CQC colleague inspector / member of staff, please raise the matter immediately. Please also provide as much information as possible including, what the providers concerns is about the CQC colleague and when the incident took place. We very much welcome receiving this information and will always use this information to make improvements and learn.	Rob Assall and Steve Holmes

- Pre-covid we had a process in place requiring inspection managers observe at least one inspection a year per team member. This process was put on hold due to the COVID-19 pandemic and the need to reduce the number of colleagues attending an inspection. This will recommence soon.

- Steve Holmes (SH) advised before the pandemic CQC had a programme for quality reviews. Whilst covid has interrupted some of the programmed work, quality assurance reviews had continued in Adult Social Care.

- In adult social care the National Quality and Improvement (NQAI) group meets monthly and sets the broad criteria for each review. The group discusses the key findings and recommendations of reports, which are then taken to the Adult Social Care Improvement Board so action can be taken to learn, update practice, and/or policy.

- The NQAI group usually looks at a sample of 24 inspections and reports spread across the country, IMs and inspectors review reports from different regions of the country. This helps to test thresholds and consistency between regions, we have experts by experience that join this group to ensure people who use care services have a say in the quality of our work.

- We've conducted three appreciative retrospective quality reviews in the last year, which focused on finding good practice.

- Liz Jones (LJ) asked do you take provider feedback into account as part of the reviews?

- SH advised we didn't previously take provider feedback as it is a retrospective process, but we would consider for future reviews.

- Amrit Sumal asked the following questions:
    - Is the peer inspector from the same team or region as the inspector who's made the report?
- RA advised we have a peer review rota, so that inspectors can review reports from different teams.

    - Who reviews inadequate and requires improvement reports that have no breaches?
- RA advised that all inadequate reports are reviewed by IMs. Requires improvement reports with no breaches are reviewed as part of the IM random selection process. Inspectors will alert IMs if they feel a requires improvement report with no breaches needs to be reviewed by an IM.

    - In terms of the wording around 'inspection managers selectively and proportionately review good or requires improvement reports' what does this mean?
- SH advised there are many factors that determine how often an inspector's reports are reviewed. When inspectors are new to the role, there reports are reviewed more frequently. We also ensure that colleagues with up-to-date expertise in specific areas of health and social care are included in the review process. For example we've been focusing on services for people with a learning disability and autistic people, we've had specialist colleagues review reports to

ensure that we are being consistent in our application of right care right support right culture. The review process is applied dependent on circumstances either around the inspector, nature of the report/inspection, nature of the service inspected, and expertise needed to assess the report.

    - What is the current methodology for ratings reviews? In a previous meeting we discussed the current risk-based approach. Feedback to CQC was that it puts good rated providers at a disadvantage, if they want to reach for an outstanding rating because there are no risk issues. Amrit referred to last month's meeting where Sue Howard spoke about CQC's capacity to meet demands from providers to hold inspections and re-rate.

- RA advised a ratings review would only apply when an inspection has taken place, the only reason for a ratings review to take place would be because of concerns that CQC have not followed the current published processes for inspections and rating.

- LJ encouraged CQC to include provider feedback in the quality review process, this would encourage a well-rounded approach and provide more insight. It is positive that appreciative reviews are happening, and that the voice of people who use services are included in the quality review process.

- SH advised we'd like to make that happen especially when we are looking for good practice examples and will come back to this meeting next year when the programme for next year has been planned. We're moving to a more multidisciplinary approach in CQC, and it would be interesting to get thoughts from this group on how we can meaningfully include provider feedback.

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- Zoe Fry (ZF) asked would there be scope to review the other end of the scale e.g. if someone is outstanding, has a lot of intelligence / evidence from key stakeholders / users etc could this not be discussed with the IM with a view to not needing to go through so much scrutiny? So, a risk-based assessment at the other end of the scale?

- RA advised before the pandemic we were reviewing the process for signing-off an outstanding rating and will take your challenge on board.

- Debbie Ivanova (DI) advised providers that are outstanding and have a strong evidence to support this move at pace through the process to get their rating confirmed. There are some providers who we have to do more diligent checks to confirm the rating.

- Comments were made about providers concerns that they cannot receive an inspection to improve their rating. This was discussed in the last Trade Association meeting and Sue Howard has organised a webinar on our monitoring approach. The webinar will be held on Monday 20 September at 3-4pm. Please register for the event through Eventbrite. This event is for all adult social care providers and organisations, please share this with your members.

• We're also organising similar webinars for Healthcare and Primary Medical Services colleagues.	
COVID-19/Sector check-in Latoya Tawodzera (LT) advised we're revisiting this item from April to catch-up on what this group is hearing from members on broader topics. As described on the presentation we'd like to know: • what are the sentiments towards CQC approach? • what are the barriers to receiving and providing good care? • what are the current issues having an impact on health and social care? • Liz Jones (LJ) advised workforce issues are prevalent in the sector, mainly absence due to covid and being ill, and absence due to covid and self-isolating. Pressures of burnout and stress, other sectors opening rapidly, and competition around pay, pressure and competition around pay in the health sector. Emerging pressure around Brexit, and mandatory vaccination as a condition of deployment in care homes coming up in November. People who don't want to take the vaccine won't take it, and people who have been pushed to their limit are leaving. • LJ has had question from providers about what extent they should communicate workforce issues with CQC. They submit workforce data and send notifications, but how much more should they communicate with CQC considering they may potentially flag as a risk in line with the current monitoring approach. Though its recognised CQC could be a valuable ally in conveying workforce pressure in the sector. • Provider feels the government could change their decision on mandatory vaccination which would reduce people leaving their roles. They could increase and extend the infection control fund, and they could consider a loyalty bonus for care staff. Providers are feeling more stress now, than over the past 18 months. We could work together so that providers give this feedback to CQC, without feeling like it may trigger an inspection and impact their rating. • Mary Anson (MA) advised there are 700 people with identified care needs who are unable to be supported in Cornwall. There are also 100 people under detox delayed transfers which is the equivalent of 5 wards. • Louis Holmes (LH) asked is CQC aware of the latest ONS data about vacancies? The Guardian summarised it quite well, there are possibly over 1 million vacancies across the country (all sectors), what can CQC do to help with recruitment and retention? (Link to Guardian article here) What more can we do together to drive to get people into care? • Mary Cridge (MC) raised there was the national recruitment campaign, asked if anyone knew whether that was returning? • LJ advised there has been feedback to DHSC about improving the campaign. It would be good to have a "care first" approach, we have to inspire people of all ages to join the care sector.	Latoya Tawodzera/ All

• Steve Holmes (SH) advised he was previously on the national recruitment campaign delivery group and has recently been invited to a meeting suggesting its restarting. It would be useful to capture feedback from this group around the effectiveness of the last recruitment campaign. The campaign was trying to be uplifting and inspire people to get into a care career, it would be useful to know how the campaign landed for providers. • Rob Assall (RA) agreed that getting feedback about the campaign would be useful. We need a national and regional approach, especially to tackle counties like Cornwall who are struggling to retain staff and attract new people due to issues in their region, like being a holiday hot spot, increasing hospitality recruitment and issues with nursing roles in adult social care. • Zoe Fry (ZF) agreed with Louis and Liz's points on workforce issues, advised providers should be contacting local Care and Business Support teams at a very early stage, they are a safe contact to initially have those discussions about workforce with. Asked if CQC could promote this as well? • LT will follow-up with Zoe on this suggestion. • Alison Murray (AM) shared a link to the CQC Statutory Notification guidance. Page 11, paragraph 15 has a section on Notification about 'other incidents'. The section on 'Events that stop, or may stop, the registered person from running the service safely and properly' would be applicable to reporting workforce issues. • MA advised the most acute issues are in Cornwall. Dorset, Devon and Somerset are unable to help. 1000 hours of care staff brought in to help from elsewhere but with no accommodation they are currently in Student halls of residence but have to leave when the students return from 1st September. More staff are now working as caravan cleaners where hourly rates are now £20. More people working as delivery drivers for takeaways - same pay as care and much easier.	
Operational Update Vaccination as a condition of deployment • Alison Murray (AM) advised that the last day for care staff to get their first covid vaccine is 16 September 2021. We know there are concerns around uptake of vaccine and awareness of the requirement to be vaccinated to work in care homes. • Following the recent webinar held by DHSC, it was clear from messages and questions in the meeting that some providers and registered managers had not read the guidance. • AM has fed back to DHSC the responsibility to ensure only vaccinated staff are deployed to care homes should be the responsibility of all providers. It is unfair to lay all the responsibility on the Registered Manager (RM) in the care home.	Alison Murray

• AM has asked DHSC to produce easy read summaries of the guidance. Which they've announced on their website will be coming soon. • AM advised CQC are trying to make this regulation is applied as simply as possible. RMs know their care homes better than anyone else, we want to support and enable RMs to meet the regulations in a way that works best for them. We'll be looking for risk assessments, RMs need to talk to teams and visiting professionals, decide how this will work in practice, and maintain record keeping of conversations. • We've got information on our website around registration, monitoring inspection and enforcement. The key principle is that we're using our normal monitoring and inspection process, where we find breaches to the regulation, we'll be using our normal judgement framework. (Click the link to read more on statement on COVID-19 vaccination of people working/deployed care homes) • The regulation is phrased very clearly, as a regulator we'll have little discretion as to whether the regulation has been breached, where the proportionality will be applied will be the action we take as a result of the breach. • It's difficult to give examples, as the context for each care home will be different. We know there are concerns around meeting the regulation and meeting the requirement around providing safe care and treatment with current staffing issues. • We are having active discussions with DHSC about medical exemptions and highlighting the urgent need for further clarification on this, so providers can have conversations with staff in advance. • AM advised we've flagged to DHSC about concerns on the data in capacity tracker showing levels of vaccinated staff. We're also aware individual local authorities are sharing their own vaccination data. • MA advised a number of providers have applied for tier 2 sponsorship, due to availability of senior care staff. Providers will need to employ people who've gotten their vaccine from outside of the country, who do not have MHRA approved vaccines. What should they do in this instance? • AM advised CQC are discussing with DHSC that some sort of provision needs to be made for these individuals. • MA raised the that there may be a need for a booster vaccine due to immunity wearing off, this has not been included in the guidance. • AM advised this is also in discussion with DHSC, a booster programme is meant to be starting in September. We're aware there may be a need to add this to the guidance. There are also discussions about how we can support colleagues who have been part of vaccine trials.	

• MA advised she has concerns about the staff who are exempt from the vaccine being exposed to relatives and carers who are not required to have the vaccine to visit residents. • Liz Jones (LJ) acknowledged the regulations around this are clear however, providers are concerned about the impact this may have on their insurance, if they are found to have breached this regulation. Asked CQC to monitor the impact of this regulation on insurance premiums. • AM has raised this concern with DHSC. CQC are putting mechanisms in place so we can capture information about vaccination concerns. We're also putting systems in place so we can monitor the actions we're taking, for example how many breaches we're finding, actions we're taking as a response and adding a bullet point on the IPC tool around this.	
Update – Transforming how we regulate services for people with a learning disability and autism Home for good report • Debbie Ivanova (DI) advised this report will be published on the 8th September. • The report features 8 stories of people who have had placements from the hospital system, who are now living in services designed around them and that meet their needs in the community. • There will also be a podcast around it published with the report. Quality of life tool • This has been developed through closed cultures work, it's been piloted in learning disability inspections in both hospitals and adult social care. • It's still in development, but we'd like providers to see what we're using, and we'll update our website and other communication channels as it develops. • The tool helps us understand how documents like care plans, and positive behaviour plans are used by staff and what this means for the daily lives of people living in a service. • Publication date to be confirmed. Pilot with experts by experience • The idea of the pilot is to build an ongoing relationship with the people in a service so we can understand what's happening there, see when changes are emerging and the impact on people living in the service. • This pilot has also come out of ongoing work on closed cultures. • The pilot will be introduced in September. An expert by experience will be linked to a service and following an inspection they will be able to speak to people in the service and talk to them about how their life is going, and any changes affecting them. • The services in the pilot haven't been chosen for a particular reason.	Debbie Ivanova

• This pilot will also benefit providers, to identify changes closed cultures emerging where it may not be visible and to highlight the good practice in their service. • Mary Anson (MA) asked is it useable or transferable for locked dementia units Debbie? • DI advised yes, but we need to start the pilots and evaluate them.	
AOB • Mary Anson (MA) asked in respect of 'emergency' access only to a care home after 11th November, how should we define 'emergency'? With respect to the staffing crisis. There's an enormous number of residents that need medication every day, but with the staff shortage, we potentially risk safe care. Registered Managers (RM) may also take on this task among the numerous other responsibilities they're picking up. • Alison Murray (AM) advised this is down to the discretion of the RM, they do need to record what the situation was and how it was handled. The mandatory vaccination in care homes guidance has a section on health emergencies. • Liz Jones – asked about workforce notifications, what should providers do with workforce concerns, in relation to informing CQC? • AM advised providers in the first instance should be talking to their local authority and system partners. Where this has not been resolved, providers should send a notification to CQC. • Terry Donohoe (TD) raised concerns from providers about the quality of CQC's registration process, namely inconsistencies in applications reviews. Providers have fed back that if their applications don't fit the template CQC reviewers are looking at then their applications are rejected out of hand. When providers do submit the right information, they're asked to provide more detail. Terry's recently seen an application where it was reviewed multiple times each time by different reviewers giving different feedback. This is causing lots of frustration. • Mary Cridge (MC) asked if there are any specific cases, for them to be shared with CQC. Registration colleagues are working hard to put resources in place to process applications. • TD has advised members to go through the process and give feedback. There are issues around franchises especially and the approach taken to corporate procedures. Issues around how franchises are inspected compared to single providers have also been raised, providers want consistency in CQC's approach.	All
Close Next meeting: **29 September 2021, 10am – 12pm**	