Homecare Association

Homecare Association's response to the CQC Local Authority oversight consultation

Submitted by online web form 21/04/22

What are the key pieces of evidence for the theme of how local authorities work with people?

Views of people receiving services and their informal carers are key.

We believe it is a significant omission that CQC appears to be ignoring the voice of professional careworkers, as they typically have as much if not more contact with people receiving services as anyone.

Outcome measures for supporting people need better definition. It is disappointing that the first one listed is focused on cost. Suggested measures focused on the people receiving support could include: loneliness and isolation; activities of daily living; pain; mood and emotional health; autonomy and control; carer burden; participation and decision-making; frailty; time spent in hospital; healthy years without disability; place of death; polypharmacy; falls.

What are the key pieces of evidence under the theme of how local authorities provide support?

Evidence listed is fine but there are some major omissions.

Again, the voice of careworkers and their employers appears to be a minor consideration for CQC, which is surprising, given that they represent most of the workforce, without whom no support for people would be possible. What is their experience?

Key aspects of commissioning and procurement of care contracts are omitted, which are mainly a feature of homecare. For example, levels of unmet need in the community and waiting times for homecare (not just delayed discharges from hospital); pattern of need (proportion referred from community vs hospital); level of assessed need (low, medium, high); commissioning model used (e.g., block contracts, framework contracts, lead providers, zones); the proportion of hours commissioned under a standard contract vs spot contracts; proportion of hours commissioned by local authority vs NHS vs jointly commissioned; total cost and average cost per hour over the life-time of a contract; how many providers that start a contract maintain provision until the contract ends; what proportion of providers cease trading and how many people are affected; proportion of visits that are 1 hour, 45 min, 30 min, 15 min; relationship between fee rates paid and care quality; relationship between fee rates paid and care recipient satisfaction; relationship between fee rates paid and pay rates for careworkers; difference in pay rates between local authority in-house staff and independent providers (ethics of commissioning practices); staff turnover in contracted providers vs others.

It's unclear how CQC will gain an accurate view of care quality now that some services have not received a full inspection for 4 years or more.

What are the key pieces of evidence under the theme of how local authorities work within a system?

Evidence list is fine with some key omissions.

Often, safeguarding issues arise at the interface between services. For example, unsafe or inappropriate discharges from hospital to homecare or care homes. There is currently no adequate system for reporting and monitoring these and no feedback loop. If a homecare provider tries to report issues with a person's discharge, they may try PALS, or talk to an operations manager in the hospital, or raise a safeguarding alert via the hospital. Invariably they receive no response and the local authority has no sight of this. There is no way to identify and solve systemic issues. This is where CQC needs to focus.

Some local authorities have actively encouraged unregulated care. Who is concerned about the safety of the individuals receiving homecare outside of the regulated care system? Does anyone care?

Efficiency and effectiveness of safeguarding procedures needs to be considered. Every local authority operates a different procedure and it would be helpful for CQC to define what good looks like and encourage uniformity and best practice.

The outcomes listed in question one should be considered in the light of safety within systems. How often, for example, do people end up back in hospital because of an unsafe discharge or lack of adequate care?

What are the key pieces of evidence under the leadership theme?

Evidence listed is fine, though there are omissions and insufficient emphasis on the experience of careworkers and care managers.

Enabling autonomy and contribution for the care workforce is key and is not mentioned. For example, evidence that contracts have been constructed with delegated authority for care providers to make decisions about people's care, as they already do in the self-funded part of the sector.

Evidence should be provided that commissioners have analysed the needs of their local population and ensured that training of careworkers is provided so they have the necessary skills and competencies to meet these needs. For example, if there is a growing number of people with complex care needs, what is the local authority and NHS partners doing to support this?

Evidence is required of treating social care provider partners with parity of esteem. For example, what type of provider engagement activity is there. How are care providers engaged in ICSs.

What do we need to consider when gathering and using data?

Ownership (data should belong to the individual receiving services); consent; privacy; security; other aspects of compliance with data protection legislation; burden of data collection; ease of sharing of data; access of relevant parties to data; analysis and reporting of data; how analysed data can be used in real-time for supporting preventative work.

How can we engage with local people to inform our evidence?

Adopt a variety of different approaches as one size does not fit all.

For example:

- Surveys (email, paper, telephone, commissioned by ICS partners and by third party organisations such as YouGov).
- Use existing community and other groups to engage with people, e.g., HealthWatch, WI, churches, youth groups, representative groups (e.g., disability groups, disease specific support groups and associations, Carers UK, Age UK).
- Offer online and in-person public meetings and focus groups, effectively advertised.
- Use social media and mainstream media, e.g., radio.
- Invite feedback via CQC website
- Invite feedback via websites of local authorities, NHS trusts, GPs etc

Any other comments?

It is disappointing that CQC appears to have sought deliberately to avoid engaging with careworkers, providers and their representatives in the development of this work, resulting in what we perceive to be serious omissions. The Homecare Association and other members of the Care Provider Alliance have asked numerous times to speak with those leading on this work and have been repeatedly ignored.

The way homecare is commissioned and purchased is a major determining factor in the way state-funded care is provided. In turn, this has a significant influence on those receiving and giving care. It is unclear from the slides and video that CQC has thought about defining what good looks like in terms of commissioning and procurement of care. CQC has certainly not yet described the latter and does not appear to be proposing to analyse the impact of commissioning and procurement models on outcomes for people receiving services.

The care workforce plays a highly significant role in determining the experience of people receiving services and the quality of care. The way they feel they are treated by local authorities and the system more widely is a major influence and this also appears not to feature much in CQC's thinking.