Care Quality Commission

directors of adass adult social services

Joint Working Protocol between CQC and ADASS

Introduction

1. This joint working protocol is between the Care Quality Commission (CQC) and the Association of Directors of Adult Social Services (ADASS). It is grounded in improving and maintaining high quality and person-centred services for people.

2. It sets out the areas in which CQC and DASSs in councils with adult social services responsibilities work together and coordinate their roles, activities and information sharing. It aims to foster an environment which facilitates open and honest conversations about quality.

3. The joint working protocol supports the principles of Quality Matters. Through effective sharing of information and appropriately coordinated actions we will tackle poor quality care and support and encourage services and local areas to improve. As part of the Quality Matters work, the Quality Matters Board, which includes ADASS and other strategic partners, will strive to develop an agreed, shared view of quality and to support a common quality dataset for adult social care, with the aim of this being collected once and shared as necessary and appropriate.

4. In order to fulfil their respective remits as effectively as possible, CQC and DASSs share a range of information on a regular basis. This involves sharing information and knowledge about adult social care services that are regulated by CQC. When appropriate, information is also shared about regulated services that provide care and support to children and young people, in line with statutory requirements.

5. ADASS supports this protocol nationally and regionally and strongly encourages its members to adopt it. We recognise that some activities will involve our members and others will involve staff who represent our members. Throughout the document, where we refer to Directors of Adult Social Services (DASSs) we mean directors or those representing them.

6. Where regular local information sharing meetings or other meetings or fora are held, these will provide an inclusive environment for all to contribute, and to offer constructive challenge to one another. Meetings should be action-orientated so that all those involved have clarity on the agreed actions and on who will have responsibility to take tasks forward.

7. The roles and responsibilities of CQC and councils are set out at Annex A to this joint working protocol.

8. This joint working protocol is to support work between CQC and DASSs and is not intended to be legally enforceable. However, CQC, ADASS and its members are committed to working in ways that are consistent with the content of this document. It will be reviewed by September 2021.

The approach of CQC and ADASS to joint working

9. Joint working will require CQC and DASSs or their representatives to exchange information. CQC and ADASS acknowledge and agree that, ultimately, any decision to share information must be compliant with data protection requirements: principles, codes of practice, guidance and information sharing agreements. In recognition of the principles of Quality Matters, CQC and DASSs should work towards reducing duplication and burden on providers wherever possible.

10. It is recommended that information held by both CQC and councils regarding the quality of services delivered by regulated providers is regularly shared where appropriate to do so. These providers could include statutory agencies such as the council or health providers. Particular attention should be paid to those rated by CQC as *Inadequate* and those that are repeatedly rated as *Requires Improvement,* to look at how we can support them to improve or to exit the market. Information should also be shared about any other locations of concern identified by the council. This information sharing can be done through regular local information sharing meetings (see Annex B for a recommended operational protocol for such meetings), which may include joint meetings with neighbouring DASSs or health commissioners.

11. In addition, between regular meetings and as and when required, it is recommended that CQC and DASSs involve each other as soon as possible if either become aware of any safeguarding issues related to regulated services, in line with local safeguarding arrangements, and that they also share safeguarding concerns regarding unregistered providers or unregulated services, if they become aware of any. When necessary, CQC and DASSs should communicate quality and safeguarding issues to the relevant Quality Surveillance Group (QSG). This includes where either party has relevant information about safeguarding issues in any regulated health service, not just in adult social care services commissioned by health. The roles and responsibilities of key agencies involved in adult safeguarding are set out in this joint statement[1].

12. CQC and DASSs should share intelligence to identify any emerging issues, patterns and themes within a local area to drive improvements in the quality of care and to stimulate market development. This should include identifying any emerging innovative practice and the development of new models of care.

13. CQC and DASSs should identify and share learning, including examples of best practice to encourage improvement and market development, ensuring

[1] This document may be reviewed and updated later in 2018/19

appropriate sharing throughout our organisations and with partners at local, regional and national level. Where we have concerns that best practice isn't being followed, we should ensure this information is also shared, particularly where national evidence-based policy, such as Transforming Care and Registering the Right Support, has not been followed.

14. To develop and sustain effective partnership working arrangements, CQC and DASSs should keep each other up to date with methodology developments, new guidance and changes to relevant personnel and local systems. DASSs should ensure that CQC have up-to-date contact details. DASSs should also notify the CQC local Head of Inspection of changes in DASS and the appropriate CQC representative will aim to meet them in their first three months in post.

15. Where concerns are raised about potential provider failure or possible unregistered providers, CQC and the relevant council(s) affected should work together to ensure a coordinated approach and agree an appropriate course of action. If this relates to the ceasing of a service (including the handing back of a contract, or enforced closure of a service), CQC and DASSs should coordinate activities in line with national guidance. For example, for care home closures we should work together in line with the managing care home closures guidance. If related to CQC's market oversight regulatory responsibilities then CQC will act in line with the published guidance. CQC is required to monitor the financial health of the most difficult to replace adult social care providers and provide a notification to impacted councils when CQC determines that service cessation is likely to occur as a result of business failure. In such cases, DASSs may find Contingency planning tips for the business failure of a major social care provider useful. Where business failure affects a number of neighbouring councils, Provider failure and emergency incidents - A checklist for regional response provides support for coordinating responses across council boundaries. In the case of home care, DASSs may also find Top Tips for Sustaining Homecare helpful, to support working with providers to prevent business failure. Where registered services are run by a council, both commissioners and providers will need to work with CQC in their respective roles. DASSs should ensure a satisfactory separation of interest between commissioners and in-house provider management.

16. DASSs should ensure they share relevant information about serious concerns and/or potential provider failure with other commissioners (social care and continuing health care), including both those in and outside their area. CQC has formal powers under Sections 62 and 64 of the Health and Social care Act 2008 to obtain any information from registered organisations, English NHS bodies and local authorities, which can override a refusal to share information. Where a provider has a number of locations across different geographical areas, CQC will ensure relevant inspection teams are updated about such concerns. This will include, where appropriate, sharing information and intelligence across primary medical services and hospital inspection teams.

17. At times, CQC, ADASS and DASSs may identify serious incidents, issues or patterns that are impacting on social care at a local, regional or even national level, where sharing information with wider stakeholders will be relevant and

important. For example, some services are commissioned at a regional level on behalf of a number of councils or Clinical Commissioning Groups (CCGs) and, where concerns are raised about a service, it may be necessary to alert commissioners across a wide geographic patch. It is recognised that the safety of the working environment and how the workforce is treated are integral to the quality of care provided, and may require the involvement of, and input from, a wider range of agencies outside of social care.

18. CQC and ADASS also commit to strategic collaboration. This includes longer-term, higher-level activity, such as national concerns, thematic reviews, and media and communications work. This will primarily be managed through the regular senior meetings (both national and regional), to which both organisations have agreed to provide a regular update on strategy, policy and communications.

19. ADASS senior representatives and CQC's chief inspectors also meet on a regular basis to ensure each organisation is aware of emerging issues and to raise any concerns.

Press and publications

20. CQC and DASSs should endeavour to give each other adequate warning of, and sufficient information about, any planned public announcements on issues relevant to the other organisation. It is acknowledged that this may be challenging in some circumstances, such as where urgent enforcement action is required.

21. Each organisation should involve the other as early as possible in the development of planned announcements, including through sharing drafts of proposals and publications that affect both organisations. CQC and DASSs should respect the confidentiality of any documents shared in advance and ensure that the content of those documents is not made public ahead of the planned publication date.

Resolution of disagreement

22. Where there is a disagreement between CQC and a council, this should be resolved in the first instance at the local working level through the relevant Head of Inspection/Head of Registration and Director of Adult Social Services. If necessary, the issue may be escalated to the relevant Deputy Chief Inspector and Council Chief Executive.

1 February 2019 **22 January 2019**

Annex A – responsibilities and functions

Care Quality Commission

23. CQC is the independent regulator for health and adult social care in England. Its purpose is to make sure health and care services provide people with safe, effective, compassionate, high quality care and to encourage them to improve.

24. CQC does this by registering, monitoring, inspecting and regulating hospitals, adult social care services, dental and general practices and other care services in England, to make sure they meet fundamental standards of quality and safety. We set out what good and outstanding care looks like and we make sure services meet these standards below which care must never fall.

25. CQC reports publicly on what it finds locally, including performance ratings for care providers, to help people choose care and encourage providers to improve. It also reports annually to Parliament on the overall state of health and adult social care in England.

Councils with adult social services responsibilities

26. Councils have the responsibility to:

- Promote the wellbeing of citizens in the area for whom it exercises its functions under the Care Act 2014.
- Prevent care and support needs.
- Promote integration of care and support with health services.
- Provide information and advice to those who may need social care services.
- Assess the needs of people with care and support needs and carers in the Council area.
- Plan and commission adult social care services that are appropriately registered, where required, by CQC, that can meet the needs of all within their area who have eligible care and support needs or support needs as carers. This includes people with a wide range of needs, including those who are entitled to public funding and those who are self-funding, carers, people from ethnic minority backgrounds and people living in rural communities. Councils should consider regulatory guidance, including registration guidance where the national service model is agreed, for example, Registering the Right Support.
- Organise procurement, commissioning and contract monitoring arrangements with providers in line with the Department of Health guidance on effective commissioning for outcomes.
- Monitor services they commission from another agency (whether that agency is in the public, private, voluntary or community sector) to ensure effective, efficient and safe services are delivered.
- Require improvements in outputs and outcomes to be delivered as necessary and as specified in contracts with adult social care providers.
- Provide adult social care services for adults with care and support needs

in prisons in the council area.

- Provide monitoring and improvement information to adult social care providers.
- Respond to provider failure in the council area, including providing alternative services, if required, for those with care and support needs, in some cases on behalf of other commissioners.
- Make safeguarding enquiries or cause them to be made (S 42 enquiries), for any adult in the council's area who has care and support needs, is at risk of abuse or neglect and because of their care and support needs is unable to protect themselves from that risk.
- Cooperate with other organisations to meet the needs of people with care and support needs or to safeguard those who are at risk of abuse or neglect, sharing information as required for this purpose.
- Consult with CQC for advice.

Annex B – Recommended Operational protocol for meetings

27. We will have open and transparent dealings with each other, at a local, regional and national level. This will include routinely sharing information about the standard of care and support provided by regulated providers, with the aim of improving the quality of regulated services.

Local information sharing meetings

28. Regular local information sharing meetings will provide an inclusive environment for all to contribute, and to offer constructive challenge to one another. Meetings will be action-orientated so that all those involved have clarity on the agreed actions and who will have responsibility to take tasks forward.

29. As a minimum, it is expected that routine meetings should be held on a two-monthly basis. They will be chaired by each organisation on a rolling basis, to change six monthly. Meetings will be minuted by the organisation that is acting as chair. Clear action points will be noted to ensure each agency is clear on their responsibilities.

30. CQC and the council will consider which relevant representatives of other agencies should routinely be invited or involved as necessary. Consideration should be given to inviting the following:
    - local Healthwatch
    - Fire Service
    - Police Service
    - Skills for Care
    - NICE
    - Clinical Commissioning Groups (CCG), especially those involved in commissioning adult social care services, such as Continuing Healthcare commissioners
    - Safeguarding leads
    - Health and Safety Executive, and council environmental health services (who share responsibility for health and safety enforcement in care homes)
    - other council services including children’s services, housing, public health, environmental health, etc as deemed necessary
    - other NHS bodies (e.g. regional NHS England) as deemed necessary

31. Local Healthwatch should routinely be invited to share intelligence gathered from their “enter and view” functions.

32. Issues for discussion at each meeting will be identified and shared in advance through completion of an agreed template. The decisions regarding what to share will follow each organisations information sharing guidance. Each organisation to send a copy of the completed template to colleagues in other organisations two days before each information sharing meeting.

33. Regular topics will include:
    - Profile of risks in regulated services, especially those services rated by CQC as inadequate or requires improvement
    - Analysis of risk factors in services where there is the highest level of risks
    - Any local approaches intended to improve the general quality of care
    - Sharing learning and examples from areas where improvements in quality have been made and sustained
    - Local market shaping and any developments of new models of care
    - Discuss if coordinated activities among CQC, the council and any other relevant agencies are in line with the principles of Quality Matters, with regards to reducing unnecessary duplication and burden on providers, and that the local system is working together in partnership and cooperation as far as possible.

34. Information shared may include where appropriate:
    - From CQC:
        - Inspection and Review reports (published) and information from regulatory work
        - Current quality rating judgement (shared with provider)
        - Other non-statutory notifications and concerns received where appropriate to do so.
        - Concerns regarding financial viability of a provider (within the meaning of Regulation 13 of the *Care Quality Commission (Registration) Regulations 2009*, but not within the context of CQC's Market Oversight duties which arise under the provisions of the *Care Act 2014*).
        - Local area profiles (which can be accessed and shared on a monthly basis)
        - Skills for Care National Minimum Data Set for Social Care (NMDS-SC)
    - From Local Authorities who are commissioners of adult social care services:
        - Monitoring reports (shared with provider)
        - Number of complaints and analysis of outcomes
        - Number of Safeguarding Adults referrals and analysis of outcomes
        - Concerns regarding business and commercial operations of provider
        - Information gathered from social workers and care managers in the course of assessing and reviewing the needs of people who use regulated services, or undertaking safeguarding enquiries.
    - From Clinical Commissioning Groups (CCG's), who are commissioners of health services we would discuss including:
        - Monitoring reports (shared with provider)
        - Number of complaints and analysis of outcomes
        - Information gathered from independent contractor input to regulated services (including GPs)

- Information gathered as a result of community nursing or other allied health care input into regulated services
- Information about the use of Accident and Emergency services and admissions to the acute sector from care services.
- Information arising from the commissioning of continuing health care.

35. In addition to routine local information sharing meetings, we will, as necessary, also:
    - Inform each other as soon as reasonably possible of any matters that have come to our attention that may require action or a response from the other, for example a safeguarding concern.
    - Inform each other about any action being taken in relation to registered providers that may be relevant to the functions of the other; this will include notification in advance when appropriate to do so and where permitted by the relevant legislation.
    - Inform each other about changes in personnel and provide up-to-date contact details.

36. We will keep each other fully informed about developments in our approaches and methodologies. This will include, but is not limited to, developments in:
    - CQC's assessment framework, regulatory requirements and ratings
    - The council's commissioning and monitoring frameworks, tendering documentation and premium payments for quality services
    - Review methodology
    - Sharing press releases, with as much notice as possible
    - Individual reviews, including any ratings.
    - Ongoing developments within the care and health sector.

37. We will work in partnership to promote improvement in the quality of services provided, including cascading information and other guidance that may be issued regarding best practice.

38. At times CQC, ADASS and/or councils may identify issues that are impacting nationally, regionally or locally on practices in the social care market, and this will be shared wherever appropriate and useful.

Regional Meetings

39. Regional meetings will focus on the wider health and care system to share intelligence about risks to quality. They will also focus on developing partnership working across the system and influence improved working practices across the system. CQC will meet with regional branches of ADASS at least every six months, to cover the following key areas for discussion:

    - Strategic commissioning and market shaping
    - Updates from CQC's registration function
    - High level provider risks – provider and / or geographical area, also consider other sector risks and impact on ASC and liaison with relevant

Quality Surveillance Groups
- Regional risks, for example, Workforce, cross-boundary work
- Focus on quality issues.
- Regional safeguarding themes
- Regional lessons learnt and promotion of best practice and regional ADASS priorities
- Review of partnership working across the system
- Plans for annual CQC / ADASS regional event
- Escalation of risk from local meetings that may have a wider impact

These meetings will be evaluated when this joint working protocol is reviewed